HOME HEALTH CARE FRAUD AND ABUSE

MF-1

HEARINGS

BEFORE THE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

FIRST SESSION

MARCH 13 AND 14, 1981

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HOME HEALTH CARE FRAUD AND ABUSE

WEDNESDAY, MAY 13, 1981

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
OF THE COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, D.C.

The subcommittee met at 9:30 a.m., pursuant to notice, in room 3302, Dirksen Senate Office Building, under authority of Senate Resolution 361, dated March 5, 1980, Hon. William V. Roth, Jr. (chairman of the subcommittee) presiding.

Members of the subcommittee present: Senator William V. Roth, Jr., Republican, of Delaware; Senator Charles H. Percy, Republican, of Illinois; Senator William S. Cohen, Republican, of Maine; and Senator Sam Nunn, Democrat, of Georgia.

Members of the subcommittee staff present: S. Cass Weiland, chief counsel; Michael Eberhardt, deputy chief counsel; Kathy Bidden, chief clerk; Marty Steinberg, chief counsel to the minority; Howard Shapiro, Greg Baldwin, Howard Cox and Carolyn Herman, staff counsels; Tim Jenkins and Karen Hainer, investigators; Sarah Presgrave, executive assistant to the chief counsel.

Also present: Representative Claude Pepper, Democrat, of Florida.

Chairman ROTH. The committee will be in order.

[The letter of authority follows:]

U.S. SENATE,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
Washington, D.C.

Pursuant to rule 5 of the Rules of Procedure of the Senate Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, permission is hereby granted for the chairman, or any member of the subcommittee as designated by the chairman, to conduct open and/or executive hearings without a quorum of two members for the administration of oaths and taking testimony in connection with hearings on Fraud and Abuse involving Home Health Care Operators on Wednesday, May 13, 1981, and Thursday, May 14, 1981.

WILLIAM V. ROTH, JR.,
Chairman.
SAM NUNN,
Ranking Minority Member.

OPENING STATEMENT OF SENATOR ROTH

Chairman ROTH. This morning the Senate Permanent Subcommittee on Investigations will commence a 2-day hearing into possible fraud and abuse in the home health care program which is administered by the Department of Health and Human Services.

Let me emphasize from the outset that this hearing is not designed to condemn the concept of home health care. Rather, it is the intent of this subcommittee to examine the methods and means by which unscrupulous operators of home health care agencies seek to undermine, abuse, and unlawfully profit from the operation of these agencies, which provide a very vital health service, particularly to the Nation's elderly.

It is particularly appropriate that we conduct this hearing at the present time since legislation has already been introduced earlier this year which, if passed, would provide more Federal support for home health care services.

Equally important, it is significant to note that home health care, as an alternative to more costly nursing home care, is still in its early stages of development as a health care system.

Certainly the Federal Government should have learned from the rampant abuse in nursing home operations during the 1970's that it is essential that antiabuse controls be implemented now within the home health care system to avoid the costly waste of taxpayer dollars in the future.

As a federally funded program, home health care has already evolved in its early years of development to the point where its financing requires over $1 billion per year. Under this program, a home health agency can be operated by a public agency, a proprietary agency or a tax exempt, nonprofit private agency.

It is with respect to some of these tax exempt, nonprofit agencies that serious questions have arisen as to the reasonableness of the costs claimed by such agencies. Indeed, similar congressional hearings in 1976 and 1977 highlighted abuses in home health agency costs which led to Federal criminal convictions.

The specific focus of this hearing will be on the investigative work performed by the subcommittee staff and the Better Government Association concerning several home health agencies in Illinois, California, and Mississippi.

Our interest in fraud and abuse in the home health care program is grounded in the jurisdiction of the subcommittee under Senate Resolution 57 of the present Congress. This resolution clearly authorizes the subcommittee to investigate "the possible existence of fraud, corruption, waste, and the improper expenditure of government funds."

[At this point, Representative Pepper entered the hearing room.]

Chairman ROTH. The central evidentiary theme which will be developed in these hearings involves the various mechanisms by which one individual or a small organization can control all aspects of the delivery of home health care services through a tax exempt, nonprofit agency while reaping profits involving hundreds of thousands of dollars.

These hearings will reveal how certain characteristics of the home health care program have not only provided the opportunity for this unconscionable profiteering in the past, but also insure that unscrupulous entrepreneurs will continue to abuse this worthwhile program in the absence of greater internal controls.

Over the past several years, this type of abuse has cumulatively cost the American taxpayer millions of dollars and in the process

seriously undermined the tax-exempt status accorded to many legitimate charitable organizations.

[At this point, Senator Cohen entered the hearing room.]

Chairman ROTH. In addition to presenting a summary of the evidence developed indicating abuse in certain supposed nonprofit home health agencies, the subcommittee will also call upon various organizations familiar with the home health care industry to elicit their specific recommendations for legislative change.

These organizations will include: the General Accounting Office, the Better Government Association, the Health Care Finance Administration of HHS, the National Association of Home Health Agencies, and the American Federation of Home Health Agencies.

Through these organizations, we hope to acquire the appropriate insight into the means, legislative and otherwise, which can be implemented to effectively deal with home health care abuse.

At this time, I would particularly like to welcome my good friend and colleague who has served on both sides of the Congress, Representative Claude Pepper. It is certainly a pleasure to have you here today.

I now call on Senator Cohen.

Senator COHEN. Thank you, Mr. Chairman. I have an opening statement I would like to submit for the record and offer a couple of observations.

[The statement follows:]

OPENING STATEMENT OF SENATOR WILLIAM S. COHEN

Mr. Chairman, I want to commend you for initiating these hearings on fraud and abuse in home health care services.

The next 4 years will reveal a great deal about our capacity as a nation to devise solutions to successfully cope with problems in our system of health care. When home health care is part of the solution, that solution must involve—in a cooperative effort—aging individuals, the infirm, their families, home health care providers and insurers, and the various forms of governmental assistance. Each will participate in home health care responsibilities and thereby will help to provide a proper and shared balance to those responsibilities. At the same time, the solution must "surgically strike" against fraud and abuse in these programs. That, of course, is why we are here today.

I hold a conviction that home health care, as opposed to institutional care, is generally, a more humane and desirable long-term setting for a recipient—especially an elderly person—and can be a less costly alternative for a significant portion of our institutionalized population.

Furthermore, home health care generally improves a patient's quality of life without diminishing the quality of care provided. In addition, it aids and abets the ultimate goal of a patient, which is that he or she might function independently to the greatest degree possible.

I believe in these principles. Accordingly, I was pleased to have joined my colleague and friend, Senator Packwood, last June, in cosponsoring S. 2809, which would further these principles.

However, all of these sound principles and good intentions are corroded and soured when the programs which implement them are tainted by fraud and abuse.

Home health care is crucial to the 14,000 people who participated in it in fiscal year 1980 in the State of Maine. Home health care is equally crucial to the 1½ million citizens who participated in it in fiscal year 1980 nationwide. The fraud and abuse perpetrated on those individuals—and on those entities which provide support to them—is a travesty perpetrated on persons and programs which can least afford to be the victims. Again, that is why we are here today.

Today's testimony will include a scenario of how such fraud and abuse can happen, where the soft points of vulnerability might lie, and who the accomplices

of such acts might be. Tomorrow, as we continue, we will focus on specific actions to translate our concerns about fraud and abuse into measures aimed at their prevention.

Again, I look forward to hearing from today's witnesses, and I congratulate the chairman for initiating this timely and valuable investigation.

Senator COHEN. I, too, would like to welcome my former colleague from the House, Chairman Pepper. I can say there has been no more vigorous advocate for the rights of the elderly than Claude Pepper. It was my pleasure to have the opportunity and privilege to share 4 years in the House with him on the Committee on Aging.

I know he has a particular interest in this particular subject matter since he and I worked to develop some amendments to H.R. 3, which dealt with the antifraud and abuse amendments to the Medicare-Medicaid Act. We are particularly concerned about home health care and I think we share the view that home health care is a more human and more desirable form of long-term care for the people of this country.

It is not designed to in any way replace or displace the institutionalized facilities that we have—nursing homes—but rather should be seen as a complement to nursing home.

The fact is, we have had studies that reveal between 14 and 25 percent of the people who are currently in nursing homes do not need that level of care, but they have no alternative. And home health care is one of the alternatives to people to allow them to remain in their homes where they prefer to remain and have a moderate amount, certainly, of help with medical personnel, nurses, nurses' aides, and paramedics. Home health care allows people to stay in their own homes and live out those final years with a good bit more dignity than to be put off into an institution.

Nevertheless, there is evidence of fraud and abuse in this system. It could threaten to undermine the movement to award greater Federal concentration on home health care as a complement to and not a substitution for nursing home care.

So I think these hearings are particularly, timely, Mr. Chairman. I want to commend you for holding these hearings to try and deal with this problem of fraud and abuse now and not after the horse has left the barn, as we had in the fraud in the medicare and medicaid systems.

I would hope that the evidence of abuse in this particular situation would not undermine the rather serious and significant commitment that has been made and is being made by others in the Congress. Senator Packwood has introduced a bill, which I have cosponsored, to move toward a more comprehensive and long-term health care system.

Chairman ROTH. I would say to Senator Cohen, that as I indicated in my opening statement, the purpose of these hearings is not to undermine in any way home health care services. It seems to me that this is a very important and cost-effective means of insuring that our senior citizens receive the kind of care to which we all believe they are entitled. What we are directing our interest to is how to establish controls and procedures that will insure that there is no abuse of the programs.

That is certainly the intent of the subcommittee.

Representative Pepper, again, we are delighted to have you with us. We will be very happy to have any comments you care to make.

Mr. PEPPER. Thank you very much, Mr. Chairman.

[At this point, Senator Nunn entered the hearing room.]

Mr. PEPPER. First, let me thank you for your kind welcome and generous words of introduction. It is a great pleasure for me to be here with you and do what I can to help you in trying to establish and preserve the integrity of the home health care system. That is what we are working for.

I am especially pleased to see my old colleague and friend here, Senator Cohen. We regretted very much to see him leave our Aging Committee in the House. He was lending great service there.

My unhappiness has been assuaged by the way in which he has continued to carry on his work here.

I would express my appreciation to you especially, Mr. Chairman, for the privilege of identifying myself with you in this commendable effort that you are making. I am grateful for an opportunity to participate, however, but I do so with mixed feelings because I believe that home health care is so important that we want to make it clear that we are trying to provide the basis for more home health care rather than less.

This phenomenon of widespread fraud and abuse in medicare is not new. Several committees in both the House and Senate have held numerous hearings over the past 10 years, including our Aging Committee in the House.

Moreover, the Congress has enacted several reform measures. What these hearings today suggest is that these reforms so far have not met the aims that they intended to achieve. Last year, the FBI testified before our Aging Committee, saying in part, "Corruption has permeated virtually every part of the medicare-medicaid health care industry. The methods to perpetrate fraud are virtually unlimited."

I was impressed with the work that the FBI is doing and I asked them how many of their 800 cases were referred to them by the Inspector General of the Department of Health and Human Services. I received the answer a few months ago. It was zero.

I wrote to the Internal Revenue Service asking how many cases were referred to them for tax fraud by the Inspector General. The answer again was zero. I sent a questionnaire to 3,000 physicians across the Nation, asking if the Inspector General's office had made any difference. Only 12 percent said the office had a positive effect in terms of reducing fraud and abuse.

This says to me that the major reform that the Congress enacted to fight fraud, the creation of the Inspector General's office is not working very well.

I am also concerned by the proposed audit cutback, even though audits generated $5 in recoveries for every $1 in auditor's salaries.

The administration is proposing reducing funds for audits by 67 percent. I think this is myopia of the first magnitude and I hope this decision will be reviewed by the administration.

I understand there is legislation pending which will subsidize the creation of more proprietary home health agencies. If the testimony from today's hearings proves anything, I believe that it is an agency

which can be funded with less than $3,000, therefore, there is no need to further subsidize the creation of any type of agencies.

Let me close with a few specific comments about the case here today. I conducted or participated in most of the hearings on home health care fraud. The problems we have been having do not relate to public agencies or church-related or hospital-affiliated, nonprofit agencies, but fraud has been perpetrated by agencies which are extensive nonprofit but subcontract with for-profit agencies, the for-profit firms then siphon off the medicare funds.

We have experienced even more problems with for-profit home health agencies. For this reason, I raised my voice in protest last year when the Congress chose to remove the restriction on for-profit home health agencies participating in medicare.

I think we are in for more problems as I said last fall. I think this hearing shows the need for tighter controls on these kinds of agencies for more accountability. I also think we need to look at a different means of reimbursing home health agencies than the reasonable cost formula by which virtually anything which is spent is reimbursed with profit. The operation of this formula in health care would make the greediest of defense contractors, I am afraid, drool with envy.

I look forward, Mr. Chairman, to the witnesses today.

Chairman ROTH. Thank you, Claude. Again, it is very nice to have you here. Senator Nunn?

Senator NUNN. Mr. Chairman, I would like to put a complete statement in the record.

[The statement follows:]

OPENING STATEMENT OF SENATOR SAM NUNN

Mr. Chairman, I want to compliment you and the new majority staff for initiating this investigation of fraud and abuse in the Federal home health care program.

Although there is no precise estimate on how much the Government loses each year to fraud and abuse, it is clear that we have a tremendous problem on our hands throughout the Federal establishment.

The General Accounting Office, in its recent report on fraud in the Government, estimated that the taxpayers lost somewhere between $150 million and $220 million to fraud and abuse between October 1976 and March 1979—and that estimate was based only on fraud cases actually uncovered, and does not even include the cost of fraud in the area of medical care.

This investigation of the billion-dollars-a-year home health care program is thus quite timely, and it carries on this subcommittee's long tradition of examining fraud, waste, abuse, and mismanagement in Federal programs. Our bipartisan efforts have saved untold millions of dollars over the years. They also have resulted in legislation to close a number of loopholes that have contributed to fraud against the Government.

One example of our past investigations was the Guaranteed Student Loan Program case in 1975. We were the first to examine the widespread abuses in that program, and we uncovered problems that were costing the Government some $1 billion in defaulted loans.

Fraud and abuse in health care programs was a special focus of the Subcommittee when I was Acting Chairman in 1976 and Vice Chairman in 1977 and 1978. We uncovered serious problems in the military's CHAMPUS program, in the prepaid health plans, and in the medicaid management information system. We also took a hard look at the internal efforts of the Department of Health, Education, and Welfare to control fraud and abuse in its programs.

I am pleased to extend my full support, Mr. Chairman, to your continuation of these important efforts. All of us on the minority side will cooperate with you in rooting out fraud and abuse wherever it can be found.

Every dollar we can save through the elimination of fraud, abuse and waste is one less dollar the Government will not have to borrow in order to pay its bill.

Senator NUNN. I regret I was a little bit late. I regret I will have to leave and come back. I have a meeting I have to go to. I am privileged to be here with Congressman Pepper, who has been an expert over the years in those areas seeing that the peoples needs are met and also fighting fraud and abuse.

Mr. Chairman, I would like to congratulate you and the majority staff in putting this hearing together. We have followed it closely. We have tried to cooperate from our end. We will continue to do so. I think the mission you are undertaking in fraud and abuse in government is enormously important.

You will get complete bipartisan support from this side, I am sure.

I have had a lot of experience in investigating fraud. It is like throwing a dart at the dartboard, you can go out in government programs and find it. We had comprehensive investigations in the student loan program 2 or 3 years ago. We got into all sorts of problems there. We have a lot of recommendations. We also had an investigation in the so-called MMIS program, Medicaid Management Information System.

That program was designed to curb fraud and abuse, and we found a lot of fraud and abuse in the program itself.

So there is no end to it, but I think it is an enormously important task we have, and I think one of the things we really need to bear down on is oversight. So I congratulate you and look forward to participating in these hearings.

Senator ROTH. At this point I would like to enter for the record the opening statement of Senator Lawton Chiles.

[The statement follows:]

OPENING STATEMENT OF SENATOR LAWTON CHILES

Home health care is a tremendously important service for thousands of elderly and disabled Americans. It is preferred to hospital and nursing home care by virtually all who receive it. And numerous experimental programs have shown that, properly administered and controlled, home health can save taxpayers significant amounts of money.

The key phrase is "properly administered and controlled." Allegations of fraud and abuse of the medicare home health program abound. We will hear testimony today echoing testimony taken by other committees in 1975—in 1976—in 1977—and in 1979.

I have discussed these problems over and over again with medicare officials, with the Inspector General, with Federal prosecutors, and with home health care providers who are understandably very concerned about allegations of unethical conduct by their peers.

What can we do?

There are many tools now in the law which can be used to effectively investigate those who are clearly abusing the medicare program. Some of these laws have been in effect since 1977, and I know they can work because prosecution has resulted in prison sentences for some operators.

During hearings I held in Florida in 1979 it was brought to my attention that the law did not allow close examination of the books and records of agencies which receive medicare funds for services provided by contract to home health agencies. We'll hear testimony on some of those contracted services today—such as legal and accounting services, and supplying home health aides and therapists.

The law was changed last year as part of Public Law 96-499, and investigators now have access to those records.

We also changed the law last year to give the Department of Health and Human Services authority to require bonding and escrow accounts for some home health agencies which receive all of their revenue from the medicare program. If a home health agency has overcharged the medicare program—but then goes out of business before repayment can be made—the money could still be recovered.

I will be interested to hear what the witnesses from the Department will have to say about implementing these new laws during tomorrow's testimony.

I introduced legislation during the last session of Congress to authorize heavy fines for a fraudulent claim for medicare reimbursement. It appears that this "civil penalties" bill is going to be passed by this Congress and that will help too. If we hit abusers in the pocketbook and do it quickly, I think a lot of abuses will be cleared up.

Many of those who investigate medicare fraud or who are involved with the home health industry will argue that we have adequate tools to investigate and prosecute fraud, and recover medicare funds which have been improperly spent.

I am not sure, however, that these laws are being adequately used. Some witnesses before this subcommittee will, no doubt, argue that there will never be enough resources available to make health care fraud a high priority for Federal and State prosecutors.

I don't think we can accept that premise. As long as unscrupulous medicare providers feel that they can operate without fear of action against them we will continue to have problems.

Some blame the medicare principles of cost-related reimbursement for providing wide-open incentives for abuse of the program. I agree. If we can come up with an alternative way of reimbursing home health providers which is fair and does not simply create new avenues for abuse, I will support it. I hope these hearings will provide us with some new ideas.

Chairman ROTH. Sam, I thank you for your kind words of cooperation. I think the issues which we are involved in on this subcommittee are of a bipartisan nature. We are all against the fraud, waste, and abuse which infects Federal programs.

We look forward to working with you and the minority staff.

[At this point Senator Nunn withdrew from the hearing room.]

Chairman ROTH. In order to begin the presentation of the evidence of abuse in the home health care program, I would like to call upon Mr. Charles Morley, who is the chief investigator for the subcommittee. Mr. Morley will summarize briefly how this program works and relate what its fundamental objectives are.

As many of you in attendance today may be aware, NBC News, in conjunction with the Better Government Association has recently aired a segment on home health care which deals generally with evidence of home health care abuse that has been examined by the subcommittee staff. However, before we review that evidence and the work of the subcommittee, I think we should all understand something about home health care as a federally funded program. For that reason, I am calling upon Mr. Morley.

Mr. Morley, under our rules we would like to swear you in. Do you swear the testimony you are about to give before this subcommittee will be the truth, the whole truth and nothing but the truth, so help you God?

Mr. MORLEY. I do.

Chairman ROTH. Please proceed.

TESTIMONY OF CHARLES MORLEY, CHIEF INVESTIGATOR, PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Mr. MORLEY. Thank you, Mr. Chairman.

I would like to briefly summarize the home health agency operations, particularly under the medicare reimbursement system, which is what we are going to focus on in these hearings today.

Home health was funded by medicare under title XVIII of the Social Security Act of 1965. Medicaid also funded home health agency operations in the same year under title XIX. Until 1977, the medicare system of home health was administered by the Social Security Administration. Since 1977, it has been administered by the Health Care Financing Administration, which is referred to as HCFA.

Home health can be licensed or otherwise legally sanctioned by the State and by the Federal Government. It can be either a public agency or private agency. It can be tax exempt or, in some States, it can be a for-profit operation.

Services provided by home health agencies consist of skilled nursing care; physical, speech or occupational therapy; medical social services; medical supplies and equipment, such as beds and wheelchairs; and the home health aid services, which generally attend to the personal medical needs of the individuals.

The home health agencies' policies are set by a group of individuals, one of whom must be a physician and one of whom must be a registered nurse.

As I mentioned, the home health agencies must meet all applicable State and Federal requirements. They must be certified by State health departments and by the Health Care Financing Administration.

To qualify for home health services, an individual must need skilled nursing care or other medically related services on an intermittent basis, which can be provided at their place of residence. The patient is given this service under a plan of treatment by the patient's treating physician.

Generally, the patient locates a home health agency, either through the physician or the physician's staff, or home health agency employees who occasionally function within hospitals in order to route the patients to appropriate home health agencies.

As of January 1, 1979, which is the last period for which we have information, 837,000 people had participated in the home health program under medicare.

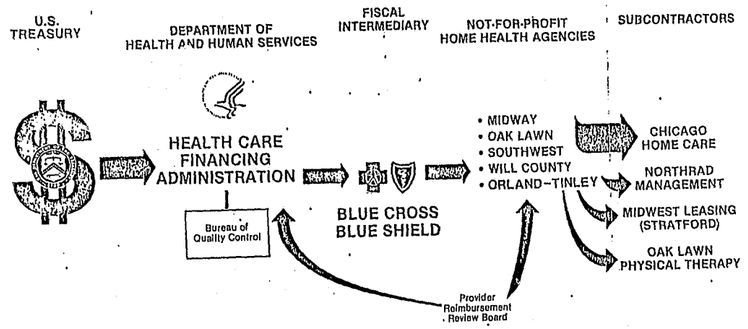
A home health agency basically operates in the following manner. Visits to the patients are supervised by a director of nursing, under a physician's plan of treatment. The agency must provide a part-time skilled nursing service at a minimum and also one of the other services previously mentioned. Public or tax-exempt agencies may contract all but one service out to a subcontractor. They must provide at least one service in-house. Proprietary agencies must provide all services through their own employees. They may not contract services out to subcontractors.

Visits to patients participating in the home health program are documented by billing forms which are sent by the home health agencies to what is known as an intermediary. An intermediary is a firm such as Blue Cross, Aetna Insurance, or similar large insurance companies.

If a home health agency were to subcontract out certain services they would, of course, pay the subcontractor. The subcontractor would bill the home health agency. Those bills also would go to the intermediary.

I would like to briefly discuss the reimbursement system which will be discussed at length later in these hearings. If you look over here at the large chart, you will see that money flows from the Treasury Department through the Health Care Financing Administration. This flow represents reimbursement money for home health care provided to patients through medicare. The Health Care Financing Administration then pays the intermediaries, Blue Cross/Blue Shield, as noted on the chart. For purposes of our hearing today, the chart shows the five home health agencies we are going to be discussing and several of the subcontractors we are going to be discussing.

[CHART 1]



The money flows from the intermediaries to the home health agencies themselves. In order for a home health agency to function, it has to receive funds on an intermittent basis.

A home health agency in its first year would be initially funded based upon cost projections by the agency and the intermediary. Funds would flow from the intermediary to the home health agency throughout the year.

At the end of the year, the home health agency presents a cost report to the intermediary. The cost report is audited by the intermediary which may or may not adjust the cost figures.

Medicare reimburses the home health agency for what are called reasonable costs. Reasonable costs include necessary and proper costs but they are otherwise rather vaguely defined. It is a fairly open ended definition.

The annual cost report submitted by the home health agency to the intermediary lists all the direct and indirect costs of the agency. It would also show the costs the agency paid to subcontractors.

To put the home health industry in some perspective, the total medicare billing for all services in 1979 was approximately $29 billion.

The total medicare billings for home health agencies in 1979 was $624 million. The total of all home health costs, medicare, medicaid, and otherwise, in 1979 was approximately $1 billion.

The home health industry is growing very rapidly and in fiscal 1981, it is projected that medicare alone will reimburse home health for $1 billion.

So you can see there is a tremendous growth from $624 million in 1979 to approximately $1 billion in 1981.

As I mentioned, home health agency cost reports are submitted at the end of the year and are then subjected to field audits which would be conducted by the intermediary at the location of the home health agency or to what is known as a desk audit. A home health agency in its first year will probably be subjected to a field audit, just to make sure the figures are fairly on point and to get a feel for the home health agency.

In subsequent years, it is more common that home health agencies would be audited by desk audit. A desk audit is done strictly on the cost report submitted by the home health agency and does not involve detailed analysis of the home health agency records.

Audits are fully appealable. If, for instance, an audit gave rise to disallowances of the home health agency's costs, the home health agency could appeal those disallowances to the intermediary. The black arrows on the chart indicate the appeal process in rough terms. Disallowances may be appealed to Blue Cross/Blue Shield, up to the Health Care Financing Administration and, once the administrative appeals are exhausted, to the Federal Court System.

In 1980, intermediaries conducted 1,149 audits of home health agencies. Those audits cost $3.3 million and as Congressman Pepper mentioned, they paid back or recovered $13.5 million. So there is quite a return on the cost of audits. According to our records in fiscal 1980, it is a 4-to-1 return on the audit cost.

Costs that have been disallowed by the audit process are to be repaid by the home health agency to the intermediary. They can be repaid in a lump sum, repaid over a period of time or they can be offset against the future reimbursement to the agency by the intermediary.

If a home health agency is financed 100 percent by medicare, their costs would theoretically have to be fully reimbursed or they wouldn't be able to continue in operation. A nonprofit agency by definition would probably not have a reserve of liquid assets from which to repay any disallowances. So if you have an agency that is fully funded by medicare with a significant number of its costs disallowed, to make that agency repay those costs could put that agency at the brink of bankruptcy or could force that agency into bankruptcy.

I think you will see in our testimony today that that has in fact happened to several of the home health agencies we are going to discuss.

One final point on fraud and abuse: If the intermediaries in the audit discover fraud or evidence of fraud, waste or abuse, they refer the case up through the Health Care Finance Administration to the Inspector General's Office of Health and Human Services. It is our information that from January 1977 to January 1981, 48 such referrals were made on the home health industry.

Chairman ROTH. In other words, if I might make one comment, there are several areas where there are what might be called loopholes. As I understand what you are saying, under the retroactive payments system, quarterly payments are made without any real audit. The audit comes at the end of the year.

Mr. MORLEY. That is correct, sir.

Chairman ROTH. So the home health agency would be paid on a quarterly basis as long as their request appears reasonable. Is that correct?

Mr. MORLEY. That is my understanding. Yes, sir.

Chairman ROTH. Second, nonprofit agencies have very little resources. If, at the end of the year, the intermediary asks for repayment of those payments found to be improper, there are no resources available to make that kind of repayment.

Mr. MORLEY. That is correct. There would be no resources available nor would there be the capability of that agency to generate those resources in the coming year as they are nonprofit. They don't build up a reserve of assets.

Chairman ROTH. Third, there is no audit made of the subcontractors under this process so that even if you have a nonprofit home health care agency the subcontractors may be profitable agencies or businesses, but they are not subject to audit.

Mr. MORLEY. In the years we are talking about in this investigation, 1977, 1978, 1979, subcontractors were not audited by the intermediaries.

Chairman ROTH. Has that been changed now?

Mr. MORLEY. Yes. I believe it was changed late last year.

Senator COHEN. Mr. Chairman, could I inquire?

Chairman ROTH. Yes.

Senator COHEN. As I look at this situation, there is an opportunity for a whole host of checks and balances against fraud and abuse. As I look at the chart and your testimony for example we have to have certification by State and Federal Governments or the home health agency. Is that not correct?

Mr. MORLEY. That is correct.

Senator COHEN. So we have a Federal opportunity to have checks and balances, and we have a State opportunity to check into the nature of the profit or not-for-profit subcontractor, even at that level.

Mr. MORLEY. That is correct.

Senator COHEN. You have the not-for-profit home health agencies which could run their own checks; couldn't they?

Mr. MORLEY. True.

Senator COHEN. You have the fiscal intermediary which could in fact run their own checks?

Mr. MORLEY. That is correct.

Senator COHEN. So what you have is an abdication really of responsibility all along the line. As I look at this chart, there are three or four different levels at which we could say if we tightened up and insisted upon strict conformity to regulations and standards, that you would have a greater capacity to eliminate this kind of fraud and abuse.

Mr. MORLEY. I would have to agree with you, particularly now that subcontractors can also be audited. There is ample opportunity given personnel and funds to do that.

Senator COHEN. Of course at the State level if they are going to start stereotyping home health agencies as far as their competence, and their ability to provide the service, I assume that they have to have some expertise as far as managing books and records.

Mr. MORLEY. I would certainly think so.

Senator COHEN. That would be part of it.

Mr. MORLEY. Yes.

Senator COHEN. I would assume also that, to the extent that a determination was made that a subcontractor was overcharging or engaging in fraud, or setting up dummy corporations and then inflating prices on goods and supplies, then that would be subject to local action for prosecution for defrauding the State certified agency?

[At this point, Senator Percy entered the hearing room.]

Mr. MORLEY. That is correct. If I may expand a little bit on that point, it is my understanding that if you have a situation where they find costs that are excessive and disallow the costs or if they feel reimbursements or payments to subcontractors are very large and inordinate, that the appeal mechanism in the auditing process itself takes an extensive period of time. For instance, the cost reports submitted by the home health agencies are submitted several months after the close of the year. It would then be probably a month or two or more before they are subjected to audit. Then it would be another period of time before those costs were disallowed. There would then be an appeal process which could take an extensive period of time.

I would asume this would be the case with the State audits also. So what you are looking at is an extended period of time from the time they actually file the cost reports to the time that one can finally say "your appeals are finished, you owe us the money." In the interim, during all of that time, they are normally continuing to be reimbursed because they are continuing to operate. So I think that kind of compounds the problem. Again that is from my observation.

Chairman ROTH. Thank you, Senator Cohen.

Thank you for your testimony.

At this time I would like to call upon Terrence Brunner, executive director, Better Government Association. Mr. Brunner, I am pleased to welcome you here as our first witness to begin the presentation of the evidence of abuse in the home health care program. As I indicated to you, all witnesses under our rules must be sworn. So would you please rise?

Do you swear the testimony you are about to give before this committee will be the truth, the whole truth and nothing but the truth, so help you God?

Mr. BRUNNER. I do, Senator.

Chairman ROTH. Thank you, please be seated.

At this time, I would like to call upon my colleague from Illinois to make any statement that he deems desirable at this time. He is, of course, a fellow citizen of Illinois so that I know that he is specifically glad to welcome you here today.

Senator Percy.

Senator PERCY. Thank you very much, Mr. Chairman.

My role is two, not only as a friend and great admirer of Terry Brunner and Better Government Association, but years ago, I raised the initial funds that began the investigative operation of BGA and they have performed an invaluable service since then and now to become a national organization. Their pioneering work in Chicago put checks and balances back in Cook County government, where we live. We have had one-party government for so long in the county.

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Claude Pepper, we certainly welcome you very warmly and commend you on your outstanding work. I know that you are aware that both Senator Cohen and I have served on the Select Senate Committee on Aging, counter-committee to your outstanding committee in the House. I would like to point out to the committee that one of the first investigations into abuses of the home health care program was conducted by the Senate Special Committee on Aging in 1977. It was a California home health care agency in which the owner siphoned Federal funds for her own use, such as purchasing a luxury automobile, jewelry, and so forth. As a result of the investigation, the owner was charged with defrauding Federal Government, pleaded no contest, was fined $10,000.

While improvements have been made since 1977, it is clear that abuse still exists and we recommend that the Special Committee on Aging and the Permanent Subcommittee on Investigations coordinate their efforts to end abuse in this area. Mr. Chairman, I want to commend you for directing the Permanent Subcommittee on Investigations into this area which has so disheartened our senior citizens.

This hearing is a good example of how fraud comes about in Federal Government. Here is an important program designed to provide Federal home nursing care to the disabled so they can live with dignity and with their families instead of being warehoused in institutions. Quite rightly, the Federal Government has agreed to pay for the cost of home nursing visits at a cost of $624 million in fiscal year 1979; almost 837,000 medicare beneficiaries took advantage of this service during that period. Yet despite the overwhelming majority of providers being honest, some clever schemers have apparently nursed this program for their own personal gain. Through a scheme that will be explained in detail later, they used medicare funds to invest in a Cayman Islands company which they allegedly used these funds to allegedly explore for Costa Rican oil.

It appears that they also used these funds to pay for credit card use for their own personal business in order to pay for lavish lobbying trips to Washington, D.C., where they dined at five-star restaurants. This case is of particular interest for four reasons: First, as a member of the Aging Committee, I am terribly concerned about the problems of the elderly as all of us are. Although this has not been investigated, I wonder out loud the quality of care the homebound elderly receive from this group if they were so interested in milking this program.

Second, I have made the discovery and stopping of Federal waste an important legislative priority. We just recently concluded hearings on the problems of debt collection with the strong cooperation of our chairman. I have introduced legislation to correct this problem which has the full support of the Reagan administration.

Mr. Chairman, I am pleased to join any effort that you might spearhead to correct these abuses through remedial legislation.

Third, I note with interest that this case centers in my own State of Illinois in the southwest suburbs surrounding Chicago. My constituents deserve the finest delivery of Federal services possible and they want fraud curbed even if it occurs in their own neighborhoods and suburbs: I might say particularly because it occurs there.

Fourth, I understand that much of the investigative work in this case has been done by the Better Government Association.

I have had a longstanding interest in Better Government Association together with the former chairman, Marge Benton. I helped to form the investigative arm of the Better Government Association. Later today, we will have and we will be hearing from Terry Brunner and some of his crack investigative and legal staff on the work that has been done. Through the years, without fail. Better Government Association has worked in the public interest through such projects as uncovering a $2 million scam affecting the security bond guarantee program of the Small Business Administration. Through its new Washington office, uncovering neglect by the Federal Railroad Administration in failing to prevent derailments; calling attention—calling my attention—to a $12.5 billion public works project in Chicago called the Deep Tunnel that is more effective in draining away taxpayer dollars than controlling sludge and flood waters. They have finally courageously uncovered arson-for-profit schemes in Chicago. Nationally, the arson fires have killed 1,000 people and caused $2 billion in damage.

Mr. Chairman, I have the fullest confidence in the Better Government Association and I applaud your initiative in securing their findings.

I regretfully must chair the hearing of another committee at 10:30 but I certainly want to warmly welcome Terry Brunner and I will read with interest the entire testimony and questions that follow.

Mr. BRUNNER. Thank you, Senator.

Chairman ROTH. Thank you for being here, Senator Percy. At this time, we will call on Mr. Brunner. If you care to have any of your legislative aides or investigative assistants to sit alongside, please feel free to do so.

Mr. Brunner, under our rules we would like to swear you in. Do you swear the testimony you are about to give before this subcommittee will be the truth, the whole truth and nothing but the truth, so help you God?

Mr. BRUNNER. I do.

Chairman ROTH. Please proceed.

TESTIMONY OF TERRENCE BRUNNER, EXECUTIVE DIRECTOR, BETTER GOVERNMENT ASSOCIATION

Mr. BRUNNER. Fine, Senator, Mr. Lyons will testify next.

Chairman ROTH. Very good.

Will you speak directly into the microphone so we can hear you, please?

Mr. BRUNNER. First of all, I would like to thank this subcommittee for inviting us to testify today to discuss what we believe to be a serious problem regarding the delivery of health care and other services to the elderly and chronically ill in their homes.

With me today is Peter Manikas, the Better Government Association's legislative counsel, who supervises our Washington office. Mike Lyons and Mindy Trossman of the Better Government Association staff are also here, Mr. Lyons and Ms. Trossman conducted the research with "NBC Magazine" on our investigation of abuses in the home health industry, which was broadcast by David Brinkley last Thursday evening.

The investigation that we will discuss today is not our first examination of health-care provider abuse. Over the last several years, many Better Government Association projects have focused on different aspects of our health care system. Our major projects in the health care area include:

A 1970 Better Government Association and Chicago Tribune investigation examining abuses by private ambulance services in Chicago. The Chicago Tribune reporter who worked with us received a Pulitzer Prize for the study.

In 1975, working with Mike Wallace and CBS' "60 Minutes," in cooperation with the subcommittee chaired by Senator Moss, the Better Government Association demonstrated that fraudulent practices were widespread in the Illinois medicaid program. To do this, the Better Government Association opened a medicaid clinic and filmed clinical lab owners paying kickbacks to receive medicaid business.

These 13 laboratories alone accounted for 65 percent of the Illinois medicaid payments to clinical laboratories. This was one of the first investigations nationally to expose irrefutable evidence of wholesale medicaid fraud.

In 1978, the Better Government Association worked with ABC's "20/20" and the Chicago Sun-Times and found that abortion clinic owners in Chicago and elsewhere were performing abortions on women who were not pregnant and operating illegal con games to defraud the medicaid program.

As a result, three clinics were closed and Illinois has prohibited bribes, kickbacks, or other payments on providing abortions or abortion referrals.

Throughout the past 10 years, the Better Government Association has worked closely with the Senate Special Aging Committee to examine abuses by nursing home and shelter care providers and we often testified with respect to our findings.

We have offered testimony in front of Chairman Pepper's committee with respect to those findings on shelter care.

Mr. Chairman, the Federal home health care program is a program that the Better Government has long supported.

I think Senator Percy was one of the initial Senators championing things like Meals on Wheels and health home care as reforms of the nursing home investigations which we conducted in Chicago in early 1970.

The nursing home industry has been plagued by financial and patient abuse for years.

One of the reforms that we repeatedly made in the wake of our investigations in the nursing home problems was that more resources be allocated to prevent the unnecessary institutionalization of elderly and disabled persons.

The Better Government Association still strongly supports the home health program. We believe that in-home services have improved the lives of millions of elderly and disabled citizens.

Because of these programs, millions of chronically disabled persons have received needed health care, as well as assistance in performing essential daily functions such as eating and bathing.

However, I think our testimony today will reveal that there are serious problems. Some home health agency providers have used medicare's home health program as a get-rich scheme at the expense of the Nation's taxpayers and the program's beneficiaries.

Mr. Chairman, the Better Government Association and NBC spent 7 months looking into the home health industry. We do not really know how widespread the abusive practices we uncovered are, but we do believe that the potential for enormous abuse is alarming. As one home health operator told the Better Government Association. "Medicare bucks are falling out of the sky, and the only thing to do is to have the biggest bucket."

Our investigation examined home health agencies in three States, Illinois, California, and Mississippi. We found evidence of fraud and abuse through overbilling, payroll padding, and submitting fradulent reports to the Government.

We found that some home health operators siphoned medicare dollars from nonprofit home health agencies they controlled through profitmaking firms they also owned. By concealing the relationships between these interrelated companies, profiteers vastly inflated their charges to the medicare program.

It is a tangled web of self-dealing designed to defraud the Government. In Illinois we found one man who controlled five nonprofit home health agencies and four profitmaking companies through which he bilked the medicare for over $1 million. He or his employees found evidence of inflated cost, overbilling, destroyed records, and padded payrolls to secure Government funds.

In California, a closely knit group of people used a management company to control three home health agencies, a physical therapy company, and a medical equipment firm. The members of the group, by conspiring to conceal the true ownership, altering records and billing the Government for services never rendered, reaped huge medicare profits.

Finally, a Mississippi home health agency owner intimidated elderly patients so they would not switch agencies to seek better care. According to a Government report, the care being administered by this agency was below acceptable standards.

In addition, agency employees forged a doctor's signature on several patients' records. There seems to be widespread agreement that the financial abuses we found are closely related to the method the Federal Government uses to pay home health providers.

The cost reimbursement system seems to have two glaring defects: First, it provides no incentive to controlling costs; and second, it is extremely difficult to monitor for fraud and abuse.

Mr. Chairman, we do not have any easy answers to these problems. However, we do have some thoughts on what remedial steps should be taken.

Peter Manikas, our legislative counsel, is scheduled to testify before this committee tomorrow to outline some of our proposals for reform. Clearly home health care is a billion dollar industry and growing rapidly. We believe it is essential to take steps now to contain home health care costs and prevent fraud and abuse before the program expands further and reform becomes even more difficult.

I want to thank this subcommittee again for inviting us to testify and I also thank the subcommittee's staff, particularly Mr. Weiland and Mr. Eberhardt, for their valuable and expert assistance to us.

Chairman ROTH. I would like to congratulate you and your Better Government Association for your good work. I think the most depressing significance of your testimony is that you state the potential for enormous abuse is alarming. It concerns me that it could be very widespread under current practices, particularly in a program that is growing very rapidly and if handled properly should. But second I find it disturbing that in each incident the abuse can be so large. We are not talking about peanuts. We are talking about hundreds of thousands of dollars, even millions, as you indicated in the individual cases of fraud and abuse. It is a matter of real concern that those funds which are paid for by the American people are not going to those we seek to aid, but to the corrupt. So we will be looking forward very much to your testimony tomorrow as to possible remedies that might be enacted.

Senator PERCY. Could I just ask one question, Senator Roth? I think as Terry Brunner knows the only book I have ever written is called "Growing Old in the Country, The Young," which I wrote after 3 years of research. I explored why in this country, where our heritage is from Europe, Asia, where age is revered, we have the opposite in this country where we have a youth cult so much that you have empty dormitory rooms on campuses all over the country and 7 or 8 year waiting lists for people to go into homes for the aging. Where you have what we call warehouses for the dying, and I tried in my book to analyze and appraise a group of outstanding retirement homes, certain intensive care clinics that are truly outstanding but then I showed the other side where the combination of fraud and abuse which results in milking and making profits from the poor, particularly the elderly poor. The exploitation of these people is absolutely unbelievable.

I can't imagine a worse offense other than peddling dope to young children. When there is milking the older people and particularly taking advantage of Federal funds we really ought to go after these people. This is why I so respect what you are doing in this particular field. We will support in every way we can your efforts.

When my book was written 6 or 7 years ago, we pointed out the abuse then, we thought we were on a program of correction. Why is it that after all of these revelations, all of these investigations we still keep turning up flagrant abuse in this field? Why can't we get a handle on this thing?

Mr. BRUNNER. Senator, I think it is rather depressing. As Chairman Pepper knows we testified before the House Committee on Aging with regard to problems in sheltered facilities in Uptown. I think we stated at that point that this was the second or third investigation we had done into that problem. We see the same thing. I think it is disappointing. I know of your personal interest in going to nursing homes in the north side of Chicago. I have done it with you on cold Sunday mornings to see what the conditions are really like.

Senator PERCY. I have also been there sometimes and been refused admittance, as probably Claude Pepper has.

Mr. BRUNNER. That is right, Senator.

Senator PERCY. I got in. [Laughter.]

There wasn't any doubt about it. But I notice the BGA investigators sometimes had difficulty getting in. But I made it perfectly clear we would close them down by night if I didn't get in. What I saw almost

turned my stomach sometimes. Sometimes it ended up Sunday night being the only guest on the registered list, if there is a registered list for 100 patients that are in that nursing home. It is a tragic thing. Government can't do anything about that. People just abandoned and left there with no one really caring about them. That is why these abuses can carry on. There just isn't enough oversight.

Mr. BRUNNER. I know you have been a champion of home health care and Meals on Wheels as reforms to those problems that we have seen ever since the initial hearings that you and Senator Stevenson held in Chicago on the Chicago Tribune nursing home scandals. Since that point, we have seen other programs come forth. Unfortunately, it seems that as soon as a new program is put together there is a new group of people out there studying and analyzing the program to figure out how they can use the reform measure as a way of making money. I applaud the efforts of this committee in looking at what may be present in the design factors of the programs that make it so easy to rip them off in the long run. As you suggest we go through the cycle time after time in which we seem to plug up the gaps of a particular program that isn't working well with various reform measures. Then we are confronted again, when we do an investigation, a reform effort that the BGA and you championed and we find the same thing happening.

Senator PERCY. Thank you very much, Mr. Brunner. Senator Cohen?

Senator COHEN. I have just a couple of questions. You say that part of the difficulty of the home health care system's cost reimbursement system is that it provides no incentive to controlling costs and it is extremely difficult to monitor fraud and abuse. How does that differ from our entire reimbursement system of all of our health care?

Mr. BRUNNER. I think it is obviously similar, but there are differences between the manner in which the costs are determined in the other programs, such as medicaid.

[At this point, Senators Percy and Roth withdrew from the hearing room.]

Senator COHEN. What about the hospitalization? What incentives do you have, for example, in controlling costs in the hospital? If someone goes to the hospital, you have a reimbursement under a Federal program. What incentive is there under that circumstance?

Mr. BRUNNER. I think it would be very similar, Senator.

Senator COHEN. What would be very similar?

Mr. BRUNNER. The problem here to the problem there.

Senator COHEN. That is exactly what I am suggesting. It is nothing unique in the home health care industry. We experience it all across the board as far as hospitals and nursing homes are concerned. We have heard before that we have gone from a $624 million budget for home health care to a $1 billion budget in a period of about a year or two. That is a dramatic growth. But what is the budget increase for nursing homes? I assume there has been a rather dramatic growth there as well as there has been in practically every facet of our health care system. There has been a tremendous amount of growth in the amount of moneys being spent. I am not using this as a justification, but I don't know that this is unique in the sense we don't have a measure for controlling costs and have difficulty to monitor the fraud and abuse. How is that different?

Mr. BRUNNER. I think what we are seeing is a shift in emphasis in the meanings of care for elderly citizens between nursing homes and home health care as I suggested to Senator Percy. Over a period of time, we have seen the abuses in the nursing homes. We have suggested that there ought to be some incentives for keeping people in the homes instead of doing it the other way. What is happening is you have a ballooning growth in the industry, a growth in the number of patients being served, the number of visits, and a growth just from the inflation with regard to costs in the home health care industry versus what is happening in the nursing homes.

Senator COHEN. That really doesn't deal with the issue. Say you have got a problem in the nursing homes, in terms of fraud, abuse, and ripping off Federal Government. So we will cure that problem by keeping people in the homes. So then you have another industry that crops up, an industry which will take care of people in the homes, and we will do the same thing in the home health care situation as in the nursing home. But we really haven't dealt with the underlying problems, have we, just by shifting the place?

Mr. BRUNNER. What we are talking about is the fact that the institutionalization process is one part of the problem with regard to the nursing homes in the way people are treated within those nursing homes. It would appear to be more humanistic to take folks out of there, and keep them in their own home, if they are given some program of tax incentives or other means of caring. That is one of the things we have testified about over this 10-year period on nursing home problems. That is a different problem than how you control the costs or how you look at problems of fraud and abuse. I think that the generalization which you are making with regard to the fraud and abuse in the programs is accurate.

Senator COHEN. Basically what you want to make sure of at the Federal and local level is that you have qualified home health agencies, people who have expertise in the field and in delivering health care services. Right? That would be No. 1. No. 2, you want to make sure that a reasonable cost is being charged. We will talk about the definition of reasonable versus actual or some fixed amount that should be set, perhaps. But if you deal with those two elements, namely subjecting home health care agencies to a rigid system of oversight, and auditing for the charges and services that are being rendered, isn't that really the nature of what we should be focusing upon to eliminate the fraud and abuse?

Mr. BRUNNER. I would think so.

Senator COHEN. I don't know that this is any different frankly than the problems we suffered throughout our Federal budget. I am sorry that Representative Pepper had to leave because in his opening statement he made reference to the fact that he believed the fundamental root of the problem is the profit motive. That raises a rather substantial philosophical issue, namely should you have profit in the health care industry, period. Should we be developing and promoting a system which eliminates profit out of the health care industry? I don't subscribe to that because I think that some of the studies that have been done in the hearings with Senator Percy have indicated that you

have just as much fraud and abuse in not-for-profit agencies or tax-exempt agencies as you have had in profit nursing homes in the past. I don't think you can say the profit agencies are the ones who are exploiting or abusing the system, as a categorical statement. I would be interested in hearing your response if you think that is the case.

Mr. BRUNNER. I think I would agree with what you said, Senator. I think this kind of investigation tends to cause you to address more philosophical issues in this area. This committee used its investigative function to look at design factors into these programs. By looking at a series of programs you can say, why do we always end up in the same place? If you look at the medical program, you find it has a different sort of auditing function and a different way of how the money is being spent because it involves State and Federal agencies. We went through that with "60 Minutes" and the Senate Committee on Aging, and saw the problems there.

We followed that up by putting through legislation. When Secretary Califano came in, we were going to have more people to audit. I stated on a number of occasions in conferences with the Justice Department that will have no effect because you are constantly trying to stick your finger in the dike.

I am a former prosecutor. I have seen these things and understand it. I think we are spinning our wheels as long as we attempt to put our fingers in the dike at the end of a long delivery system, whether it is one like this where it is policed by Blue Cross/Blue Shield or by medicaid where you have a State agency doing the duty of an anti-fraud audit function.

Unless we can figure out a better way to deliver the money or the needed services to those people at the end of the line, I think we are always going to have the same problems.

If you examine the prosecution record carefully, and I think we are going to get into that in testimony here, of what has happened over the years, either in medicaid or in this particular program, you will find, in effect, no one is going to jail. You have a law enforcement background, I believe, with the Bureau, and I think we are in a position with regard to these programs that is similar to a position we found ourselves in in the early 1970's.

By massive efforts by the State Justice, we found Federal judges weren't putting anybody in jail. I think you are in a similar position now because it is clear you can make millions of dollars off these schemes with there being very little deterrent at the end of the line.

Whether that deterrent will solve the problem is my question. I think you have to look at the program, how do we design it, how do we design the delivery time and why is it every time after we change it, we have the same result?

Senator COHEN. Hopefully we will deal with that tomorrow.

Mr. BRUNNER. This is Mike Lyons, who did the work for the Better Government Association on this investigation.

Senator COHEN. Mr. Morley, will you also assume the position at the witness table?

Mr. Lyons, would you stand?

Mr. BRUNNER. I would also like to introduce our legislative counsel, Peter Manikas, who will be sitting up here with us.

Senator COHEN. Do you swear the testimony you are about to give this subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. LYONS. I do.

Mr. MANIKAS. I do.

Senator COHEN. Mr. Lyons, why don't you begin by indicating the nature of the investigation and what the investigation disclosed concerning the Chicago Home Health facility that was the subject of your investigation?

TESTIMONY OF MICHAEL LYONS, STAFF INVESTIGATOR, BETTER GOVERNMENT ASSOCIATION

Mr. LYONS. The Better Government Association, in conjunction with "NBC Magazine," conducted a 7-month investigation into the home health care industry in three States. The primary focus of the hearings today will be what we uncovered in Illinois, and the chart at the left reflects the different not-for-profit, tax-exempt, fully medicare-supported home health agencies that we looked into as well as a series of profitmaking companies that were set up in conjunction with the not-for-profit agencies. Very early in our investigation, sir, it became apparent that these home health agencies were established to siphon medicare funds to profitmaking companies.

By concealing the relatedness between the not-for-profit home health agencies and the for-profit companies, the principals were able to make excessive profits from medicare that would have otherwise been disallowed under the program's regulations.

The principal beneficiary of this plan was also its author, Michael Morrisroe. Mr. Morrisroe's control of the home health agencies and the profitmaking companies was accomplished primarily with the assistance of three Chicago families and the use of his management consulting service, Northrad.

Mr. Morrisroe is a Ph. D. in English and an attorney. He held a private detective's license in Illinois until 1980 and before incorporating Southwest Community Home Health Agency in April 1976, he had some prior experience in the health care delivery field.

On at least one occasion, in reference to his private detective license, he approached the husband of one of the administrators for one of his agencies and attempted to hire the gentleman who is a police sergeant with a suburban community in South Chicago, to follow a senior Federal official who he felt was the author of some of his difficulties.

A later witness, Jean Williams, can testify to this particular case.

If you look at the agency staff of Southwest Community Home Health in 1976, it will reveal the names of the primary people who were involved in running all of the home health agencies.

Senator COHEN. Would you explain something for me as you go along here? You indicated that the principal beneficiary and the author of the scheme is Mr. Morrisroe. Why couldn't they have set up a for-profit home health agency to begin with? Why did they have to go through this charade, as you labeled it, by establishing a not-for-profit home health agency? Is there a local law or State law about this matter?

Mr. LYONS. In Illinois?

Senator COHEN. Yes.

Mr. LYONS. Illinois did not at the time have a proprietary home health licensing law. They just got one and they could not receive medicare funds.

My opinion would be that it is an extremely high competitive business in Chicago. We have something on the order of 60 home health agencies. I think based on the research that we conducted, Mr. Morrisroe's pattern was established long before he set up these particular agencies. He would set up a not-for-profit company and for-profit company. For example, in the early 1970's, he set up a for-profit home health agency, as you are referring to, and set up a not-for-profit company to achieve a certain amount of benefits which included the use of a not-for-profit franking machine to mail brochures and things like that.

Senator COHEN. Also it is for surface appearances that one would operate a not-for-profit home health agency, so as to give a much more charitable appearance that one is not in it for the greedy profit and that one is more reliable and trustworthy. I suppose that setting up a for-profit home health agency somehow immediately conveys the notion that this is something less than desirable. Is that also some part of the underlying scheme, seeking to profit as holding himself up as a charitable individual?

Mr. LYONS. I would agree. He ran into a great deal of difficulty in his early years by using a trade name, "Homemakers," which was the trade name of the Upjohn Pharmaceutical Co., and was sued for it. At least two of his home health agencies are called VNA for Visiting Nurses Association. One is called VNS, Visiting Nurses Service. I think the intent here was partially to play upon people's confidence in a very longstanding traditional institution.

I think that was part of the plan.

Senator COHEN. But under Illinois law—in most States—they can have one or the other; is that true?

Mr. LYONS. Yes, they can. He did have an abortive venture into profitmaking around the same time that these were set up, and that institution did go under, although one of the principles that was involved in it later reappeared in one of the profitmaking companies.

Senator COHEN. Go ahead.

Mr. MORLEY. I might add, Senator, as I mentioned earlier, that during the period we are talking about, the contractors are not subjected to audits by the intermediaries. Therefore, it would have been difficult for them to know what we have determined and just how much money was going out the door. That shielded them to a degree from an audit of this whole group.

Mr. LYONS. Also I would like to point out, sir, that during 1978, in regard to your question, only 24 States provided licensing for profitmaking home health agencies.

When Mr. Morrisroe incorporated Southwest, it brought him into contact with three Chicago families—the Ryans, Krusiecs, and Flanigans—each of whom had at least one family member on Southwest's payroll in 1976.

When Morrisroe's operations expanded to five not-for-profit agencies and four profitmaking companies, members of these families as

well as friends and previous associates were used to incorporate and staff the companies.

The essence of Mr. Morrisroe's strategy was simple and composed of four major components: Create the not-for-profit medicare-supported home health agencies, create for-profit service companies; sell the services to the agencies often at highly inflated prices and receive medicare dollars; and, most importantly, conceal the relationship between the agencies and the companies from the Government.

The personnel present at Southwest in its first year of operation became the resource needed by Mr. Morrisroe to accomplish that goal.

Northrad Management Corp. was the parent company to which medicare funds eventually flowed. It is a Delaware corporation incorporated on October 8, 1976, and licensed in Illinois on October 18, 1976. From the very beginning, Mr. Morrisroe's interests and Northrad's were exactly the same and the boundary between these medicare-supported home health agencies and Northrad were extremely thin, or nonexistent. I think that Northrad's real existence as a business is best summed up in the words of a former Morrisroe employee: "Northrad was a drawer in Michael Morrisroe's desk in Southwest."

In effect, Northrad was a primary vehicle that enabled Mr. Morrisroe to do business with himself; that is to say, doing business with agencies he actually controlled, while the medicare funds provided the profit. One person at the BGA interview described a map on the wall of Mr. Morrisroe's office at Southwest that contained the boundaries and names for all of the not-for-profit home health agencies before four of them even began to do business. In an interview with the BGA, Mr. Ronald Boorstein, who was the registered agent for Northrad as well as three of the agencies, confirmed the existence of the map and volunteered that setting up the agencies and then selling them consulting services was Mr. Morrisroe's plan from the very beginning.

The BGA investigation revealed that Northrad charged four of the agencies approximately $12,400 each as startup costs and all five of the agencies approximately $1,500 per month per agency for consulting. Northrad billed the agency, the agency billed the Government.

On several occasions the staff of one of the Morrisroe-related agencies would consult with the staff of a second Morrisroe-related agency on Northrad's instructions. The staff of yet a third Morrisroe-related agency would compose, type, and deliver the Northrad bill.

There was a subsidiary of Northrad, a business called Midwest Leasing. It leased office furniture to the Morrisroe-related agencies. The owner, president, and full-time staff of both Northrad and Midwest Leasing was Michael Morrisroe.

To achieve control of the not-for-profit agencies and thereby assure a medicare income to Northrad and Midwest Leasing required the efforts of a very closely knit group of people.

One month after incorporating Southwest Community Home Health as a not-for-profit corporation, the same three people, Mr. Morrisroe, Connie Ryan Kubica, and Ronald Boorstein, incorporated the Home Health Agency of Orland-Tinley Park, in May 1976. In September of the same year, on the same day, the three remaining not-for-profit agencies, Will-Cook County, Midway, and Oaklawn-Burbank were incorporated exclusively using people that were involved in the two previous agencies.

The pattern among all the agencies and the profitmaking companies was similar: Insure that the actual control of each agency was vested in family and friends and never under any conditions admit to being related with any other agency or profitmaking firm. Wherever possible conceal and confuse the interrelationships so that greater profits could be realized from medicare. This is an effort by Mr. Morrisroe to get around the provisions of the medicare regulations which deal with the issue of control.

The regulations are very explicit, I think, in this regard. They say that control includes any kind of control, whether or not it is legally enforcible and however it is exersizable or exercised. It was not in Mr. Morrisroe's interest or in the interest of these families to have the relationship that they had be explicit.

Rose Krusiec Gallagher's history is illustrative of what related meant in practical terms. She was a nurse with Southwest in 1976, while Mr. Morrisroe was the administrator and her husband become the agency's administrator for a short time after Mr. Morrisroe went into the background in 1977. That is to say, he formed Northrad and began to operate exclusively out of that particular profitmaking company.

Rose was on the board of directors of a second agency, the Home Health of Orland-Tinley, in late 1976 and when her sister, Barbara Krusiec Kedzior became the executive director, Rose became a consultant to her sister.

Rose Gallagher was also an incorporator of a third Morrisroe-related agency, Midway Visiting Nurses Service. And she finally became the administrator of the Home Health Agency of Will-Cook County which was originally incorporated by her father, John Krusiec and her sister, Mary Krusiec Lynch.

The pattern of interrelatedness and family control became complete when, as an administrator, she hired her mother, Marie DePaulo Krusiec as an agency employee and board member. Medicare paid all of their salaries.

[At this point Chairman Roth entered the hearing room.]

Mr. LYONS. While her history is an illustration, a similar story exists for both the Flanigan and Ryan families. The pattern at times, was extremely difficult to understand because it shifted very often and maiden or married names were used to replace family names.

I would like to emphasize that while the majority of the medical staff at these agencies apparently made every effort to provide quality care, the results of our investigation indicate that financial abuses repeatedly occurred.

To cite four very brief examples: Ineligible patients were deliberately enrolled by at least one of the agencies. A later witness, Jean Williams, can describe this.

Patient records were fabricated by staff, in this case by staff of one of the profitmaking companies, Chicago Home Care, in response to questions by Blue Cross/Blue Shield, the agency's intermediary. Another witness, Tim Scanlon, will later describe this.

In all of the cases, the agencies went to extraordinary lengths to keep patients on their rolls. At least six nurses that BGA interviewed from different Morrisroe-related agencies told us that they were in-

structed to "keep the patients in bed" and "never write that they are improving."

The results of this policy are best demonstrated in utilization rates which are averages of the number of visits a typical patient receives. If you look at the Morrisroe-related agencies, you will discover the rates are extraordinarily high and in at least one case, the Home Health Agency of Orland-Tinley the rates are almost three times the national average.

Senator COHEN. Where was the Provider Reimbursement Review Board during this process?

Mr. LYONS. The Provider Reimbursement Board finally ended up hearing the evidence regarding some of the disallowances that the intermediary in 1976, Aetna, found for Morrisroe's first agency, Southwest Community Home Health Agency, in November of last year, I believe. This is for the cost period ending 1976.

There were a whole variety of different delay techniques that were employed by agency staff that prevented it from ever getting before the Provider Reimbursement Review Board earlier. There was one lawsuit filed in Federal district court where four of the agencies tried unsuccessfully to get a restraining order to prevent the Government from collecting the funds. That occupied a great amount of time.

Senator COHEN. While you are describing a rather graphic and outrageous situation, perhaps I am just becoming cynical up here, but it goes on every single day in every single agency. Senator Levin and I have been holding hearings in the field of default and fraud cases where it has been determined that a particular contractor with the Government has in fact either defrauded the Federal Government or has defaulted on a number of contracts which would render that company unworthy of further consideration for Federal contracts. Yet they simply go to a different agency and do it again. You have a situation where a contractor, and defense contractors in particular, have a wholly owned subsidiary or major share of that subsidiary and sell the parts to the contractor. Those parts are inflated, and that goes into the cost and it is passed onto the Government. This is simply a variation of that whole scene of creating a sham in order to inflate costs at a different level which is more disguised and less detectable. It is really no different than what we have seen in thousands of other cases.

The question really is where on this chart that you have and what along that chain of events should be changed to tighten it down to try and control this. You are not going to eliminate it. There is always going to be somebody out trying to develop a scheme whereby they can evade the rules and regulations. The question we have to decide is what can be done to reduce the opportunity.

Mr. LYONS. I believe, sir, that tomorrow my organization will address specific recommendations that we have on areas we feel are insufficient in preventing Mr. Morrisroe's operation from beginning and preventing it from operating along the way.

Senator COHEN. When should they have had a red flag raising about these rates that are three times the national average, and the costs that are twice as high as what we have seen in other cases? At what point in time should somebody have been aware this is not a normal operating procedure?

Mr. LYONS. There was a difficulty here based on medicare regulations which allow the agencies themselves to control the actual disbursement of funds. They decided where the money went. The Government, through the fiscal intermediary, Blue Cross, came in later and said certain costs were not allowed. The problem is that was an ineffective technique to use.

Blue Cross would disallow a portion of Northrad's consulting costs because they would have insufficient documentation for it but that did not prevent the agencies through their administrators and interrelated boards of directors from ordering payments to Northrad in any case and even holding out the prospect of appealing to the very PRRB we were discussing earlier.

Senator COHEN. You recommend you go to HCFA as the one who is to control the disbursement of funds?

Mr. LYONS. No, sir, I think our General Counsel, Peter Manikas will be addressing it tomorrow, but I think there has to be some type of mechanism in the hands of the Government representative, in this case perhaps the fiscal intermediary, to prevent the expenditure of funds for items that are clearly improper during the course of a given year before it becomes academic at the end of the year. A number of these agencies, two at least are bankrupt today. The Government is holding the bag on a quarter of a million dollars on those two. Sources have indicated at least two more are in severe financial strains, but the personal assets of the people who incorporated the agencies are unencumbered.

If anything, our investigation not only in Illinois but the other two States we have looked at, have indicated to me and to the Better Government Association that there has to be some sort of mechanism, or a wide variety of mechanisms, available to the fiscal intermediaries in the role of representing the Government's interest to stop the payment of funds that are clearly improper—that they have already decided upon in previous years before those funds are expended. In the case of some of the profitmaking companies, which Mr. Morley will testify to later, there are great amounts of money being expended in spite of the very best efforts by Blue Cross-Blue Shield.

Chairman ROTH [presiding]. I would say to the Senator from Maine, we are going to spend considerable time tomorrow looking at possible remedies to the situation. What we have here today is, I guess you might call, is a case study that demonstrates or illustrates where the program has gone wrong, not only where it has gone wrong but potentially where future abuses could be created.

I would like to ask you at this time what is the relationship between Northrad Consulting and the home health agencies? What abuses were disclosed by your investigation?

Mr. LYONS. Sir, during the course of the BGA's investigation, it sometimes became difficult to ascertain where Northrad left off and a separate tax-exempt, not-for-profit medicare agency began. All the agencies executed contracts with Northrad and took instructions directly from Mr. Morrisroe. As I previously mentioned, Northrad's resources were the agencies' staff and equipment and these constituted the faucet that enabled the medicare funds to be siphoned.

Even when the agencies' fiscal intermediary, Blue Cross-Blue Shield, would disallow Northrad's costs, the agencies which under medicare regulations controlled the actual disbursement of funds, would pay Northrad and fail to pay other legitimate creditors. When the creditors demanded their moneys, the agencies would argue that Blue Cross and the Government didn't pay them enough. At times the cash flow problem caused by the drain on their resources by Northrad became so critical that various agency employees went without pay until Blue Cross would send another check.

One thing that you would never find, sir, in a Morrisroe related agency, was an unpaid Northrad bill. When the Government paid the agencies, the agencies paid Northrad. It is illuminating to see what the Government was paying for. The Northrad contract with Oaklawn-Burbank states in part that Northrad would provide for "the establishment of training programs and seminars for administrative personnel of the agency," and that "such programs and seminars shall be at Northrad's expense," except, of course, for transportation.

In practice, this meant that Rose Krusiec Gallagher of the Home Health Agency of Will-Cook County was sent in early 1978 to help train Oaklawn's administrators on the preparation of a State survey. Although Ms. Gallagher was away from her agency all day for several days, the Government paid her salary as the administrator of Will-Cook County, paid to have a secretary at Orland-Tinley type and deliver the Northrad bills to Oaklawn-Burbank, paid Northrad as her work as a consultant, paid the automobile lease and the gasoline used to travel back and forth and ironically even paid Mr. Morrisroe for some of the office furniture Ms. Gallagher used.

Mr. Morrisroe had a subsidiary company to Northrad called Midwest Leasing. He sold his interest in Midwest Leasing to a company called Stratford Leasing in late 1977. The BGA investigation has uncovered that in that contract, for which Morrisroe got $19,100, there was also a provision that Midwest Leasing, a subsidiary of his wholly owned company Northrad, would receive 50 percent of all the future renewals, if any, if the agencies would renew with Stratford Leasing. Even today they would be obliged to pay 50 percent of that cost of furniture rental to Mr. Morrisroe's subsidiary, Midwest Leasing.

In a conversation with Blue Cross-Blue Shield on June 22, 1978, Mr. Morrisroe indicated he was the only full-time employee of Northrad but that he sometimes hired part-time help. What he did not mention was that at the direction of Northrad, this help was supplied by Morrisroe-related agencies to other Morrisroe-related agencies.

If you look at the same Northrad contract, sir, it indicates that Northrad will provide "assistance in the development of public professional awareness of the operator's agency by providing a community awareness program." This provision was implemented through the mass mailings of brochures that advertised both the agency's services and the medicare program. Several nurses were required to give speeches during their working hours to church and civic groups. Some of the nurses told the BGA that these activities actually interfered with patient care. Mary Krusiec, Rose Krusiec Gallagher's sister, was hired at Will-Cook County Home Health Agency with medicare funds and the title director of community awareness. Much, if not all, of the activities that I described violates medicare regulations.

If you look at the Northrad contract, you will see there is a provision under clause 2(i) that Northrad would provide "assistance with respect to the development of operation budgets and cash-flow projections." We were told by several former Morrisroe-related agency employees that in practice this assistance included instructions that came directly from Mr. Morrisroe to "keep the costs high" and pay the profitmaking Morrisroe-controlled companies first.

The Northrad contract enabled Mr. Morrisroe to inspect the records of the agencies on their premises. According to persons the BGA interviewed, this allowed Mr. Morrisroe to remove or hide files before a Blue Cross audit. We identified this occurring on at least three occasions. In addition, the contract indicates that the agency was under a $150,000 penalty to be paid as fair compensation as injury to Northrad in the event the agency terminated its contract and still continue to operate in the home health business.

In every respect that BGA could determine, Northrad was a medicare-financed operation. From Mr. Morrisroe's car lease and his office at Southwest Community Home Health, to the secretary who typed the bills, to the part-time staff that consulted when real expertise was required, the Government paid the overhead. A perspective on the profit that medicare provided to Northrad will be given by Mr. Morley of the Senate Permanent Subcommittee on Investigations a little bit later.

In spite of Northrad's official demise in December of 1979 for their failure to pay a State franchise tax, Mr. Morrisroe has billed a number of the agencies for legal fees approaching $1,000 per month per agency as late as June 1980. This is the most recent period for which Blue Cross-Blue Shield has audited these agencies' records. So it is the most recent period that they may have these particular bills.

I think that answers the question, sir, and pretty well characterizes the relationship between Northrad and the not-for-profit home health agencies.

Senator COHEN. Could I inquire whether any legal proceedings have been instituted against Mr. Morrisroe?

Mr. LYONS. As near as I can determine the Office of Program Integrity which is the investigative arm of HHS that looks into abuse and waste launched an investigation of the Morrisroe agencies. Subsequent to that, in 1979, based on information provided by the Office of Program Integrity the Federal Bureau of Investigation simultaneously subpenaed records from a number of these agencies. As I understand it now, there is a grand jury that is considering potential violations of the IRS code on Mr. Morrisroe and some of the people that he was involved with. That is the extent of it. I know there was an investigation.

Senator COHEN. There is a current grand jury investigation underway now?

Mr. LYONS. It is my understanding that there is a grand jury investigating. I have talked to some people who have indicated that they were subpenaed by the grand jury or at least I am thinking now of one person who was asked to give a deposition to the grand jury.

Senator COHEN. Are there criminal sanctions under the Medicare Act? You stated rather clearly that Mr. Morrisroe is engaged in a rather patent case of fraud.

80-881 O - 81 - 3

Mr. LYONS. Yes, sir. Based on the evidence that we have managed to uncover I would suggest that there are criminal provisions that could apply to some of the instances that we have uncovered. Some could be characterized as abusive and certainly wasteful. In other cases, a later witness will testify that when the Federal Bureau of Investigation subpenaed at least one of the agency's records, what the FBI actually received in response to their subpena may have been less than what they asked for and of some questionable quality. And Carol Radatz a little later will address that issue.

Senator COHEN. Mr. Chairman, the reason I raise the question is that this committee in the past has had examples of investigations being conducted at a time when certain criminal investigations were underway. I would be interested in learning whether or not the Justice Department is going to be testifying on this matter, and whether in their judgment, we ought not to proceed until they have completed their investigation. Are we in any way jeopardizing what they currently have underway?

Mr. MORLEY. May I speak to that? There is definitely a Federal title 18, title 26 grand jury investigating this matter right now. To my knowledge they are investigating tax charges and possible violations of the medicare laws. We have coordinated our investigation with the Department of Justice. They are aware of what we are doing and it is their opinion and our opinion that this hearing will not interfere with their grand jury operations.

Mr. LYONS. I would also point out that the Better Government Association has been contacted by the IRS agent who is conducting some of the investigation and we have indicated that we intend to fully supply him with the information that we have in that regard.

Chairman ROTH. To continue with the case study I wonder if you could comment on how these home health agencies delivered their nursing and nurse aide services, and what actually was the role of Chicago Home Care?

Mr. LYONS. Sir, the second profitmaking corporation and perhaps the most ambitious undertaking was Chicago Home Care. It was incorporated initially by Patricia Tinder who, by that time, had some experience in Morrisroe-related agencies since she had been the supervisor for nurse aides at Well-Cook County Home Health Agency. It was clearly uncovered during the course of our investigation that Chicago Home Care was a Morrisroe-related operation. The one thing that I would suggest is that it was concealed to a much greater extent than most of the other related profitmaking companies.

When Chicago Home Care began to do business one of the first questions that the fiscal intermediary had was the question of costs. Chicago Home Care was created during a remarkable series of events. The nurses aides of the five home health agencies were all terminated on one day and told that they could go and get a job with Chicago Home Care which all five of the Morrisroe-related agencies were going to contract with. So all of the nurses aides either quit or went to Chicago Home Care. Immediately it began to do business. Previously the agencies had been paying their nurses aides $6 and $6.50 an hour. Chicago Home Care which was run by one of the people

that was involved in the Morrisroe-related agencies, took the exact same nurses' aides, gave them back to the agencies to provide nurses aide services and charged nearly $18 an hour, specifically $17.87. What Blue Cross-Blue Shield could not determine at the time, because the law did not enable them to look at or audit the subcontractors books for relations, was whether or not the company, Chicago Home Care, was related. We have developed a tremendous body of evidence and I have included some of that in my written testimony that I think characterizes Mr. Morrisroe's control directly. In fact, a later witness, Tim Scanlon can describe a first-hand conversation in which Mr. Morrisroe indicated very strong involvement in Chicago Home Care.

What I would like to do, sir, though is to introduce into the record, a memo that was prepared for the Home Health Agency of Oaklawn in Burbank. It was prepared by the agency's administrator, who will be testifying later, and it was in response to questions that the agency's attorney was asking when that agency and all of the Morrisroe-related agencies were asked to defend their decision to move their nurses' aide services to Chicago Home Care. I think it gives a very graphic perspective of the extent of the finances that were involved here. Questions 15, 16, and 17 indicate that in December of 1977 there were 335 nurses aides visits performed by the agency's nurses aides. That was a total cost, according to this memo, of $1,997.48. The next month the agency had 340 nurses aides visits—this time under contract with Chicago Home Care. This was a net increase of five visits, but their cost to Chicago Home Care was $7,148, slightly over a $5,000 increase in 1 month for one agency. I think that gives you the perspective. I would like to introduce this into the record if I may, sir.

Chairman ROTH. Without objection.

[The document referred to was marked "Exhibit No. 1," for reference and may be found in the files of the subcommittee.]

Mr. LYONS. One of things that we noticed during our investigation, I have emphasized already, was Mr. Morrisroe's policy to pay the profitmaking companies that he controlled on a priority basis. He would order the checks be paid immediately regardless of how much was ultimately allowed or disallowed, and that money would immediately go to the profitmaking companies.

I think that the most graphic example that I can submit, sir, of what paid a "priority basis" means is in photocopies of five checks paid to Chicago Home Care from Southwest Community Home Health Agency. The most remarkable part about these particular five checks, checks for approximately $11,000, $5,000, $9,000, $3,000 and $2,000, is the fact that although the checks are dated, as an example, August 1, 1978, the checks are stamped paid before the date, for example July 31, 1978.

So in essence the check is paid before it is written.

In one case here, the check is paid on the same date that it is written. I think that this is a fairly graphic demonstration of what paid on a priority basis actually meant in practice.

I would like to submit this into the record as well.

Senator COHEN. Without objection.

[The document referred to was marked "Exhibit No. 2," and follows:]

EXHIBIT NO. 2

SOUTHWEST COMMUNITY HOME HEALTH AGENCY
REVENUE AND EXPENSE ACCOUNT

1573

PAID ASHLAND STATE BANK
2445 AUG 3 1 1978 2445
CHICAGO, ILLINOIS

Sept 1 1978 $\frac{2\text{-}445}{710}$

PAY TO THE ORDER OF Chicago Home [illegible] $ 11436.80

[illegible] Thousand and Four Hundred and Thirty Six and 80/100 DOLLARS

ASHLAND STATE BANK 9443 SOUTH ASHLAND AVENUE CHICAGO, ILLINOIS 60620

SOUTHWEST COMMUNITY HOME HEALTH AGENCY
REVENUE AND EXPENSE ACCT.

Patricia Carroll

⑈001573⑈ ⑆07100445⑆ ⑈29⑈759⑈8⑈ ⑈0001143680⑈

SOUTHWEST COMMUNITY HOME HEALTH AGENCY
REVENUE AND EXPENSE ACCOUNT

1574

PAID ASHLAND STATE BANK
2445 AUG 3 1 1978 2445
CHICAGO, ILLINOIS

Sept 1 1978 $\frac{2\text{-}449}{710}$

PAY TO THE ORDER OF Chicago Home [illegible] $ 5,378.87

Five Thousand and Three Hundred and Seventy Eight and 87/100 DOLLARS

ASHLAND STATE BANK 9443 SOUTH ASHLAND AVENUE CHICAGO, ILLINOIS 60620

SOUTHWEST COMMUNITY HOME HEALTH AGENCY
REVENUE AND EXPENSE ACCT.

Patricia Carroll

AUTHORIZED SIGNATURE

⑈001574⑈ ⑆07100445⑆ ⑈29⑈759⑈8⑈ ⑈0000537887⑈

Southwest Commun HHA.
[illegible] [illegible]
Revenue Cancelled Checks

SOUTHWEST COMMUNITY HOME HEALTH AGENCY
REVENUE AND EXPENSE ACCOUNT

1532

PAID ASHLAND STATE BANK
2445 JUL 3 1 1978 2445
CHICAGO, ILLINOIS

Aug 1 1978 $\frac{2\text{-}445}{710}$

PAY TO THE ORDER OF Chicago Home Care $ 9,417.49

Nine Thousand and Four Hundred and Seventeen and 49/100 DOLLARS

ASHLAND STATE BANK 9443 SOUTH ASHLAND AVENUE CHICAGO, ILLINOIS 60620

SOUTHWEST COMMUNITY HOME HEALTH AGENCY
REVENUE AND EXPENSE ACCT.

Patricia Carroll

AUTHORIZED SIGNATURE

⑈001532⑈ ⑆07100445⑆ ⑈29⑈759⑈8⑈ ⑈0000941749⑈

SOUTHWEST COMMUNITY HOME HEALTH AGENCY
REVENUE AND EXPENSE ACCOUNT

1533

PAID ASHLAND STATE BANK
2445 JUL 3 1 1978 2445
CHICAGO, ILLINOIS

Aug 1 1978 $\frac{2\text{-}445}{710}$

PAY TO THE ORDER OF Chicago Home Care $ 3,627.61

Three Thousand and Six Hundred and Twenty Seven and 61/100 DOLLARS

ASHLAND STATE BANK 9443 SOUTH ASHLAND AVENUE CHICAGO, ILLINOIS 60620

SOUTHWEST COMMUNITY HOME HEALTH AGENCY
REVENUE AND EXPENSE ACCT.

Patricia Carroll

⑈001533⑈ ⑆07100445⑆ ⑈29⑈759⑈8⑈ ⑈0000362761⑈

SOUTHWEST COMMUNITY HOME HEALTH AGENCY
REVENUE AND EXPENSE ACCOUNT

1411

PAID ASHLAND STATE BANK
2445 MAY 1 6 1978 2445
CHICAGO, ILLINOIS

May 16 1978 $\frac{2\text{-}445}{710}$

PAY TO THE ORDER OF Chicago Home Care $ 2376.71

Two Thousand and Three Hundred and Seventy Six and 71/100 DOLLARS

ASHLAND STATE BANK 9443 SOUTH ASHLAND AVENUE CHICAGO, ILLINOIS 60620

SOUTHWEST COMMUNITY HOME HEALTH AGENCY
REVENUE AND EXPENSE ACCT.

Patricia Carroll

⑈001411⑈ ⑆07100445⑆ ⑈29⑈759⑈8⑈ ⑈0000237671⑈

Mr. LYONS. I have one further thing to add about Chicago Home Care, if I may, sir. It is difficult to ascertain when the idea to create Chicago Home Care came about. It is not difficult for us to ascertain that Mr. Morrisroe controlled Chicago Home Care, but it is difficult to ascertain when the idea came about. I would like to submit into the record a letter to Mr. William Colson, who was the attorney for the Oaklawn-Burbank Home Health Agency. It is an explanation from the executive director, Agnes M. Flanigan of the Flanigan Family, as to why she ultimately made the selection of Chicago Home Care.

She states in part that she finally signed the contract with Chicago Home Care in January of 1978, although she had been "considering the move for some time." That is somewhat ironic since Chicago Home Care wasn't officially incorporated until February of 1978 and was not even doing business in 1977. Yet, according to Ms. Flanigan, she had been actually "considering the move for some time." I would like to submit this into the record as well.

Senator COHEN. Without objection, that will be included.

[The document referred to was marked "Exhibit No. 3," and follows:]

EXHIBIT No. 3

OAK LAWN, ILL., *December 8, 1978.*

WILLIAM COLSON,
Attorney at Law,
West Dearborn Street,
Chicago, Ill.

DEAR MR. COLSON: I was the Executive Director of the Home Health Agency of Oak Lawn-Burbank during 1977, and I was in charge at the time that our home health agency contracted with Patricia Tinder's Chicago Home Care Service. The agreement was made in late December, but I had been considering the move for some time.

One of the most difficult and frustrating jobs in running the agency was finding home health aides. I tried calling other temporary services, but none of them seemed to fit the bill. Meanwhile I did not have enough aides to fill our needs, and the aides that we did have were a constant source of difficulty. They didn't show up to work, came late and left early, and were a constant center of attention. Many of my days were spent on the telephone trying to get people to come in just for an interview!

My only reservation about dealing with Chicago Home Care Service was that I wanted to make sure that the couple of good aides that I had would be kept on working with the same patients, and Patricia Tinder agreed to see that they would. I considered other factors, also.

The cost was lower with Chicago Home Care Service than with the other agencies. Moreover, it seemed to me—all things being added into the price—that it was cheaper to contract for the aides than to send out my own.

Perhaps the most important part, however, was that I felt that I could rely on Pat to do the job well. She had been an aide herself, and she really cared about patients. When you come right down to it, the well-being of the patients has to outweigh other factors.

Yours truly,

AGNES M. FLANIGAN.

Mr. LYONS. I think, sir, that to the best that the Better Government Association could determine during the course of this investigation, Chicago Home Care was clearly the most ambitious undertaking and certainly the one that brought the closest scrutiny by the fiscal intermediary, Blue Cross.

I also would like to suggest that the scenario may not be over even today. There is a new organization which is now supplying aides

to at least one of the remaining agencies which hasn't gone bankrupt. The name of the new profitmaking company is Harvey Home Care. Its chief executive officer is Patricia Tinder who was the former chief executive officer of Chicago Home Care. The company is operated out of a house.

At a meeting recently with Blue Cross and Ms. Tinder, her attorney indicated the company was incorporated August 1, 1980, and had some 12 employees, including some of the aides that worked for Chicago Home Care.

So I think there is reason to believe that the phenomenon may be occurring again in a different form.

Senator COHEN. What are some of the other abuses that you turned up in your investigation concerning as the operation of the agency?

Mr. LYONS. Sir, we looked at one additional profitmaking company that I haven't discussed. I characterized Northrad, which was the consulting firm. I characterized Midwest Leasing, which was a subsidiary of Northrad and I just characterized Chicago Home Care.

I think the fourth profitmaking company which is of some interest to these hearings is Oaklawn Physical Therapy Associates. Once again, it was formed by a person who was related to the entire Michael Morrisroe operation, a woman named Maureen Flanigan, who had considerable experience in the Morrisroe-related agencies, including being a physical therapist at Southwest and incorporating a second of the agencies, Midway Visiting Nurses Service.

I would like to submit into the record a photocopy of the initial Illinois survey report of Midway Visting Nurses Services, of which Maureen Flanigan was the president, on the board of directors, the administrator and one of the incorporators. On pages 3 and 10 of this document is listed a physical therapist by the name of Catherine Couter. It indicates she would receive $12 per physical therapy visit. It also indicates her Illinois physical therapy license and that she is under contract with Midway Visiting Nurses Service.

It is a State requirement that employees who work for these agencies be under contract or be full-time employees of the agencies. It came as quite a surprise to Ms. Couter that she was mentioned on this particular document. In addition to introducing this initial State survey, I would like also to introduce the affidavit of Catherine Couter Zito, which is now her married name, where she states, signs and swears to the fact that she never worked for Midway, never intended to work for Midway VNS, and her name was used to satisfy the State requirements without her knowledge or without her authorization.

I would like to introduce, if I may, these two.

Senator COHEN. They will be introduced into the record without objection.

[The document referred to was marked "Exhibit No. 4," and follows:]

EXHIBIT No. 4

State of Illinois County of Cook SS;

AFFIDAVIT OF CATHERINE COUTER ZITO

I, Catherine Couter Zito do solemnly swear that the following information is true to the best of my knowledge and belief.

1. I am a Physical Therapist residing at 3228 Sunset Lane, Franklin Park, Illinois and my physical therapy number is IL# 70-1766. I am a graduate of St. Louis University. I have a license to practice physical therapy in the State of Illinois.

2. I have reviewed the document presented to me by the Better Government Association that is represented as being the initial State of Illinois survey report for the licensure of Midway Visiting Nurses Services at 7809 South Western Avenue, Chicago, Illinois, a not-for-profit Home Health Agency in the State of Illinois.

3. I have never worked as a physical therapist or in any capacity for either Midway Visiting Nurses Services or any person affiliated with Midway Visiting Nurses Services. Nor have I ever entered into a contract with Midway Visiting Nurses Services or any person affiliated with Midway Visiting Nurses Services.

4. The use of my maiden name and physical therapy number was without my knowledge and authorization and I do not know who used it or authorized its use.

5. I have never collected any money nor any other remuneration from Midway Visiting Nurses Services or any person affiliated with Midway Visiting Nurses Services.

6. The representations made on the State of Illinois initial licensure survey for Midway Visiting Nurses Services as they relate to me are totally false.

CATHERINE COUTER ZITO.

Witness my official signature and seal as Notary Public in and for Cook County, Illinois, on this 10th day of May A.D. 1981.

JENNIFER C. ELLIS.

My commission expires October 31, 1983.

Form Approved
OMB No. 72-R0735

HOME HEALTH AGENCY SURVEY REPORT

PROVIDER NUMBER 01: Initial

1) ☒ INITIAL 2) ☐ RESURVEY 02

DATE OF SURVEY 03: 2-17-77.

NAME OF HOME HEALTH AGENCY	ADDRESS (STREET)	CITY	COUNTY	STATE	ZIP CODE
Midway Visiting Nurse Service	7809 S. Western Ave.	Chicago	Cook	Il.	60620

NAME OF SURVEYOR	SURVEYOR'S PROFESSIONAL TITLE
Gay A. Young	R.N.

04 GEOGRAPHIC AREA SERVED (DESCRIBE)

Bounded on the East by Western Ave.
" " " West by Rt. 45
" " " North by Madison St.
" " " South by 95th St.

NAMES AND TITLES OF ADDITIONAL SURVEYORS 05

NAME	TITLE

	YES	NO	N/A		EXPLANATORY STATEMENTS
06				☒ MET ☐ NOT MET **I. Compliance with Federal, State and Local Laws. Condition — (405.1220)** The home health agency and its staff are in compliance with all applicable Federal, State and local laws and regulations. If State or applicable local law provides for the licensure of home health agencies, an agency not subject to licensure must be approved by the licensing authority as meeting the standards established for such licensure. A proprietary organization which is not exempt from Federal income taxation under Section 501 of the Internal Revenue Code of 1954 has to be licensed as a home health agency pursuant to State law. If no State law exists for the licensure of a proprietary home health agency, (see 405.1202(o)) it cannot be certified for participation in the Medicare program.	Staff members are currently licensed. Articles of Incorporation filed 9--27--76. Certificate # 30728 Employer ID number: 36-2885015
					Date IRS exemption issued, if applicable 12-3-76 Expiration date of licensure, if applicable Not applicable
07				☒ MET ☐ NOT MET **II. Organization, Services, Administration. Condition—(405.1221)** Organization, services provided, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable. Administrative and supervisory functions are not delegated to another agency or organization and all services not provided directly are monitored and controlled by the primary agency, including services provided through subunits (see 405.1202(w)) of the parent agency. If an agency has subunits, appropriate administrative records are maintained for each subunit.	Organization of agency is set forth in bylaws. Organizational chart is available for review - needs minor revision.

FORM SSA-1572 (11-74)

NAME OF FACILITY Midway Visiting Nurse Service

	YES	NO	N/A		EXPLANATORY STATEMENTS
				(iv) ensures the accuracy of public information materials and activities, and (v) implements an effective budgeting and accounting system. A qualified person is authorized in writing to act in the absence of the administrator.	(iii) is partially delegated to Medical Director and Director of Nursing. Medical Director, Javier Zavaleta, is authorized to act in absence of admin.
012				☒ MET ☐ NOT MET *(d) Supervising Physician or Registered Nurse.* The skilled nursing and other therapeutic services provided are under the supervision (see 405.1202(y)) and direction of a physician or a registered nurse (who preferably has at least 1 year of nursing experience and is a public health nurse (see 405.1202(q)). This person or similarly qualified alternate, is available at all times during operating hours and participates in all activities relevant to the professional services provided, including the qualifications and assignment of personnel.	Supervising physician is Javier Zavaleta (also designated as Medical Director) Ill 36-44669 Il-41-86769 Pat Carroll RN will act as Director of Nursing. Recommended that Director of Nursing also assume part of the responsibility.
013				☒ MET ☐ NOT MET *(e) Personnel Policies.* Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications, licensure, performance evaluations, and health examinations and are kept current.	Personnel policies are appropriate. Job description for Director of Nursing requires that the nurse hold a degree from NLN approved school. Mrs. Carroll is a 1956 Diploma grad. from St. Bernard's Hospital. Refer to SSA 2567, item #2.
014				☒ MET ☐ NOT MET *(f) Personnel Under Hourly or Per Visit Contract.* If such personnel are utilized by the home health agency, there is a written contract between such personnel and the agency clearly designating: (i) that patients are accepted for care only by the primary home health agency, (ii) the services to be provided, (iii) the necessity to conform to all applicable agency policies including personnel qualifications, the responsibility for participating in developing plans of treatment, (iv) the manner in which services will be controlled, coordinated, and evaluated by the primary agency, (v) the procedures for submitting clinical and progress notes, (see 405.1202(d) and (n)) scheduling of visits, periodic patient evaluation, and (vi) the procedures for determining charges and reimbursement.	Sue Cavoto O.T. Reimbursed 15.00/visit Maureen Flanigan R.P.T. $12.00/visit Cathy Couter R.P.T. $12.00/visit Catherine Weaver CCC $18.00/visit Lawrence Hammerman MSW $20.00/visit Contracts meet specifications in (f).

NAME OF FACILITY: Midway Visiting Nurse Service

	YES	NO	N/A		EXPLANATORY STATEMENTS
G35 →				☐ MET ☐ NOT MET Not applicable *(b) Duties of the Qualified Licensed Practical Nurse (see 405.1202(l)).* The qualified licensed practical nurse: (i) provides services in accordance with agency policies, (ii) prepares clinical and progress notes, (iii) assists the physician and/or registered nurse in performing specialized procedures, (iv) prepares equipment and materials for treatments observing aseptic technique as required, and (v) assists the patient in learning appropriate self-care techniques.	No LPN's are employed.
G36 →				☒ MET ☐ NOT MET **VI. Therapy Services. Condition — (405.1225)** Any therapy services offered by the agency directly or under arrangement are given by or under the supervision of a qualified therapist in accordance with the plan of treatment. The qualified therapist (see 405.1202(f) (i) and (u)): (i) assists the physician in evaluating level of function, (ii) helps develop the plan of treatment (revising as necessary), (iii) prepares clinical and progress notes, (iv) advises and consults with the family and other agency personnel, and (v) participates in inservice programs.	Maureen Flanigan R.P.T I/# 70-1879 B.S. in P.T 1974 U of Ill. Catherine Coates I/# 70-1766 R.P.T. St. Louis Univ. 1973 P.T. Duties of the therapist are described.
G37 →				☐ MET ☐ NOT MET Not applicable *(a) Supervision of Physical Therapist Assistant (see 405.1202(j)) and Occupational Therapy Assistant (see 405.1202(g)).* Services provided by a qualified physical therapist assistant, or occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapist assistant or occupational therapy assistant: (i) performs services planned, delegated and supervised by the therapist, (ii) assists in preparing clinical notes and progress reports, and (iii) participates in educating the patient and family, and (iv) inservice programs. No. Physical Therapists 2	Sue Couota O.T. AOTA 296855 U of Illinois 1976 O.T. No assistants are used by the therapists.

Mr. LYONS. It almost becomes redundant in looking at the Morrisroe-related profitmaking companies, but one thing becomes very apparent. Mr. Morrisroe controlled this operation as he controlled the other three and the overhead for the operation was supplied and paid for by medicare funds.

The typewriters that were used for Oaklawn Physical Therapy were supplied by the Home Health Agency of Oaklawn Burbank, one of the Morrisroe-related agencies which incidentally was run by Maureen Flanigan's family. The beepers that the physical therapists used to get in contact with each other were supplied by another of the Morrisroe-related agencies, Southwest Community Home Health.

Once again, we developed evidence that indicates that Mr. Morrisroe had a direct day-to-day control in terms of the operation of Oaklawn Physical Therapy Associates.

Senator COHEN. He remained rather invisible for all intents and purposes, did he not?

Mr. LYONS. Yes. He did. His relationship is especially concealed when he is dealing with the profitmaking companies and becomes extremely difficult to determine.

On the first two profit companies, Northrad and Midwest Leasing, his name appears on the documents. On Chicago Home Care and Oaklawn Physical Therapy, any dealings he had would have been either as a private individual or as another corporation, both privately held.

So it becomes extremely difficult at times to ascertain exactly where decisions were made and how they were made.

Senator COHEN. What about his personal conduct in terms of the taping and telephone conversations?

Mr. LYONS. Yes, sir. We have an extremely strong indication from a number of sources that on direct instructions from Mr. Morrisroe a number of staff at the agencies were required to tape phone conversations.

This is illegal under Illinois law. It is a two-party consent State. What they would do is tape these particular phone conversations, notably with Blue Cross/Blue Shield, and with various attorneys who would call in.

They played these tapes back for Mr. Morrisroe's benefit so he could get an idea of what their posture was, so that he could understand what it was they were saying when he wasn't there. He is an extremely elusive man, very secretive, and he went to extraordinary lengths to conceal any relationships. One time at Chicago Home Care, when an employee came in that he didn't expect, he physically jumped behind the door to avoid being seen. He exercised any kind of caution he could.

Senator COHEN. Would you care to summarize your testimony?

Mr. LYONS. Sir, the central fact that our investigation uncovered was that Michael Morrisroe controlled four profitmaking companies and five not-for-profit home health agencies, that he did so in spite of the fact that he does not appear sometimes on corporate documents and that he did so sometimes in using some questionable tactics.

As examples, he instructed agency staff to actually destroy gasoline receipts that he had incurred while he was in California and then bill them to medicare through that one particular agency.

All of his activities that we have been able to identify were paid for by medicare as well as all of the activities of the various profitmaking companies.

His was an attitude that "everyone is out to get us," according to the agency staff that we talked to. They became extremely concerned.

He used tactics such as interrelated boards of directors. Actually, the boards of directors are supposed to provide a check on whether an agency is being fiscally imprudent, but they were primarily composed of members of these three particular families. That becomes a very effective tactic in terms of controlling some people when their parents or husbands would be listed on the board of directors. When they would later resign because they had discovered that the agencies were operating in what they suspected was a fraudulent manner, and it became extremely difficult to go to the Federal Government and say that there is fraud occurring at this agency when your husband or your mother is on the board of directors.

Senator COHEN. I will declare a 5-minute recess so I can go and vote. I believe Senator Roth will be back momentarily and we can continue with the testimony. The subcommittee will stand in recess for 5 minutes.

[Brief recess.]

[Member of the subcommittee present at the time of recess: Senator Cohen.]

[Member present after the taking of a brief recess: Senator Cohen.]

Senator COHEN. The subcommittee will come to order.

Mr. Morley, would you proceed to describe some of the financial considerations of this investigation?

FURTHER TESTIMONY OF MR. MORLEY

Mr. MORLEY. Yes, Mr. Chairman.

I think Mr. Lyons has done a very detailed and clear job of describing the interrelationships among the players in this operation, the five home health agencies and the subcontractors. The scope of the subcommittee investigation had to do primarily with what all this interaction and control meant with regards to finances; what happened to the money that medicare paid these five health care agencies, where did it go, who got it, what did they do with it?

In our investigation we issued 11 subpenas to the various principals that we have identified in this operation and to several banks. We also subpenaed the corporate and partnership books and records of the subcontractors, Chicago Home Care, Northrad and Oaklawn Physical Therapy.

Michael Morrisroe and several of the other principals in this investigation declined through their attorneys to testify in front of the subcommittee as they felt that their testimony might tend to incriminate them in light of the ongoing title 26 grand jury in Chicago.

With your permission, I would like to introduce into the record the letters from their attorneys in which they decline to testify.

Senator COHEN. Without objection, it is so ordered.

[The document referred to was marked "Exhibit No. 5," and follows:]

EXHIBIT NO. 5

SILETS & MARTIN, LTD.,
ATTORNEYS AT LAW,
Chicago, Ill., April 28, 1981.

Re Chicago Home Care Services, Inc.

Mr. S. CASS WEILAND,
Chief Counsel, Committee on Governmental Affairs, Permanent Subcommittee on Investigation, U.S. Senate, Washington, D.C.

DEAR MR. WEILAND: My client, JoAnne Stevens, has advised me to relate to you that she would not be willing to submit to an interview in connection with your investigation, until such time as she receives assurances from both your committee, as well as the Department of Justice, that nothing she would say, nor any documents she might provide, could or would be used against her in any criminal proceeding.

If you wish to discuss further your investigations of the role of Ms. Stevens in this investigation, please do not hesitate to call me.

Very truly yours,

ROYAL B. MARTIN, Jr.

GEORGE J. COTSIRILOS & ASSOCIATES, LTD.,
Chicago, Ill., April 24, 1981.

Re Rose Gallagher and John Krusiec.

Mr. CHARLES MORLEY,
Subcommittee on Investigations, Committee on Governmental Affairs, U.S. Senate, Washington, D.C.

DEAR MR. MORLEY: This will confirm our earlier conversation during which I advised you that in light of the pending federal grand jury investigation in Chicago looking into the same matters being investigated by your subcommittee, and consistent with the position we have taken in the grand jury investigation, neither Ms. Gallaher nor Mr. Krusiec would consent to an interview at this time and would invoke their fifth amendment privilege at any session of the subcommittee. If my clients were to be granted formal immunity which would protect them during the course of the subcommittee's investigation and the grand jury's investigation, they would, of course, be happy to be interviewed and to testify.

Very truly yours,

JAMES R. STREICKER.

GEORGE J. COTSIRILOS & ASSOCIATES, LTD.,
Chicago, Ill., April 17, 1981.

Re Barbara Kedzior.

Mr. S. CASS WEILAND,
Chief Counsel, Subcommittee on Investigations, Committee on Governmental Affairs, U.S. Senate, Washington, D.C.

DEAR MR. WEILAND: I am in receipt of your letter of April 13, 1981, confirming our earlier phone conversation. I have discussed this matter with my client, Barbara Kedzior. In light of the pending federal grand jury investigation in Chicago looking into the same matters being investigated by your subcommittee, and consistent with the position we have taken in the grand jury investigation, Ms. Kedzior would not consent to an interview at this time and would invoke her fifth amendment privilege at any session of the subcommittee. If Ms. Kedzior were to be granted formal immunity which would protect her during the course of the subcommittee's investigation and the grand jury's investigation, she would, of course, be happy to be interviewed and to testify.

Very truly yours,

JAMES R. STREICKER.

ISHAM, LINCOLN & BEALE,
Chicago, Ill., April 15, 1981.

Re Michael Morrisroe.

Mr. S. CASS WEILAND,
Chief Counsel, Senate Permanent Subcommittee on Investigations, U.S. Senate, Washington, D.C.

DEAR MR. WEILAND: This letter will confirm our telephone conversation of April 14, 1981, concerning Michael Morrisroe. In addition, it, hopefully, will respond to your letter of April 9, 1981.

As you are aware, Michael Morrisroe is a "target" or "subject" of a Federal Grand Jury investigation in the Northern District of Illinois. That investigation is being conducted by Charles Sklarsky, Deputy Chief, Criminal Litigation Section of the United States Attorney's Office, with the assistance of Special Agents of the Federal Bureau of Investigation and the Internal Revenue Service. During the course of that investigation my client, Michael Morrisroe, has produced numerous documents to the grand jury. I have no objection to your reviewing those documents. As we discussed on the telephone, you can either make arrangements to review them with Mr. Sklarsky or you can review them at my office at your convenience.

As for your request to review personal records of Mr. Morrisroe, I will discuss it with him and get back to you. As I indicated to you, however, my general policy is to advise clients not to produce personal records unless they receive some assurance that the records will not be used against them.

As for your request that Mr. Morrisroe appear before the Subcommittee and testify, given his status in the present Federal Grand Jury investigation, I will recommend to him that he not make such an appearance unless he is immunized prior to any such testimony. It has been represented to me by Mr. Sklarsky that he presently is uncertain as to how long it will take to conclude the investigation. If the Government does not indict Mr. Morrisroe and closes its investigation of him, I would hope that there would be no problem in executing an immunity agreement so that he could testify before your Subcommittee.

If you have an questions or if I can be of further assistance, please contact me at your earliest convenience.

Very truly yours,

JAMES B. BURNS.

Mr. MORLEY. Our investigation revealed that all five home health agencies listed on this chart, were formed in fact in 1976.

[At this point, Senator Roth entered the hearing room.]

Mr. MORLEY. Northrad management was next formed in October 1976, with the total capitalization of $5,000. Oaklawn Physical Therapy was next formed in September of 1977 with the total capitalization of $1,000.

Chicago Home Care was then formed in February of 1978 with the total capitalization of only $2,000.

The capitalization figures will become significant as we go through this testimony because basically what we will see is it takes very little money to set this operation up, yet it produces an incredible amount of money down the road.

We examined the books and records of the subcontractors. We also had significant information from Blue Cross.

The examination of Blue Cross records and the subcontractor's books and records indicated that all the funds going to the five home health agencies were medicare funds. These were taxpayer dollars. They did not receive funds generally from any other source. It was all medicare money.

Likewise, the investigation revealed that the five home health agencies dealt exclusively with the subcontractors.

They did not deal with other subcontractors. They dealt with these that show up here. On the other hand, Chicago Home Care, Northrad and Oaklawn Physical Therapy, according to their own books and records and other information we have developed, dealt only with these five home health agencies. What we have here is a closed group. This isn't a group operating in the general marketplace. It is a closed group.

As the entire amount of funds flowing into this group came from medicare and, as we saw earlier, medicare reimburses based upon costs, obviously the way to pump more money into this operation is to increase costs.

These home health agencies and the subcontractors used two primary ways of increasing their costs. Number one, they had an extremely high utilization rate. As Mr. Lyons has testified they had a utilization rate that was very abnormal for the Chicago area. Utilization, again, is the total number of visits made per patient during the total time that patient is in the home health program.

If you look over here to Chart No. 2, entitled "Utilization Rate, Visits by Nurses' Aides per Beneficiary," you will see that the average utilization rate for the 50 to 60 home health agencies in Chicago in 1977, before the formation of the Chicago Home Care, was 19.9 or 20 visits per patient.

[CHART 2]

UTILIZATION RATE
VISITS BY NURSES AIDES PER BENEFICIARY

	1977	1978
AVERAGE VISITS-5 MORRISROE AGENCIES	30.9	33.2
AVERAGE VISITS-CHICAGO AREA AGENCIES	19.9	21.2
PERCENT DIFFERENCE	55%	56%

However, the five home health agencies that we are discussing here today had an average of 31 visits per patient, 55 percent higher than the Chicago average.

Chicago Home Care was formed in February 1978. The Chicago Home Care utilization rate as noted on the chart is 33 visits per patient, whereas the average in Chicago was 21. Chicago Home Care then is 56 percent higher than the Chicago average.

This becomes significant when you think that the costs that are being charged to medicare are basically a function of the number of patients these home health agencies are dealing with. So, obviously, if you have far more visits per patient you have far more reimbursement coming into your operation.

The second method used by this group to increase their cost is reflected in the next chart, noted as nurses' aide costs. That is Chart No. 3 in your folders. As has been previously explained, the five home health agencies used their own nurses' aides prior to the formation of Chicago Home Care. Blue Cross in their audits of the five home health agencies computed the average cost per visit of a home health aide provided by the five home health agencies.

[CHART 3]

NURSES AIDE COSTS

	1977 COST PER NURSES AIDE VISIT-5 HHA's	1978 COST PER NURSES AIDE VISIT-CHICAGO HOME CARE INC.	% INCREASE
SOUTHWEST	$10.73	$17.87	66%
ORLAND-TINLEY	$10.63	$17.87	68%
MIDWAY	$10.73	$17.87	66%
WILL CO.	$12.33	$17.87	45%
OAK LAWN-BURBANK	$12.32	$17.87	45%

This chart reflects those in the column noted 1977, cost per nurses' aide visits. As you look down the chart you will see the Southwest cost was $10.73 per visit; Tinley, $10.65 per visit; Midway, $10.73 per visit; Will County, $12.33 per visit; and Oaklawn Burbank, $12.32 per visit.

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Blue Cross believes their estimation of these costs to be very liberal. They have bent over backward to give the agencies every benefit of the doubt. Chicago Home Care was then formed and charged the five home health agencies $17.87 per visit. As has been testified to, the nurses' aides from the five home health agencies quit one day and were rehired by Chicago Home Care the next. It is the same operation, same service.

A couple of interesting factors should be noted here. Chicago Home Care paid the nurses' aides $6 a visit. So if they are charging the home health agencies $17.87 per visit and paying the nurses $6 a visit, you can see there is a lot of profit generated in this.

On the right side of the chart is indicated the 45 to 68 percent increase in rates charged by Chicago Home Care over what was charged when the nurses' aides were in the five home health agencies.

Blue Cross, when they examined the home health agencies, allowed a total of $14 per nurses' aide visit. They disallowed $3.87 per visit of the amount of money paid to Chicago Home Care. However, it is important to realize that the home health agencies had already paid Chicago Home Care the total of $17.87 per visit. So Chicago Home Care was not out any money. The people who were out the money were the home health agencies if, in fact, that money could be collected—and we will see that some of those disallowances were never collected by the intermediaries.

Prior to Blue Cross' disallowance, this mechanism of forming Chicago Home Care in effect increased the costs to the medicare system by almost $7 per nurses' aide visit. When you consider there were 56,000 visits made in 1 year by this operation, you can see that $7 times 56,000 generates an awful lot of money. Even after Blue Cross examined this, audited this, and disallowed this system or part of it, there was still $3 to $4 in excess charges being generated on behalf of Chicago Home Care. As an example, Blue Cross computed $10.63 to be reasonable for Orland-Tinley, but allowed them $14, an increase of over $3 per visit.

Another point which should be noted is that Chicago Home Care had very little overhead. It operated out of a very small office and, therefore, its costs were in no way any more than the five home health agencies. So basically it would appear that Chicago Home Care's sole purpose was to substantially increase costs.

Senator COHEN. Even after the Blue Cross audit and rejection, in other words, there was a significant increase.

Mr. MORLEY. Absolutely, $2 to $4.

Senator COHEN. Sort of on the principle of an attorney arguing to a jury, where you ask for 100 percent hoping to get 50. Even 50 would be acceptable.

Mr. MORLEY. That is correct, that is what happened here basically.

I might also point out that Blue Cross' allowance of $14 per visit is based upon the expectation that these visits will be 1 to 2 hours long. Whether or not they were 1 to 2 hours long, I don't know. I don't personally have evidence one way or another. I think we may see evidence later today that would indicate that not all of them were 2 hours long.

Senator COHEN. Were some fabricated altogether?

Mr. MORLEY. I believe that is the case, yes.

Mr. LYONS. We have uncovered some evidence that will be addressed later by Tim Scanlon and Jean Williams that records for Chicago Home Care were literally drawn up on Mr. Morrisroe's instructions. They were given a sheet of paper and told to pick a number of standard phrases. I think that is clearly fabricated, at least in some cases.

Mr. MORLEY. If we can move now to chart 4 which is over here, entitled "Income and Disallowances." This chart shows the amount of revenues paid from 1977 through 1980 by the five home health agencies to the three principal subcontractors that we are going to talk about today. It also shows the amounts of those payments that the intermediaries allowed with the relevant percentages of disallowance. If you look at the chart, you can see the five home health agencies paid Northrad Management a total of $213,000 from 1977 to 1979, 83 percent of which was disallowed by the intermediary. Blue Cross disallowed $177,000 of that.

[CHART 4]

INCOME & DISALLOWANCES

	NORTHRAD MANAGEMENT CORP. 1977-1979	CHICAGO HOME CARE INC. 1978-1979	OAKLAWN-PHYSICAL THERAPY, INC. 1978-1980
TOTAL PAYMENTS FROM 5 MORRISROE AGENCIES	$212,741	$1,317,558	$336,390
TOTAL DISALLOWANCE BY INTERMEDIARY	$177,100	$231,700	0
% DISALLOWED	83%	17%	0%

Northrad Management provided two basic types of consultation. One was consultation as to how to set up a home health agency. That was charged to each of the five home health agencies and that, by the way, was allowed as reasonable by Blue Cross.

The second type of management consulting allegedly provided by Northrad consisted of ongoing management consulting as to how to operate a home health agency. That was disallowed by Blue Cross as being unreasonable and because there was absolutely no documentation they could find as to what kind of consultation was occurring. There were no records to indicate that consulting service was being provided.

Second, Chicago Home Care, as we have seen, had the $3.87 disallowed and that is reflected in the 17-percent disallowance on the chart. Chicago Home Care from the period 1978 to 1979, 2 years, was paid a total $1,318,000 by the five home health agencies. Blue Cross allowed all but 17 percent of that.

Blue Cross disallowed $232,000 of that which represents the $3.87 disallowance.

Oaklawn Physical Therapy was paid a total of $336,000 over a 2-year period by the five home health agencies. All of that was allowed by the intermediary. The reason that was allowed is because the medicare regulations put a specific cap on the amount a home health agency can charge for a physical therapist visit. The home health agency charged right at that cap but didn't exceed it. Therefore, all of the charges were allowed by Blue Cross. Apparently they had substantiation that those visits were made.

It is interesting to note that in Blue Cross' audits of the five home health agencies, they disallowed 20 to 30 different items, such as furniture rental, et cetera. These two disallowances here, Northrad and Chicago Home Care comprised the vast majority of the actual dollars disallowed.

Senator COHEN. Would you tell me again, what is the difference between Chicago Home Care, Northrad, Midwest Leasing, and the Oaklawn Physical Therapy? What different functions do they perform?

Mr. MORLEY. Chicago Home Care was formed to provide nurses' aides to the five home health agencies. It was operated by Pat Tinder and JoAnn Stevens. Northrad Management was a pure management consulting firm. Midwest Leasing was a subsidiary of Northrad Management.

Senator COHEN. What did it do?

Mr. MORLEY. It leased office furniture to the five home health agencies. I might point out that the income and disallowance chart does not reflect the $100,000 paid by the five home health agencies to Midwest Leasing, most of which was disallowed by Blue Cross as being unreasonable and not done through the market system. Oaklawn Physical Therapy provided physical therapy services for the five home health agencies. It was run by Maureen Flanigan.

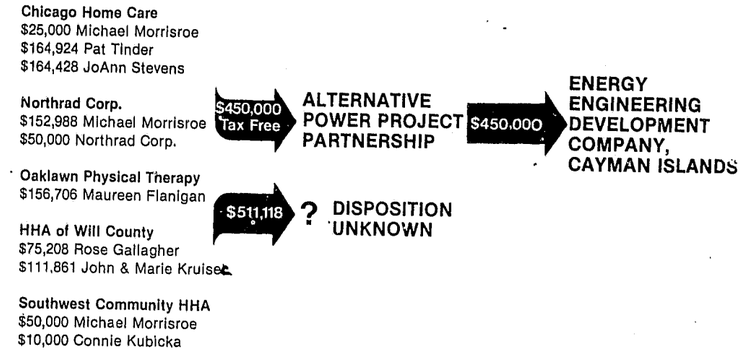
As we mentioned before, it is one thing to disallow a cost and it is another thing to collect costs. As Blue Cross came in and looked at these records, they disallowed a total of $409,000 in costs from the home health agencies with regards to Northrad Management and Chicago Home Care. However, Orland Tinley, one of the five home health agencies, is now bankrupt. It went bankrupt owing $81,000 to the Federal Government which will never be recovered. Will County also went bankrupt with $189,000 still owing to the Federal Government. So even though these costs have been disallowed they are not going to be collected.

Chairman ROTH. Can you tell us what happened to these increased revenues? Did they expand their business, provide more services?

Mr. MORLEY. Yes, sir, I think if you look at chart 5 over here called Diverted Medicare Funds, you will see pretty much what happened to these funds. The five home health agencies paid $1,867,000 in medicare funds to Chicago Home Care, Northrad Corp., and Oaklawn Physical Therapy. We looked at the books and records of these organizations and various bank records. What we found was that 38 percent of that amount was taken right off the top by the various people involved in these companies. Of the $1,867,000 paid to these three subsidiaries, $714,000 was withdrawn by Michael Morrisroe, Pat Tinder, JoAnn Stevens, and Maureen Flanigan.

[CHART 5]

DIVERTED MEDICARE FUNDS



Going down the chart quickly, Chicago Home Care was formed using $2,000 capital. It received one-third million dollars in funds, medicare funds. Twenty-seven percent of that was withdrawn off the top. Michael Morrisroe withdrew $27,000 for his personal use. Pat Tinder got $165,000 for her own personal use. JoAnn Stevens received $164,000 for her own personal use.

Senator COHEN. What period of time was that, how many years?

Mr. MORLEY. A period of 2 years, 1978 and 1979. It is interesting to note that Pat Tinder, prior to becoming associated with the Morrisroe Agencies, was a welfare mother.

The books and records indicate Pat Tinder and JoAnn Stevens withdrew at one point a check for $210,000. That represents $105,000 each which they reported on their income tax returns. I have a copy of that check right here. It is a check drawn on Chicago Home Care Services, it is signed by the stamped signature of JoAnn Stevens and is in the amount of $210,000. That check never went to Pat Tinder and JoAnn Stevens, even though they reported it on their tax returns. It went into a certificate of deposit in the amount of $450,000 payable to Michael Morrisroe, Ltd.

Looking next at Northrad Corp., Northrad Corp. was capitalized with $5,000. During the 3-year period 1977 through 1979, it was paid one-quarter of a million dollars from the five home health agencies. Michael Morrisroe withdrew 95 percent of that amount for his own personal use. He withdrew $153,000 on his own behalf and withdrew $50,000 on behalf of Northrad which he then invested in an operation that he controlled.

Oaklawn Physical Therapy, capitalized at $1,000, operated during the period 1978 through 1980 and received a third of a million dollars in medicare funds. Maureen Flanigan withdrew 47 percent of that right off the top. She pulled that out in salaries and dividends. Therefore, with regard to just these three subcontractors, we see a total capitalization of only $8,000, and four people withdrawing three-quarters of a million dollars—and it is all medicare funds—taxpayer's funds.

Further down the chart you see Home Health Agency of Will County. Rose Gallagher withdrew $75,000 from that agency. John and Marie Krusiec, while holding full-time jobs elsewhere withdrew $112,000 from that home health agency and finally, the last item on the chart shows Southwest Community Home Health Agency. Michael Morrisroe withdrew $50,000 from that agency and Connie Kubicka withdrew $10,000.

Chairman ROTH. You say these individuals withdrew the funds for their personal use. How do you know the withdrawals were for that purpose?

Mr. MORLEY. There are several ways we know that, Mr. Chairman. Again, looking at chart 5, you will see an arrow of $450,000 pointing to Alternative Power Project Partnership. Alternative Power Project Partnership is a tax haven. Alternative Power Project was formed allegedly to invest in oil drilling operations off the coast of Costa Rico. We traced $450,000 right from these individuals into Alternative Power Partnership.

The $210,000 check that I mentioned with regard to Pat Tinder and JoAnn Stevens went into the certificate of deposit for Michael Morrisroe. The certificate of deposit for Morrisroe was in the amount of $450,668. That certificate of deposit was cashed in and invested directly into Alternative Power Project. The tax return for Alternative Power Project and related documents are here in front of me. I would like to introduce those into the record if you have no objection.

Chairman ROTH. Without objection.

[The document referred to was marked "Exhibit No. 6," for reference and may be found in the files of the subcommittee.]

Senator COHEN. What happened to the tax return of Pat Tinder and JoAnn Stevens? You said they listed that money as part of their income tax return even though they never received the money, and it went into the certificate of deposit, then in turn to Alternative Power Project Partnership. I assume on $164,000 they would pay considerable tax.

Mr. MORLEY. Not at all. They didn't pay a penny of tax.

Senator COHEN. Why?

Mr. MORLEY. They didn't pay a penny of tax because Alternative Power Project as a tax shelter had substantial losses in its oil drilling

operations. Alternative Power Project received the $450,000 into its bank account and immediately disbursed the same amount to Energy Engineering Development Co., a Caymen Island company which you see on the chart over here. The Caymen Islands is what is known as a tax haven country which has such tremendously tight bank secrecy laws that the flow of money cannot be followed through their banking system. Energy Engineering Development then, according to the records we have, invested that money in drilling operations off the coast of Costa Rica. During the years for which we have records which is 1979 and 1980, they did not strike oil, even though they allegedly sunk $1,791,000 into their oil exploration. Therefore, as the Alterntaive Power Project is a partnership, those losses—a million and three-quarters flowed right through to the partners of Alternative Power Project.

Senator COHEN. Alternative Power means alternative what? Alternative power to oil?

Mr. MORLEY. That is what the partnership states.

Senator COHEN. It connotes you are talking about developing alternative sources of energy for this country.

Mr. MORLEY. That is correct.

Senator COHEN. When, in fact, it is going back into drilling for oil.

Mr. MORLEY. Allegedly, yes, sir.

Senator COHEN. Along with the tax benefits inherent in that?

Mr. MORLEY. That is correct. What has happened, just so you get a very brief perspective of the effects of this and without going into great detail, the partners of the Alternative Power Project, which are the people listed on the left on this chart, had total income in 1978 and 1979 as reported on their tax returns of three-quarters of a million dollars. They paid tax of $16,000 on three-quarters of a million dollars in income. Most of that tax was paid by John Krusiec and his wife on their legitimate outside jobs.

Not only did they not pay hardly any tax on the three-quarters of a million dollars they withdrew, but they can continue to earn half a million in future years because they have not used up all of the tax loss on the Alternative Power Project. So what has happened is that these people have withdrawn $450,000, invested it into the Alternative Power Project and have written off three-quarters of a million dollars. I am sorry, they have written off $1.75 million.

Chairman ROTH. Could I ask one further question?

Did you check with the State Department to see whether the drilling actually took place?

Mr. MORLEY. Yes, we did. We checked the State Department and asked them if they had heard of Alternative Power Project, Energy Engineering, or the other Costa Rican company that was allegedly involved in the drilling. I have here two cables from the State Department saying that they are unable to confirm the existence of these companies and that the only drilling that they are aware of in Costa Rica is on the other side of Costa Rica on the Atlantic coast.

I would like to introduce these cables into evidence, if I may.

Chairman ROTH. So done, without objection.

[The documents referred was marked "Exhibit No. 7," and follows:]

EXHIBIT No. 7

Mr. Jenkins: In case you lack a map of Costa Rica, I should note that Guanacaste is on the Pacific coast of Costa Rica, bordering Nicaragua. Limon Province surrounds the port city of Limon, on the Atlantic Coast, bordering on Panama.
I hope this is useful for you.

CARL S. MATTHEWS,
Regional Affairs Officer,
Office of Central American Affairs.

[CABLE]

SAN JOSE, *May 7, 1981.*

From American Ambassador, San Jose.
To: Secretary of State, Washington, D.C.
Subject: Senate committee request for assistance.

1. We're unable to confirm existence of a "Costa Rican Development Company" involved in petroleum exploration/development in either Guanacaste Province or any other area of Costa Rica.
2. FYI: According to Costa Rican State oil monopoly, Recope, only repeat only exploratory drilling going on is Pemex (Mexican State Oil Co.) supported effort in Province of Limon.

MCNEIL.

[CABLE]

SAN JOSE, *June 1981.*

From: American Embassy, San Jose.
To: Secretary of State, Washington, D.C.
Subject: Costa Rica Development Co.

1. Re: Subject company. To the best of our knowledge (a) it does not currently exist here. (B) It has never engaged in oil gas exploration in Guanacaste—or, for that matter, anywhere else in Costa Rica. (C) No entity (save Mexican Oil Company Pemex) has explored in Costa Rica in recent years. (D) As far as the Costa Ricans are concerned, there is no "SW Quadrant. Tract 6."
2. FYI: Volcanic geology of most of Guanacaste is such that no one in right mind would seek gas/oil deposits there.
3. We are searching local registry again to determine if Costa Rican Development Co. has ever, RPT, ever been registered locally.

MCNEIL.

Mr. MORLEY. That takes care of half of the amount of the $961,000 that these people withdrew. The other half a million dollars reflected on the chart as "disposition unknown" was not traced beyond the fact that they actually withdrew the funds.

We know that they withdrew the funds because we traced the specific withdrawals to these individuals and we also saw the funds reported on their individual income tax returns.

By examining the books and records of Chicago Home Care, Northrad, and Oaklawn we know those funds did not go back into those companies, they were not reinvested in those companies because all the income from those companies came from medicare funds. Therefore, I think we are on pretty firm ground in saying that $961,000 was withdrawn from this operation over a period of 3 to 4 years, the bulk of it coming out in 2 years, all tax-free.

Chairman ROTH. Time is growing late, but I would ask you, if you could, to briefly summarize your findings.

Mr. MORLEY. To try and put it in simple terms, what we have here is five home health agencies and three subcontractors dealing exclusively with those home health agencies all being paid by taxpayers' funds out of medicare. By escalating their charges, by somehow having very high utilization rate, they manage to increase to a maximum the amount they could pull out of medicare. Certain individuals that

we have discussed here bled those companies for 27 to 95 percent right off the top. They put 47 percent of this into a tax haven and therefore insured that the amounts they withdrew and the amounts they will be earning for years to come will be tax-free.

It is perhaps best stated this way: These individuals with very little capital, only a moderate amount of ingenuity and really not much financial sophistication walked away with a million dollars of taxpayers' funds tax-free.

Chairman ROTH. Any questions?

Senator COHEN. Just a couple of questions, Mr. Chairman.

Mr. Morley, you indicated that cases of suspected waste, fraud and abuse discovered by the intermediaries were referred to HCFA, then on to the Inspector General's Office, I assume of the Department of Health and Human Services.

Mr. MORLEY. That is correct.

Senator COHEN. There have been 48 referrals made between January 1977 and January 1981?

Mr. MORLEY. That is the information we have.

Senator COHEN. What happens after the Inspector General handles these cases? What has happened?

Did they go on to the Justice Department?

Mr. MORLEY. I believe some of them did. Unfortunately, I don't have that right at my fingertips, but we can get that information for you.

Senator COHEN. I find this all fascinating, disturbing, shocking, as a matter of fact. But I want to come back to my initial problem, what has been done about it, where are the leaks in the system, and what can we do to correct them? I know that is coming tomorrow. My initial question, as I look at the chart about Midway, Oaklawn, and Southwest, is why are they in existence, basically? Why do you have a not-for-profit home health care agency that doesn't provide any services and has to contract out? It seems to me the more you start contracting, subcontracting, getting your equipment and devices over here and buy your furniture from another company and you get your nurses from a third, you go on and on and on, you keep subcontracting, and then it becomes much more difficult to prevent the kind of fraud and abuse we have seen here.

You are distorting the services and making it very difficult to track, certainly from a cost-accounting basis, where that money is going and why it is going there. I don't understand what functions these not-for-profit home health agencies are providing if they have to contract everything else out.

Mr. MORLEY. I suppose that is a good question. I think we will probably hear testimony with regard to that tomorrow.

Senator COHEN. A home health agency that has to go to another agency to get nurses? You have a home health agency that has to go to another agency who has to get management advice. You have a home health agency to go to another to get wheelchairs? What function are they serving?

Mr. MORLEY. I think we can say in the case of these agencies today, the function they serve is escalating costs. I don't know that that statement can be made in every situation of subcontracting.

You asked what happened to the cases referred to the Inspector General's Office. We are aware of at least 3 convictions of those 48. The other disposition we can find and enter into the record at a later date. I previously neglected to enter into the record the $210,000 check that represented the alleged salaries of Pat Tinder and Jo Ann Stevens. I would like to introduce these into the record also, if there is no objection.

[The document referred to was marked "Exhibit No. 8" and follows:]

EXHIBIT No. 8

...AGO HOME CARE SERVICES, INC.
...COME AND EXPENSE ACCOUNT
1205 WEST 103RD ST. 312-445-7500
CHICAGO, ILL. 60643

1293

9/29/78 2-445/710

Chicago Home Care Serv., Inc $755.54

...Hundred Fifty Five + 54/ DOLLARS

ASHLAND STATE BANK 9443 SOUTH ASHLAND AVENUE CHICAGO, ILLINOIS 60620

Jo Ann Stevens

⑈001293⑈ ⑆07100445⑆ ⑈29⑈844⑈8⑈ ⑈0000075554⑈

...AGO HOME CARE SERVICES, INC.
...COME AND EXPENSE ACCOUNT
1205 WEST 103RD ST. 312-445-7500
CHICAGO, ILL. 60643

1279

Sept. 15 19 78 2-445/710

ASHLAND STATE BANK $210,000.00

...RED TEN THOUSAND-AND-NO/00 DOLLARS

ASHLAND STATE BANK 9443 SOUTH ASHLAND AVENUE CHICAGO, ILLINOIS 60620

Jo Ann Stevens

⑈001279⑈ ⑆07100445⑆ ⑈29⑈844⑈8⑈ ⑈0021000000⑈

DEBIT Date Oct. 2 1978

Total $

29-844-8

Drawn by

ASHLAND STATE BANK
9443 SOUTH ASHLAND AVENUE
CHICAGO, ILLINOIS 60620

Cancel 11/2/78

2724

DATE October 2, 19 78

THIS CERTIFIES THAT Michael Morrisroe Ltd. - Escrow Account * * *
deposited with the above named Bank,

FOUR HUNDRED FIFTY THOUSAND SIX HUNDRED SIXTY EIGHT AND 84/100--- DOLLARS $ 450,668.84

PAYABLE TO THE ORDER OF Michael Morrisroe Ltd. - Escrow Account * * *

31 Days MONTHS AFTER DATE.

RATE 8 3/8 % PER ANNUM 11/02/78

AUDITOR

INTEREST TICKLER

AUTHORIZED SIGNATURE

ASHLAND STATE BANK
APPLICATION FOR TIME CERTIFICATE OF DEPOSIT

I/We hereby apply for a ASHLAND STATE BANK SAVINGS NON-NEGOTIABLE RENEWABLE TIME CERTIFICATE OF DEPOSIT ...

CERT. NO. 2599 2724 DATE 9/1/78

WANTED BY Michael Morrisroe Ltd. - Escrow Account AMOUNT 100,000.00 450,668.84

ADDRESS

PAYABLE TO

ADDRESS

TELEPHONE

NO. OF MONTHS

RATE

No. 36-2851993

Michael Morrisroe

100,000 of this C.D was a renewal of #2599
350,668.84 was added in to make $450,668.84
At maturity two cashier's checks were issued.
180755 + 180756

110,668.84

Senator COHEN. What actually happened to the money disallowed by the intermediaries to Northrad and Chicago Home, 83 percent and 17 percent, respectively? Has that been recovered?

Mr. MORLEY. No, sir, a lot of that has not been recovered.

Senator COHEN. Cannot be recovered? How about the two home health agencies, Will-Cook and Orland-Tinley?

Mr. MORLEY. They exist on medicare funds. They only receive sufficient medicare funds to cover their costs. As they don't have any liquid assets, there is little likelihood it will be recovered.

Senator COHEN. What about Midway, Oaklawn, and Southwest?

Mr. MORLEY. They have no liquid assets from which to recover nor will they generate excess revenues in the future from which to recover.

Senator COHEN. HCFA can't go now against the subcontractors Chicago Home Care, Northrad, or Oaklawn Physical Therapy?

Mr. MORLEY. No, sir, they disallow the costs of the home health agency, not the subcontractor.

Senator COHEN. If there is fraud, there is no provision in the law to recover that money?

Mr. MORLEY. I don't know the answer to that, Senator.

Senator COHEN. That is all, Mr. Chairman.

Chairman ROTH. I would point out that we do have a letter from the Justice Department which was sent to HHS to point out the problems of bringing criminal prosecution.

One question I would like to ask before you leave, Mr. Morley, how many of these subcontractors and and home health agencies are operating today?

Mr. MORLEY. I have the figure for home health, I believe. If you will bear with me just a second.

Chairman ROTH. I mean the specific subcontractors that we are dealing with, Chicago Home Care, Northrad, Midwest Leasing, Oaklawn, then you have the four or five agencies, Orland-Tinley, et cetera. Are any of these continuing to function today? If so, which ones?

Mr. MORLEY. Two of the five home health agencies are bankrupt. The other three, to my knowledge, are still operating. Chicago Home Care has been renamed, I believe, as Mr. Lyons testified, and it is still operating. Midwest Leasing became Stratford Leasing. It is still operating. Oaklawn Physical Therapy is still operating. I might point out we looked at Oaklawn Physical Therapy's office. If you recall, Oaklawn Physical Therapy received a third of a million dollars in medicare funds. Oaklawn Physical Therapy is an answering service. But it is still operating as an answering service.

Chairman ROTH. Could I direct a question to either one of you? Do we have any grounds for believing they have changed their practices? Do we have any reason to believe this operation is not continuing as before?

Mr. LYONS. Senator, I would suggest we have every reason based on the BGA investigation, to disbelieve that they have changed their practice. I think we have every evidence to believe they are doing exactly the same kind of thing. I think what we are seeing is the results of a very, very sophisticated in some sense bust out scheme where the final result is that the Government is left holding the bag.

Chairman ROTH. Has the intermediary done anything to try to remedy or correct this?

Mr. LYONS. They have done all that—in my understanding, they have done all they can under the law.

They referred it over to the investigative arm of the Health Care Finance Administration, the Office of Program Integrity.

Chairman ROTH. Are you saying under current law and regulation there is nothing they can do to stop these improper practices?

Mr. LYONS. As I understand it, sir, under current regulations, they can retroactively disallow some costs and they have been doing that, as Mr. Morley testified to. That has had no effect. They pay the costs in any case and the agency eventually goes bankrupt. They certainly could, I believe, under medicare regulations, exclude providers from the programs. But I believe, and here the General Counsel of the BGA would know the statistics, there have been incredibly low number of providers excluded from the home health care program.

Chairman ROTH. That is the question I want to raise. Cannot HHS terminate these agencies?

Mr. LYONS. They can do that, sir.

Chairman ROTH. Has any effort been made, do you know, to do so?

Mr. LYONS. No, sir, I know of no such effort. In fact, there have been only four home health agency providers ever excluded from the system. All the information we develop during the course of the BGA investigation indicates that there were instructions by the Office of Program Integrity to continue to pay these providers while they were carrying forth with an effort to make a substantial fraud or abuse case.

As far as I know, they continued to pay all the way along and today they are continuing to pay. Maureen Flanigan is now a physical therapist with Oaklawn-Burbank.

Chairman ROTH. You are saying despite the corrupt taking of $1 million, the same home health agencies and subcontractors are basically continuing to function?

Mr. LYONS. Yes, sir, that is exactly what I am saying.

Mr. MORLEY. I might add, Mr. Chairman, Maureen Flanigan is indeed apparently still operating as a physical therapist. She recently, within the last year or so, purchased a condominium in a suburb of San Diego for in excess of $200,000. Apparently even though she has no known permanent residence in Chicago where she is operating as a physical therapist, she does have an expensive condominium in San Diego.

Senator COHEN. I thought you were going to say Costa Rica.

Mr. LYONS. The calls from San Diego, Chicago, and the Cayman Islands were billed through the home health agency at Will-Cook County. So even the phone calls are billed to medicare.

Chairman ROTH. Needless to say, one of the questions of HHS I am going to want to ask is why hasn't there been any followthrough action? It is incomprehensible to me that when you have an outrageous illegal abuse of this sort that no remedial action would be taken.

Senator COHEN. Mr. Chairman, could I also raise the issue? We have something like 3,000 home health agencies in this country. The intermediaries have conducted, as I recall, maybe 1,100 audits in a $1 billion industry. It seems to me there are undoubtedly limitations in the man-

power and capabilities of intermediaries. But to have 1,149 audits on a $1 billion industry or billion dollar program does not sound even practical on our part.

Mr. LYONS. When we were in California and saw a similar system operating out there in this case using management companies, physical therapy companies, and medical equipment companies, when we talked to representatives of the fiscal intermediaries, of the 39 agencies they had responsibility for, they had audited 2.

Chairman ROTH. I do want to proceed with the next panel of witnesses. Thank you, gentlemen, very much. At this time I would call as the next panel of witnesses the three individuals who worked for one or more of the five home health agencies under investigation. The first witness is Mr. Martin Scanlon who was the administrative assistant at Southwest Home Agency from 1977 to 1979. The second witness is Jean Williams, who was a nurse at Will-Cook County Home Health Agency and Oaklawn Home Health Agency during 1978. She subsequently became the administrator at Oaklawn until her resignation in May 1979. The third witness is Carol Radatz. Mrs. Radatz provided bookkeeping services to the Orland-Tinley Home Health Agency during 1978 and 1979. I ask all three if you would please stand. Raise your right hand.

Do you swear the testimony you are about to give before this subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. SCANLON. I do.

Mrs. WILLIAMS. I do

Mrs. RADATZ. I do.

Chairman ROTH. Mr. Scanlon, earlier today the subcommittee staff introduced evidence of an interrelationship among the five home health agencies identified on the charts. Can you tell us what, if anything, you know about this interrelationship and, if you would, provide us with some background information concerning your association with the home health agencies in South Chicago that would enable you to respond to this question?

TESTIMONY OF MARTIN SCANLON, JEAN WILLIAMS, AND CAROL RADATZ

Mr. SCANLON. I will start with the background of my agency.

Chairman ROTH. Speak directly into the mike.

Mr. SCANLON. I started working at Southwest Home Health Agency in January 1976. I was hired as a work study student on a part-time basis. I was referred to the agency by Chicago Urban Corps, a placement agency. When I started at the agency, Michael Morrisroe was the administrator, Miss Kubicka was director of nursing, and Rose Gallagher was one of the nurses on the staff. Later on, Mr. Morrisroe resigned as administrator, became the consultant to the agency but maintained offices in the back of the agency. For all intents and purposes he controlled the daily business of the agency. Miss Kubicka stayed on as director of nursing. Miss Gallagher went to Orland-Tinley to work as an administrator. There she became administrator at Will-Cook County Home Health Agency.

Mr. Morrisroe controlled all five agencies. One example I can give you to prove this is that I had a variety of duties at Southwest, everything from office work to cleaning up, to carpentry work. While at Southwest I found a map. On the map I saw each of the five agencies that later came into existence. I took the map, it looked curious. It had different names scratched out as if Morrisroe was playing with ideas. I asked Miss Kubicka what it was. She laughed and said that Mike Morrisroe sat down and mapped out this plan for the southwest suburban side of Chicago and that he eventually planned to start all five agencies himself.

He would have me go over and paint the offices, put in walls, in order to prepare for the employees. He would have me go out to Will-Cook County, paint offices, put in walls, in other words get the offices ready. The same thing occurred at Orland-Tinley. I would go from agency to agency and bring messages back and forth and drop off different information.

Chairman ROTH. We also have seen evidence of a less than arm's length relationship between the home health agencies and Chicago Home Care, Oaklawn Physical Therapy. What, if anything, do you know about these relationships?

Mr. SCANLON. Later on in the history of the agency, I was offered a full-time position by Connie Kubicka. I was in college and was offered a position when I was graduated. I became administrative assistant. While administrative assistant I worked more closely with Mr. Morrisroe and Ms. Kubicka. On one occasion, I called Pat Tinder, of Chicago Home Care, and asked her a question. Ms. Tinder directed me to Mike and said, "Ask Mike, he takes care of everything, why are you calling me?" I went back to see Mike and Mike cringed when I told him that Pat Tinder said to see him about the problem. He said, "Don't say that, I am not supposed to be associated with Chicago Home Care, you are never supposed to say that." He said he would take necessary action with Ms. Tinder to stop her from saying things like that and then proceeded to tell me what to do.

Regarding Oaklawn Physical Therapy, Maureen Flanigan initiated Oaklawn Physical Therapy with Mr. Morrisroe. Maureen Flanigan was our physical therapist at the time. Maureen called me up and asked me different questions, requesting information about different procedures dealing with Blue Cross. I would answer her, if I could, or I would direct her to Mike. Or she would ask me to ask Mike what to do and I would relay a message to her.

Senator COHEN. When you spoke with him, where did you ask him the question of what to do?

Mr. SCANLON. In Southwest or on the phone, Mike kept in close contact with me.

Senator COHEN. After you became assistant administrator, did he still maintain an office in the back?

Mr. SCANLON. Once I became administrator assistant, Mike did maintain an office. The back office he used to occupy became my office but he would come in and out and we would share the office but not on the full-time basis as before.

Senator COHEN. Were there any files kept in the office that were not available to you?

Mr. SCANLON. Yes. Next door to the office was a storeroom. There were two file cabinets that were locked with padlocks. They were Mr. Morrisroe's files. There were also file cabinets in Miss Kubicka's office. They were locked. They contained her files, including board minutes, things like that, which later on I was able to get access to. Initially I was not.

Senator COHEN. When you wanted to talk to him, where would you call?

Mr. SCANLON. Call his answering service.

Senator COHEN. His answering service, what was it, Oaklawn?

Mr. SCANLON. No; the answering service was just an answering service that answered Northrad Corp. It answered Mr. Morrisroe's answering service.

Senator COHEN. Was there an office for Northrad?

Mr. SCANLON. No; there was never an office for Northrad. If I wanted to contact Mike, I would call one of the other agencies.

Senator COHEN. So Northrad Management Co. did not in fact have a separate physical existence to your knowledge?

Mr. SCANLON. To my knowledge, no. At the outset of the agency, its physical location was Southwest Community Home Health Agency. I took his orders to the printer and got the letterhead printed up and put it in his drawer for him.

Chairman ROTH. Earlier we had some testimony with respect to exhibit 3, the nurses' aide costs. There was testimony that the cost per visit was $10.73 in 1977 and this rose to $17.87 for each of the agencies. Are you familiar with this cost increase?

Mr. SCANLON. There was a change at Southwest Community Home Health Agency concerning our delivering of home health aide services. We switched over from delivering in-house home health aides services to subcontracting for these services from Chicago Home Care, for home health. Blue Cross-Blue Shield questioned the cost-effectiveness of that move. Mr. Morrisroe directed me to make a cost comparison of in-home home health visits to contracted home health aide visits. When I told him that it was more cost effective to do it in-house, he said we don't want those figures, make it work, make it look as if it is more expensive to contract; that is, to have in-home service than to contract out when in fact it was not.

Senator COHEN. You did that. Right?

Mr. SCANLON. We did a study with Alexander Grant Co. and the accountant fixed it in such a way that it was less expensive to contract out for these services. However, we never submitted that study to Blue Cross-Blue Shield.

Senator COHEN. Blue Cross-Blue Shield never saw that?

Mr. SCANLON. They saw a variation of it but not that one.

Senator COHEN. Did they reimburse based upon the contracting out?

Mr. SCANLON. They reimbursed us based on the cost of contracting out for these services until such time as Blue Cross disallowed $3.83.

Senator COHEN. I don't understand the time frame. If they came to you and said we want a justification for the switch of services and then you had a justification prepared but never gave it to them, what happened?

Mr. SCANLON. They didn't follow up until sometime later.

Senator COHEN. That is the point I want to raise again, Mr. Chairman. The question is Blue Cross-Blue Shield has no incentive to really follow up since it is not their money either, is it?

Mr. SCANLON. Blue Cross-Blue Shield was persistent in trying to follow up, but in this particular case we kept stalling, which was one of Mr. Morrisroe's tactics. In addition, a series of other events took place, so this problem got lost in the shuffle.

Chairman ROTH. So the end result is that nothing really happened.

Mr. SCANLON. $3.83 for the home health agencies was disallowed.

Chairman ROTH. That was never recovered?

Mr. SCANLON. That was never recovered.

Chairman ROTH. Continuing with the operation of Chicago Home Care, we have seen evidence that the home health aide utilization rates was much higher in 1977 and 1978 than other agencies operating in the Chicago area, that these agencies billed 55 percent more home health aide beneficiaries than other agencies in the area.

Do you have any explanation for this? Can you tell us what might account for this greater utilization?

Mr. SCANLON. Yes. I do. This is a long story. Chicago Home Care provided home health aide services to our patients. They were supposed to provide 1 to 2 hour visits depending on the orders of the doctor. However, the aides were actually staying in the homes about half an hour. Chicago Home Care would bill us for an hour visit, which was the standard visit. Usually it did not exceed an hour. We would bill Blue Cross-Blue Shield for an hour visit. Blue Cross-Blue Shield, our intermediary becomes suspicious, perhaps because our utilization was so high that we couldn't possibly be staying the whole hour. They instructed us to provide home health aide notes which would indicate the type of services provided by the home health aides and the length of their stay. Mr. Morrisroe instructed the people at Southwest Community Home Health Agency and Chicago Home Care to make up notes. He had the aides fill them out. It became apparent that an aide who could only do 7 visits in the day had done 15 or 10 that is, she wasn't spending a full hour. So Mr. Morrisroe then instructed me to have one of the secretaries Xerox a bunch of blank forms and he began to manipulate the forms in such a way that it looked as if an aide spent 7 visits a day instead of the 15. So in actuality we were being paid for 15 visits when we should have been paid for only 8.

Chairman ROTH. How did he cover his tracks? In other words, did he use different names to cover these?

Mr. SCANLON. He obtained their names from me. He started filling out the forms. He would check to see which days the aides were off and put down the days they actually made visits. Those aides who worked part time suddenly became full-time employees for purposes of these notes but not the payroll.

Chairman ROTH. Was it generally known that this was the practice?

Mr. SCANLON. This was the first time we provided the notes and it was the first time that it became a practice.

Chairman ROTH. Did this practice become common knowledge?

Mr. SCANLON. It was known to me and shortly thereafter I resigned.

Chairman ROTH. Mrs. Williams, it is my understanding that you were the administrator of the Oaklawn Home Health Agency during

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1978 and 1979. That means you were in charge of the agency. Is that correct?

Mrs. WILLIAMS. That is correct. I started out as a staff nurse at Will County. For approximately 3 weeks I worked as a registered nurse at Oaklawn Home Health Agency. Then I was immediately promoted to administrator. Needless to say, this promotion was without my knowledge. I walked into the office one day and was told I became the administrator.

Chairman ROTH. That you became what?

Mrs. WILLIAMS. Administrator.

Chairman ROTH. Would you describe your experience at Oaklawn with respect to the enrollment of patients?

Mrs. WILLIAMS. The first week, I was instructed to go to Oaklawn and help them open up some of their new referrals, new patients. There was a stack of about 15 referral sheets. Before visiting the patients the nurse must call the doctor, verify doctor's orders and then call the patient or family member at the patient's home, perhaps make an appointment to assess the patient's condition and then start enrollment in the program.

Approximately only 9 or 10 patients out of the 15 referrals indicated over the telephone that they wanted or, otherwise had received doctors orders that they needed, home health agency services. In arriving at all of the patients' homes I was greeted at the door by a family member who showed me a piece of paper from the medicare system, either the intermediary or perhaps it was HCFA.

At this point I wasn't sure what these papers were because I had only been at the home health agency for approximately 5 weeks, including working at Will County and Oaklawn. So I was not familiar with the medicare system regarding patient records and disallowing claims.

When I was instructed to go to Oaklawn and open up these patients by my boss at Will County Home Health Agency, Rose Gallagher, told me that if I had any problems in admitting these patients to Oaklawn Home Health Agency that I was not to talk to or to ask or to confide in the administrator presently at Oaklawn, but I was to directly call her at Will County from the patient's home.

This was told to me prior to seeing the patients.

So when I saw this piece of paper which said that the patient was no longer eligible for home health benefits, and that they would be charged for any additional services, I called Ms. Gallagher directly and told her that they had this piece of paper that says they are not eligible for medicare benefits, what should I do?

I am here, you sent me here. The doctor has verified that in his eyes, they are in need of medical assistance. Gallagher said open them up anyway, get the medicare numbers, fill out the necessary forms, assess their patient condition and just forget about the piece of paper.

Consequently, all 9 or 10 of these patients were serviced by the home health agency in Oaklawn Burbank for over a year. What had happened was that these patients benefits were medically exhausted. What I mean by medically is that perhaps the claims examiner at the intermediary felt that there was no medical justification for continuing under the program and disallowed the claim.

Mr. Morrisroe had instructed Rose Gallagher to shift these patients from Orland-Tinley to Oaklawn Home Health Agency to see if the computer or the claims examiner would not catch that a patient had been switched from one agency to another. Invariably, it was not caught.

They continued to be serviced for an additional year until their benefits were renewed.

This is a very common practice of the agency's because at that particular time Mr. and Mrs. Flanigan, the so-called owners or incorporators of Oaklawn, decided that they did not want to stay in the agency. They wanted to recoup the money they had put in to finance the agency.

So Mike had this agency dumped in his lap with no administrators or executive directors. He quickly promoted a nurse temporarily as administrator because all the Flanigans left. He ran the agency from his home. The patient load was about 40, but 40 a month is not enough to pay expenses.

So he switched patients from one another agency to build that agency up.

Did I make myself clear?

Chairman ROTH. We have also heard quite a great deal about the so-called consulting firm, Northrad Management. Could you describe how it operated, what services it provided?

Senator COHEN. Could I just inquire, Mr. Chairman? When you were elevated from a nurse to administrator, did your salary go up correspondingly?

Mrs. WILLIAMS. Yes.

Senator COHEN. Dramatically?

Mrs. WILLIAMS. No. As a staff nurse I was making $1,200 a month, flat. As an administrator he raised my salary from $1,500 a month with a company car and gas expense account.

Chairman ROTH. And a what?

Mrs. WILLIAMS. Gas expense account. I had a company credit card for gasoline.

Senator COHEN. So you did not derive significant benefits from the change in responsibilities?

Mrs. WILLIAMS. No. I really wasn't sure what was going on.

Chairman ROTH. I would like to go back to the consulting firm, Northrad Management. As I understand it, it was to provide various services such as business consultation and training.

Could you describe how it operated, what services it provided?

Mrs. WILLIAMS. Certainly. Our average bill from Morrisroe was $2,000 a month for Morrisroe's consulting services. His consulting services consisted of an occasional, usually daily, social phone call of, "Hi, how are you, what is new today; did you have any phonie calls; did Blue Cross harrass you today; what was in the mail"; that type of thing.

As for training, Mr. Morrisroe himself did very little training or consulting. Since I was a nurse who never had been in an administrative position before, he sent Rose Gallagher to spend approximately 2 to 3 days with me trying to show me the ropes, so to speak.

Later on, after I had been there a while and began to understand the medicare system, he told me to go to Midway Home Health Agency and train others for him.

So once he felt that I was competent enough to know what I was doing he then sort of farmed me out and billed the agencies for Northrad services.

Senator COHEN. Did he increase your gas mileage?

Mrs. WILLIAMS. No. [Laughter.]

Chairman ROTH. Mrs. Williams, are you aware of any instances where illegitimate costs were claimed by the home health agencies?

Mrs. WILLIAMS. Yes. I do. I believe the medicare regulations stipulate that in order to substantiate a company car you have to put approximately 2,000 miles on it per month. Many of the nurses, and especially the administrator of personnel, did not drive the company cars that amount of mileage per month.

Morrisroe would have you do one of two things, either he would tell you to take the car on a long vacation and put a lot of mileage on it, or on your mileage monthly sheets just make up per day mileage.

He also was big on a school called University of Beverly Hills. I had asked if it was all right if medicare provided for reimbursement for continuing education and he said, "Well, don't bother going to school, we will buy you a degree."

As a nurse I didn't think that was proper. But Morrisroe suggested that I call the University of Beverly Hills to inquire about it. It was a paper mill university.

They told me that if I mailed them $1,500, that I would get my bachelor's degree in business or whatever I wanted at the expense of the agency.

However, I never did that. But to my understanding some of the other administrative personnel from the other agencies did use this university.

Senator COHEN. Mr. Chairman, I believe "60 Minutes" did do a special on this particular University of Beverly Hills.

Mrs. WILLIAMS. Also there was another instance where we came to Washington to lobby for help on our disallowances and see if we could get some sort of support from our congressional people.

Connie Kubicka, Martin Scanlon, myself, our lawyer and Mike Morrisroe went to Washington. We stayed in Washington for 3 days. We went to a restaurant called Hugo's, which is at the Hyatt Regency here on Capitol Hill. We had a meal which cost over $300. Mr. Morrisroe paid for the meal in cash.

When we returned home the following day, Morrisroe came to the office and gave me the receipt from Hugo's. He demanded that I pay him that $300 out of our petty cash.

In the event I was ever questioned by Blue Cross about this cost, he had me put 15 initials on the receipt as if we were dining with 20 people or so, so that it would look obvious that it was justified.

Chairman ROTH. I would like to turn to Mrs. Radatz. I understand you were employed as bookkeeper in 1978 and 1979 for the Orland-Tinley Home Health Agency. Is that correct?

Ms. RADATZ. That is correct.

Chairman ROTH. You have just heard from Mrs. Williams about how Northrad was being paid although it provided for virtually no services at the Oaklawn Agency. What evidence did you see at Orland-Tinley that the Northrad Management Co. was earning its fee for consultant services?

Ms. RADATZ. I personally never saw Mr. Morrisroe for more than 1 to 2 hours a month during regular business hours.

I was made aware that there were often meetings before 6 o'clock in the morning or after working hours so that the general office personnel was not aware of his connection with our agency.

We received monthly bills from him for between $1,200 and $1,500 a month and a set-up fee of $22,710. We were instructed to keep a phone log so that when he came in to do his billing to our agency, he could look through the phone log and see how many times he called us so that he could use that as a basis for billing.

Chairman ROTH. Were you aware of any incidents involving inflated expenses at Orland-Tinley similar to those mentioned by Ms. Williams?

Ms. RADATZ. Certainly there were many. Several of our personnel were instructed to go to gas stations and get blank receipts, and then they were filled in later for whatever amounts that they needed to be filled in before they were put into petty cash. Gas receipts from California were paid by our agency and the girls were instructed to tear them up in little bittie pieces and throw them away. We were told to buy extra office supplies and extra medical supplies and store them in the back room so the costs would go up. Pat Tinder from Chicago Home Care would call and order office supplies, stationery, whatever she needed, and we would order them and pay for them, and we would send them over, or she would send someone over to pick them up.

The typewriter at Chicago from Home Care was leased to our agency and we paid for it. One of the secretaries in our agency helped set up Chicago Home Care while she was on our payroll. Exaggerated vacation costs were billed to Blue Cross/Blue Shield. The personnel were told we had 10 vacation days where actually medicare was billed for 12 to 22 days. Medicare was billed for training time, minimum of 7 days per person per year and the personnel was not made aware of that. We had a fancy three-color Xerox copy machine for quite a while in the office. It was never used while I was there. It just sat in the office and collected dust, but the monthly bills were paid for it.

The personnel in the agency were instructed to pay their own hospitalization insurance while the medicare was told that the agency was paying for it.

Out of petty cash, I remember when Mr. Morrisroe came to our agency, we bought him lunch, there were gifts paid to him out of petty cash. Back salary to me of $4,430.10 was charged to Blue Cross and I have not been paid.

Chairman ROTH. Were any of these practices at any time ever protested by the employees there?

Ms. RADATZ. We were told to do what we were told and not ask questions.

Chairman ROTH. Mr. Scanlon, what do you know about inflated costs?

Mr. SCANLON. While working for Southwest, the general policy of the agency was to purchase or lease expensive office machinery, we had a composer, large IBM typewriters, large Xerox machines. As Ms. Williams said, we had the same situation with our cars. We leased cars and behind all of this inflated cost was that you got a large cash flow into the agency, keep the agency afloat and just keep the creditors at bay and pay off the employees, keep the agency open as long as possible, the higher our expenses, the more we were paid for our costs per visit. Those kinds of unnecessary expenses were incurred at the agency.

Chairman ROTH. Ms. Radatz, we have heard a brief description of how records were destroyed at Orland-Tinley after a grand jury subpena was served in 1979. What information do you have about that event?

Ms. RADATZ. FBI agents came to our office door. We had a very secure security system, if you will. Everyone in the agency was instructed, under no circumstances were we to let anyone in the office unless we personally knew the people or we had prior knowledge that they were coming and it was OK to let them in.

If any stranger came to the door, we were told under no circumstances were we to let them in. The FBI agents came to the door, the secretary—she was the office manager at the time—answered the door, went to the door. They said they had a subpena to serve her. She had her instructions never to let anyone in the door. So the only way that they could possibly serve the subpena was to put it under the door, which they finally had to do because we just wouldn't open the door. Lynn picked up the subpena and went in to Barbara Kedzior, executive director's office, and closed the door. She called Mrs. Kedzior at home. Mrs. Kedzior said, "Sit by the phone, don't move." Five minutes later Mr. Morrisroe called Lynn, and the first question he asked her was to describe the men and their car.

The second thing she was told to do was read the subpena, which she did. She was then told to lock it in the drawer and tell no one that the subpena had been served. The next day Mrs. Kedzior came in to work, went into Lynn's office where the personnel records were kept, records of payments, policy, office policy records. She opened the file cabinets, had a big opaque garbage bag, and she put many files into the garbage bag. That night she took the garbage bag home with her.

The following day, and for several days afterward, she had several nurses, several office personnel and herself take the Home Health Aid records which were in the backroom, they had been kept very methodically, the girls sat on the floor with staple removers, they pulled all of the staples out of the records, they dumped all of the records on the floor and they made a complete mess of them. They mixed them up as much as they could. They had several cardboard cartons, they put bunches from hither and yon in each carton so that the records would all be mixed up, some had no names on them at this point, because the name was on the head sheet.

Mrs. Kedzior stood there and laughed and said, "Well, the FBI said we had to give them the records, but they didn't say what condition they had to be in." There was a concentrated effort of several days to mix the records all up so that they would be useless.

Chairman ROTH. For the purpose of the record, I would like to point out that we asked the woman you are referring to, Mrs. Kedzior, to come to testify but her attorney told us that she would take the fifth if she came.

I have one more question I would like to ask each one of you. Is it fair for this subcommittee to conclude that Michael Morrisroe controlled not only all of the five home health agencies in question but also all of the primary subcontractors, Northrad, Chicago Home Care, and Oaklawn Physical Therapy. Mrs. Radatz, is that correct?

Mr. RADATZ. That is correct.

Chairman ROTH. Mrs. Williams?

Ms. WILLIAMS. Yes. That is correct.

Chairman ROTH. Mr. Scanlon?

Mr. SCANLON. Yes. That is correct.

Chairman ROTH. Senator Cohen, do you have anything further?

Senator COHEN. When did your employment terminate?

Mr. SCANLON. I worked as administrative aid for 7 months.

Senator COHEN. Why did it terminate?

Mr. SCANLON. Mike told me I was too idealistic for the business [Laughter.]

Chairman ROTH. I wish to thank each of these witnesses who have come here from Chicago.

The committee will be in recess until 10 o'clock tomorrow morning.

[Members present at time of recess: Senators Roth and Cohen.]

[Whereupon, at 12:40 p.m., the subcommittee was recessed to reconvene at 10 a.m., Thursday, May 14, 1981.]

HOME HEALTH CARE FRAUD AND ABUSE

THURSDAY, MAY 14, 1981

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
OF THE COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to recess, in room 3302, Dirksen Senate Office Building, under authority of Senate Resolution 361, dated March 5, 1980, Hon. William V. Roth, Jr. (chairman of the subcommittee) presiding.

Members of the subcommittee present: Senator William V. Roth, Jr., Republican, of Delaware; and Senator William S. Cohen, Republican, of Maine.

Members of the subcommittee staff present: S. Cass Weiland, chief counsel; Michael Eberhardt, deputy chief counsel; Kathy Bidden, chief clerk; Carolyn Herman, Eleanor Hill, staff counsels; Charles Morley, chief investigator; Richard Shapiro, Greg Baldwin, Tim Jenkins, investigators; Sarah Presgrave, secretary to the chief counsel, and Mazie Haley, secretary.

Chairman ROTH. The subcommittee will please be in order.

[The letter of authority follows:]

U.S. SENATE,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
Washington, D.C.

Pursuant to Rule 5 of the Rules of Procedure of the Senate Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, permission is hereby granted for the Chairman, or any member of the Subcommittee as designated by the Chairman, to conduct open and/or executive hearings without a quorum of two members for the administration of oaths and taking testimony in connection with hearings on Fraud and Abuse involving Home Care Operators on Wednesday, May 13, 1981, and Thursday, May 14, 1981.

WILLIAM V. ROTH, Jr.,
Chairman.
SAM NUNN,
Ranking Minority Member.

Chairman ROTH. At yesterday's hearing, this subcommittee heard substantial evidence of how unscrupulous profiteers have abused the home health care system by creating their own nonprofit home health agencies as well as their own profitmaking for contractors who feed off the Federal dollars being paid into this program. In one instance, we saw how a Chicago-based operation generated tremendous profits with very little capital investment.

While it is important for the work of this subcommittee to identify abuse and fraud, I believe it is particularly important that we consider the causes for such problems and the legislative means by which such abuse can be eliminated or at least minimized.

Today we will have two panels of witnesses to discuss some of the causes and the means by which correction can occur. The first panel is composed of the following and I would ask you to come forward.

Peter Manikas of the Better Government Association, Mr. Gregory Ahart of the General Accounting Office, Mr. Hadley Hall of the National Association of Home Health Agencies and Mr. Ronald Reck of the American Federation of Home Health Agencies.

Gentlemen, I appreciate you being here today. Each of you has been asked to respond to the same basic set of prepared questions. These questions ask for your comments on the following:

One, the effectiveness of the cost reimbursement system or proposed alternatives; two, the effectiveness of intermediary audit coverage; three, the effectiveness of oversight and administration of HCFA; four, the means by which disallowances can be recovered by the Federal Government without rendering insolvent the bona fide home health agencies; five, the means by which the Federal Government may terminate irresponsible home health agencies from participation in federally funded home health programs.

Gentlemen, as I am sure you are aware, our rules require that you be sworn so I would ask you to please rise. Raise your right hand. Do you swear the testimony you are about to give before this subcommittee will be the truth, the whole truth and nothing but the truth so help you God?

Mr. MANIKAS. I do.

Mr. AHART. I do.

Mr. HALL. I do.

Mr. RECK. I do.

Chairman ROTH. Thank you. Please be seated. Each of you have submitted prepared statements which will be inserted into the record.

[The prepared statements of Mr. Manikas, Mr. Ahart, Mr. Hall, and Mr. Reck will appear at the end of their testimony.]

TESTIMONY OF GREGORY AHART, GENERAL ACCOUNTING OFFICE; HADLEY HALL, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES; RONALD RECK, AMERICAN FEDERATION OF HOME HEALTH AGENCIES; PETER MANIKAS, LEGISLATIVE COUNSEL, BETTER GOVERNMENT ASSOCIATION

[The prepared reports follow:]

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES,
Washington, D.C., April 23, 1981.

Hon. WILLIAM V. ROTH, Jr.,
Chairman, Committee on Governmental Affairs, Permanent Subcommittee on Investigations, U.S. Senate, Washington. D.C.

DEAR SENATOR ROTH: Thank you for your letter of April 14, 1981 concerning your committee's investigation of problems attendant to the delivery of services under the Medicare Home Health Agency benefit. We appreciate the opportunity to comment and provide you with our perspective.

Since 1975 more than 15 Congressional hearings have focused in full or in part on the delivery of Home Health Agency services. These hearings included, among others, joint Senate and House Aging Committee hearings in 1975; hearings by the Senate Governmental Affairs Subcommittee on Governmental Efficiency in 1976 (Chiles); combined House Ways and Means Oversight Subcommittee and Interstate and Foreign Commerce Health Subcommittee hearings in 1977; Ways and Means Oversight Subcommittee hearings in 1978; Senate Finance Committee hearings in 1979; Senate Aging Committee hearings in 1979 (two); and Senate Small Business Committee hearings in 1979.

During the same period, Home Care has been the focus of three major GAO reports, five field hearings by the Department of Health, Education, and Welfare (in 1976), and a report to Congress (the HR-3 Report mandated by Congress in 1977 and delivered in 1979).

The objective of each of these activities has been to identify and remedy the problems in Home Care. Several of those investigations reached conclusions identical to those your Committee now pursues.

In each case, these activities were followed by a seemingly ceaseless flurry of regulatory reaction attempting to deal with long-standing problems identified and reidentified. Cost caps were imposed, utilization screens and special audit programs developed, an Inspector General was designated and asked to become involved in Home Care, criminal penalties were stiffened, a unified cost report has been implemented, training for Home Health Aides has been mandated, and there is a movement toward consolidating intermediaries for Home Health Agencies. But the problems have continued.

The National Association of Home Health Agencies (NAHHA) supported the development of unified cost report, the movement toward regional intermediaries and upgraded training requirements for Home Health Aides. NAHHA supported the appointment of the Inspector General and the development of more appropriate criminal statutes. While we have expressed concern that the mechanisms designed might be ineffective or uneconomical, we have supported the objectives of public accountability inherent in the cost caps, utilization screens and audit programs.

The point lost in all of this and the reason the problems continue revolves around the question of fitness of means to ends and the incentives provided by the program. These fundamental issues have not been addressed.

It would be unrealistic to suggest the problems that afflict Home Care will ever be entirely eliminated. We must recognize that there will always be those who will try to take advantage of the system. We believe that number to be a small proportion of those in home care; but, the fact of their existence must be recognized with appropriate safeguards and regulations. Our main concern, however, should be to design a system that eliminates the incentives leading to abuse and, instead, reward efficient and effective service.

To be specific:

1. The reimbursement system: NAHHA has repeatedly testified the reimbursement system for Home Health Agencies simply does not work. The process is openended, needlessly complex and presents the wrong incentives. Its "reasonable cost" basis is vague and undefined, necessitating volumes of regulations and interpretations. As a result agencies find their income tenuous and unpredictable and their expectations constantly subject to retroactive adjustments. At the same time, program costs have escalated and the total number of Home Health Agency visits increased at the rate of 12 percent a year.

2. Cost Caps: The Administration has attempted to control cost by placing limitations on Home Health Agency costs per visit. This approach has only exacerbated the problems inherent in the reimbursement structure by adding to the incentives leading to over-utilization. The critical problem here is that no one has ever defined the term "cost" as it applies to Home Health. Home Health is a flexible, coordinated care system with an installment payment plan. The cost of care is not the component, nor is it in the installment. Cost should be calculated per patient or per spell of illness.

3. Private not-for-profit providers: Private organizations, distinguished from community agencies such as Visiting Nurse Associations, have been the focus of several Home Health Agency investigations. The judgement has been made that private not-for-profit providers are more likely to abuse the system, but no one has attempted to find or state the reasons. Is it because of the nature of the

people involved in private business-like organizations? Or, must we look elsewhere?

It is somewhat ironic that private not-for-profit providers have attracted so much of the program's concern since they are almost completely creatures of the Medicare program. More than any other provider segment, they react to the pressures of the program and reflect its problems. All other auspices have in some measure a cushion—be it the resources of the community, a hospital host, a state or local government or a parent company. Private not-for-profit organizations walk the razor's edge. They are totally dependent on the Medicare program and, as such, are the best barometer of its problems.

4. Corporate shell games: The program has been concerned about the dealings of related organizations since 1971. The futility of dealing with these problems given the current reimbursement structure is emphasized in several of the administrative Home Health Agency provisions of last year's Budget Reconciliation Act. The fact that Congress found it necessary to legislate 25-year contracts as unreasonable would at first seem to be legislating the obvious. On second thought, it says a good deal about the vagueness of the definitions and the problems inherent in administering "reasonable cost." Little can be gained by following this path much further.

5. Programmatic shell game: Beyond the question of self-dealing and front operations within Medicare lies a larger concern—the abuse or potential abuse of playing programmatic shell games. NAHHA has repeatedly requested attention be directed at the development of a national Home Care and Long-Term Care policy with common definitions, reimbursement and eligibility criteria. Congress requested the Administration to address these issues in 1977 following the Senate Aging Committee and House Ways and Means Committee hearings covering the activities of several California providers. These individuals found considerable advantage in shifting patients and costs, taking advantage of the cracks between the programs and the gaps in administration and enforcement of Medicare, Medicaid, Social Services and the Older Americans Act.

Congress requested these issues be addressed in a comprehensive report (HR-3), the development of a uniform reporting mechanism, consolidation of intermediaries and single cost report encompassing all Home Care activities. The cost report has been completed and implemented but is restricted to Medicare. A draft reporting system has been circulated and withdrawn. Consolidation of intermediaries is under consideration. The Home Care report was a debacle. But, the need is still there. It is reflected in the New York Office of Welfare Inspector General (OWIG) audit included for our review with your letter and in the General Accounting Office (GAO) Title XX study completed last year for the Senate Aging Committee.

6. Standards: A consistent concern has been the adequacy and appropriateness of standards developed for Home Care. Since standards developed by the industry have yet to be widely accepted or utilized, the Medicare Conditions of Participation are effectively the only standards to which certified agencies subscribe. Most Home Care providers do not meet even these rudimentary requirements. Even in states with licensure requirements, more often than not, the licensure law is a virtual duplication of Medicare requirements. For these reasons, NAHHA has long maintained that the Conditions must be strengthened. We believe they can be revised to reflect more accurately internal operations, tracking the activities an agency requires for its internal management and at the same time providing the government with a more effective tool with which to evaluate the agency's performance.

With respect to the specific questions you addressed in your letter of April 14, 1981:

A. The effectiveness of the cost reimbursement system has been answered in part. It is ineffective at best. We would recommend a prospective reimbursement system be developed.

Cost is more than a unit change for an item of service. Cost is the units of service times their costs times the number of units utilized in a given period of time. Length of stay and recidivism are also cost factors.

One way this could be approached is with the establishment of a target rate (based on total cost per patient or per spell of illness) capturing the agencies' past cost experience multiplied by the units of service. Alternately, the agencies could be requested to prepare and submit a budget (in essence a negotiated rate) which would serve as the basis for reimbursement. In either event, the essential ingredients are that reimbursement be at the rate target which would define

cost to the program and expectations to the provider. Costs exceeding the target would not be reimbursed unless warranted by exceptional circumstances. Service delivered at a cost below the target by increased efficiency should be rewarded by allowing the agency to keep a portion of that savings. Retroactive judgements should be eliminated. The reams of regulations spun out of "reasonable cost" could be discarded. The current incentives for running up costs and "front" arrangements such as you described would be eliminated.

B. The effectiveness of intermediary audit coverage the answer has to be mixed. Some intermediaries have performed quite well. Others have not. NAHHA's concerns in this area have been—first for consistency; second for for fairness; and, third for accountability.

C. The effectiveness of oversight and administration the Department's overall performance has been poor. For a protracted period, there was no apparent concern for Home Care or awareness of the specificity of that program and its needs. There is good evidence one of the continuing problems is the vagueness of many regulations guiding providers and intermediaries. Many of these are related to the reimbursement system and problems previously identified. There is also an argument that the Department has been trapped into the untenable situation of trying to make reasonable and workable a system that is inherently irrational and unworkable.

D. Recovery of disallowances. NAHHA would suggest that this entire process is ill conceived. There may always be a need to recover inappropriate expenditures or fraudulent claims, but emphasis should be placed on limiting to the extent possible the circumstances where these activities may occur. By addressing the problems fundamental to the reimbursement system, the need for these retroactive activities could be substantially limited. It's the difference between treating causes and the effects.

Within the current structure, the line of recovery that has most consistently been disregarded is the accountability of the intermediary. Consistently in the past, intermediaries have denied responsibility, limiting their role to that of payment. In the field this often translates to a simplistic process of review by comparatively untrained and unskilled people. In some cases, it is clear the intermediary uses the program as a training ground for new employees who are promoted into non-Medicare activities of the Fiscal Intermediary as soon as they acquire basic experience.

NAHHA believes the intermediary should be at least as accountable as the provider. Many of the problems your Committee has identified and most of the related program expenditures have undoubtedly been approved by the local intermediary. In some cases, arrangements and contracts specifically approved by the intermediary have subsequently been contested. When this occurs, by Department or GAO review, the entire burden falls on the provider. We would suggest the intermediary be required to establish an escrow account and that the program be reimbursed from this fund for at least some part of every inappropriate expenditure the intermediary approved.

E. Termination NAHHA believes there are adequate provisions in law and regulation in existence. The simple problem has been getting people to do their jobs. There is no reason why it should have taken six years to obtain a conviction in the Souza case. The Department can help by defining the regulations with more specificity (i.e., the Merlo case) or requesting specific regulatory activity. But ultimately, for the reasons previously mentioned we believe the answer lies in restructuring the program, particularly its reimbursement aspects, and providing a rational, integrated Home Care system. The best evidence of this need is contained in Deputy Attorney General Charles "Joe" Hynes' testimony before the Senate Finance Committee in May of 1979.

In summary, all aspects of the Home Care program can be faulted. Some providers have clearly taken advantage of the program. Some intermediaries have failed to perform conscientiously. The Department's record is inconsistent at best. Law enforcement agencies have rarely shown an interest in pursuing "low-yield" fraud cases. But the largest measure of responsibility, and the one most frequently ignored, belongs to Congress. Most of the problems we have identified are locked into the process and parameters of the program Congress established.

There will be no long range solution to these problems until Congress recognizes this fact and restructures the program and process. This Association and its members will do all we can to help you in that endeavor.

Sincerely yours,

BILL HALAMANDARIS,
Executive Director.

TIGHE, CURHAN, REUKAUF & CASE,
Washington, D.C., May 4, 1981.

Senator WILLIAM V. ROTH, JR.,
Chairman; Committee on Government Affairs, Permanent Subcommittee on Investigation, U.S. Senate, Washington, D.C.

DEAR SENATOR ROTH: This is in response to your letter of April 14, 1981, in which you requested assistance from one of this firm's clients, the American Federation of Home Health Agencies (AFHHA) in your investigation of certain issues which related to problems in the home health agency industry. AFHHA is a national trade association representing "free standing" private non-profit and proprietary home health agencies. Most of the organizations represented by this association are private non-profit companies.

AFHHA in no way condones or supports fraud or abuse by any agency within our industry. We are as interested as your subcommittee in eliminating the onus placed on an entire industry by the actions of a few individuals. Organizations whose fraudulent conduct has been proven should be omitted from the Federal program pursuant to existing procedures and pursued with the full force of the law.

In the past the phrase "fraud and abuse" has been used to characterize every problem or questionable practice raised regarding a home health agency. In many cases, the practice characterized was committed out of ignorance on the part of the agency with no intention of abusing the system. In other instances previously acceptable practices have been changed and applied retroactively by the intermediary. The term fraud has a special definition in law, akin to intentional deceit, with a connotation of criminal conduct in the mind of most people and may be applied to only a very few instances regarding home health agencies.

You noted in your letter that the subcommittee staff has evidence of specific individuals establishing several not-for-profit home health agencies and controling them off the books through the use of "front" people. While we do not defend fraudulent conduct or deception, that statement implies that any owner of a home health agency who conducts business with their own profit making supplier of products or services, does so for dishonest reasons. While such types of transactions may be more open to abuse, they are not in themselves fraudulent. AFHHA is prepared to offer specific recommendations which would allow the honest individual to develop a working relationship between a profit making business and non-profit agency.

On page two of your letter, you request our comments on the effectiveness of the cost reimbursement system or other proposed alternatives. AFHHA believes the present cost reimbursement system is a very poor system which easily lends itself to abuse. In our prepared testimony, we will propose a new system of reimbursement on a prospective basis. Under such a system we believe fraud, abuse and waste could be diminished with a reduced cost to the government. There are pilot programs now under way testing the feasibility of prospective reimbursement.

You have also requested our comment on the effectiveness of the intermediary audit coverage. Our opinion is that a "full scope" audit has proved itself to be very effective. The problem in some areas is that such an audit has not been performed frequently enough. Our recommendation will be that a full scope audit be performed for every home health agency every three years and annually for agencies where problems have developed.

You have also requested our comment on the effectiveness of oversight and administration of the program by HCFA. For the most part, existing regulations do allow HCFA to police and address some of the problems areas within this industry. We will recommend that a uniform method of cost accounting be adopted. We also have reservations about the role and competence of some of the intermediaries who have the job of communicating and working with the providers.

You have also requested our comment on the means by which disallowances may be recovered by the federal government without rendering insolvent the bona fide home health agency. We believe a partial answer to this would be the creation of a prospective reimbursement system. One of the major problems faced by home health agencies involves the retroactive disallowances by the intermediary of an expenditure (for up to 3 years) based on either a new interpretation of the regulation (evidenced by a recent intermediary letter) or on an interpretation totally

unknown to the agency in question at the time the expense was incurred. The usual reaction from the intermediary is to immediately begin offsetting income to the agency prior to any determination of liability. It is an understatement to characterize these actions as unfair.

Our recommendation would be to supply the provider with the same information received by the intermediary, to require intermediary letters issued and other policy interpretations to be applied on a prospective only basis and require HCFA and the intermediary to provide better information "up front" to home health agencies so that later problems are avoided.

Where the intermediary has determined that an overpayment has been made, we believe monies due the agency should not be withheld until after a final determination of liability has been made. Where repayment is necessary, a schedule of monthly payments should be required unless a more satisfactory arrangement can be mutually agreed to by the agency and the intermediary.

You have also requested our specific comment on the means by which the federal government may terminate the "irresponsible" home health agency from participation in federally funded home health programs. Our initial problem is your use of the term "irresponsible" as the touch stone for termination from the Medicare program. Fraudulent and intentionally abusive home health agencies should be terminated from the program. The term irresponsible is an inappropriate term to apply.

AFHHA does not defend the fraudulent operator. We do defend the honest owner who has been wrongfully tainted by the actions of a few, or who has been accused of abusing the program due to ignorance related to poor or non-existent advice from the intermediary, or who has been retroactively disallowed based upon an unknown and communicated changes in policy or interpretation.

We look forward to presenting more specific recommendations when Mr. Ronald Reck, President of AFHHA testifies before your subcommittee on May 14, 1981.

Sincerely,

FRANK H. CASE, III.

BETTER GOVERNMENT ASSOCIATION,
Chicago, Ill., April 27, 1981.

Senator WILLIAM V. ROTH, Jr.,
Dirksen Senate Office Building,
Washington, D.C.

DEAR SENATOR ROTH: On behalf of the BGA I am responding to your letter of April 14 which asked for our views on the operation of the federal home health program. The following is in response to the specific questions that you raised.

A. THE EFFECTIVENESS OF THE COST REIMBURSEMENT SYSTEM OR PROPOSED ALTERNATIVES

There appears to be widespread agreement that the system of retrospective cost reimbursement is highly vulnerable to abuse. Additionally, the "reasonable cost" and "prudent buyer" standards which the system incorporates pose substantial problems for the government's ability to control health care costs.

The Department of Health and Human Services (HHS) and its Health Care Financing Administration (HCFA) have found that several illegal practices associated with the home health industry are directly related to the program's payment mechanism. HHS, for example, has reported that many illegal practices "are concomitants of a cost reimbursement system" (HHS, Home Health and Other In-home Services: A Report to Congress, undated). HCFA, as well, recently concluded that "many if not most of the ills historically related to HHA reimbursement were directly related to retrospective cost reimbursement" (HCFA, Home Health Agency Task Force: Final Report, 1980). The BGA's examination of financial abuses in the home health industry fully supports these conclusions.

There seems to be three general problems related to the inability of the present payment mechanism to control cost and prevent fraud and abuse:

1. The cost reimbursement system precludes the use of price competition or pre-established budget restraints as a means of controlling provider costs. The problem is further exacerbated by regulations that require that costs be reimbursed "however widely they may vary from one institution to another."

2. Costs are difficult to control and monitor because providers are granted considerable discretion in allocating public funds. Operating under broad and often vague statutory and regulatory guidelines providers make the initial determinations concerning eligibility and utilization. Consequently, providers have the ability to commit program resources to serve their own needs which may at times be inconsistent with the needs of the more general public.

3. Government officials and fiscal intermediaries face technical difficulties in defining the scope and level of services to be provided. It is, for example, quite difficult to determine what costs are "related to patient care". As a practical matter intermediaries have generally failed to challenge provider claims unless they are clearly not allowable; that is, prohibited by statute.

HCFA, it should be noted, states that it is presently exploring alternatives to the present retrospective cost reimbursement system and will specifically examine a "prospective based system" (HCFA, Task Force Report, 1980).

Clearly, prospective based systems and other alternatives to the present payment mechanism contain their own unique combination of advantages and disadvantages. What is important is that a wide range of alternatives be considered and analyzed for no single alternative is likely to meet all of the home health care program's goals.

The BGA will submit a more detailed report to the Committee in the coming weeks that proposes guidelines for the examination of alternatives. We will include a brief discussion of what we believe are the major advantages and disadvantages of several proposed alternatives.

B. THE EFFECTIVENESS OF INTERMEDIARY AUDIT COVERAGE

Because fiscal intermediaries have a great deal of discretion in how they undertake their review of provider claims there is wide variation in how that task is performed. Yet, while it is difficult to evaluate the performance of intermediaries generally, one problem has become quite clear to the BGA; routine audits do not disclose complex financial transactions that lead to program abuse or represent schemes to defraud the government.

HCFA's more thorough auditing procedures under its Office of Program Validation do appear to effectively identify program abuse. However, a recent report issued by HCFA's Bureau of Quality Control stated that "we are discontinuing our focus on HHAs. While we believe problems persist and will perform reviews on a few HHA's, we do not have sufficient ability through validation with existing resources to deal effectively with these problems" (HCFA, Task Force Report, 1980).

Since the home health program is expanding rapidly, the discontinuance of the validation program might well have an adverse impact on efforts to control waste and abuse.

The BGA understands that HCFA is in the process of implementing new intensified auditing procedures and comment on their impact would be premature. However, two general comments about existing procedures are in order:

1. There has, to date, been no effective cross-auditing of agencies that provide in-home services under Titles 18, 19 and 20. Until there is, the potential for program abuse will remain high.

2. Intermediaries have frequently relied on the size of the population served by an HHA and per visit costs as indicators of a need for more intensive review. The BGA suggests that intensified audit review be triggered instead by examining various "cost centers." It might, for example, be useful to review those HHAs that spend a specified percentage of their income on legal and consulting fees, transportation or subcontracting for other services. Furthermore, excessive utilization may be a better indicator of program abuse than cost per visit cost figures.

C. THE EFFECTIVENESS OF OVERSIGHT AND ADMINISTRATION BY HCFA

It is quite clear that no government agency (federal, state or local) has effectively come to terms with the general problem of containing health care costs nor have they been able to devise an effective strategy for reducing waste and abuse to acceptable levels. However, the home health program's statutory framework (especially the retrospective cost reimbursement system) and the limited resources available to HCFA to address issues concerning program integrity certainly restrict HCFA's ability to respond to problems that have plagued the program since its inception.

Moreover, oversight responsibility concerning HHAs is seriously fragmented. HCFA, state and local governmental agencies as well as private fiscal intermediaries each share the responsibility of monitoring provider performance. They also each exercise considerable discretion in determining how their oversight responsibility will be undertaken.

In short, as a result of this fragmentation, it is difficult to hold any single entry accountable for how providers perform. To whom, for example, should beneficiaries complain if they are dissatisfied with an HHA's services: to the HHA, the intermediary, the state department of public health or HCFA?

In fact, the question seems almost academic because many beneficiaries do not know what agency is providing the service, what services they are eligible for, or how they came to be enrolled in the program. A 1978 Inspectors General report indicates that program beneficiaries who are elderly, disabled and sometimes disoriented have little knowledge of their entitlements nor do they know who to contact when problems arise. That report states: "Patients seldom know what services are available and accept the services provided as a windfall without further inquiry. Most patients (75 percent) could not remember how they came to know about the home health services they were receiving."

The Inspector General's finding is wholly consistent with the BGA's discussions with beneficiaries in Mississippi and elsewhere. The BGA found, for example, that some home health recipients believed that they would lose their medicare or medicaid eligibility if they switched from one provider to another. The potential for abuse that might result from such misunderstanding is clear.

We believe that the lack of institutional accountability should be considered a major problem area and urge the Committee to examine this problem in detail.

D. THE MEANS BY WHICH DISALLOWANCES CAN BE RECOVERED BY THE FEDERAL GOVERNMENT WITHOUT RENDERING INSOLVENT THE BONA-FIDE HOME HEALTH AGENCIES

The procedures by which providers have been disallowed payment for various costs incurred seems to work to everyone's disadvantage. The disallowances have failed to prevent irresponsible providers from abusing the system and have penalized responsible providers for thier honest mistakes.

Retrospective denials cause an especially serious problem for those agencies that deliver services exclusively to medicare beneficiaries (often called "100 percenters"). Since medicare funds are the sole source of income for these agencies, retrospective payment denials result in serious cash flow problems and could drive a HHA into insolvency.

Section 802 of the Omnibus Reconciliation Act (HR 7765) contains a requirement that HHAs demonstrate an ability to repay overpayments. It is obviously too early to assess the impact of the new provision. However, most officials with whom the BGA has spoken believe that this requirement will alleviate the problems that disallowances have caused many HHAs.

E. THE MEANS BY WHICH THE FEDERAL GOVERNMENT MAY TERMINATE IRRESPONSIBLE HOME HEALTH AGENCIES FROM PARTICIPATING IN FEDERALLY FUNDED PROGRAMS

Termination of providers should be used as the ultimate sanction imposed against HHAs that seriously and repeatedly abuse the program.

According to the figures provided to the BGA by HCFA, termination or exclusion of home health providers (as set forth in 42 CFR, Part 420, et seq.) is rarely used. According to HHS, since 1969 fifty-one cases involving HHAs have been referred to U.S. attorneys for prosecution and investigation. However, only four home health providers (agencies and individuals) have been excluded from the program since its inception.

A wide range of administrative sanctions should be available for imposition against errant health care providers. Unfortunately, the home health industry presents a unique set of problems that limit the usefulness of several sanctions that might be invoked.

Because many home health providers receive only medicare dollars, for example, the imposition of monetary penalties against an agency or requiring large repayments could seriously damage the ability of the agency to continue its operations. Since there are a limited number of agencies (about 2500) relative to demand for their services, measures that would result in decreasing the total number of providers could have an adverse impact on the program's ability to fulfill its statutory responsibilities.

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The difficult task facing officials then is to establish sanctions that discourage program abuse but do not jeopardize a HHA's capacity to deliver services. HCFA might therefore consider exploring how individuals could be held personally liable for funds obtained through program abuse.

If a HHA has paid unreasonable compensation to an individual, for example, and a disallowance of the overpayment would result in severe financial hardship for the HHA, a financial penalty invoked against the individual to recover the overpayment might be an appropriate response.

The range of administrative or civil sanctions that may effectively be employed against HHAs will remain limited as long as the program includes many "100 percenters" and the retrospective reimbursement system remains as the payment mechanism. Consequently, the BGA urges the Committee to view this problem in light of these constraints.

Finally, you have asked the BGA to address the problem of abuse involving subcontractors. The BGA believes that two steps should be seriously considered to prevent abuses from occurring in this area: prior approval of the subcontract when a specified percentage of an HHA's expenditures are used for that purpose (eg. over 5 percent) and bidding when a dollar threshold is reached and it is otherwise appropriate.

The BGA appreciates the interest the Committee has shown in our examination of abuse in the home health care field. If we can provide you with any additional information concerning our findings, please do not hesitate to contact me.

Sincerely,

PETER M. MANIKAS,
Legislative Counsel, BGA.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., April 24, 1981.

Subject: Response to the Senate Permanent Subcommittee on Investigations' Queries on Abuses in the Home Health Care Industry (HRD-81-84).

Hon. WILLIAM V. ROTH, Jr.,
Chairman, Permanent Subcommittee on Investigations, Committee on Governmental Affairs, U.S. Senate.

DEAR MR. CHAIRMAN: This report is in response to your April 14, 1981, request for our views on whether existing legislation and regulations are adequate to prevent profiteering in the home health industry under the federally financed health programs. As an example you mentioned situations in which individuals established home health agencies (HHAs) and control them "off the books" through "front" people. These individuals then establish for-profit companies to provide the HHAs a variety of services at excessive cost to the financing programs.

In providing our assessment, we were to give specific comments on:

A. The effectiveness of the cost-reimbursement system or proposed alternatives.

B. The effectiveness of intermediary (Medicare paying agent) audit coverage.

C. The effectiveness of oversight and administration by the Health Care Financing Administration (HCFA).

D. The means by which disallowances can be recovered by the Federal Government without rendering insolvent the bona fide HHAs.

E. The means by which the Federal Government may terminate irresponsible HHAs from participation in federally funded home health programs.

With two exceptions, we believe the existing legislation and regulations (including the new authorities provided by the Omnibus Reconciliation Act of 1980—Public Law 96-499) give HCFA sufficient authority to address the Subcommittee's concerns. The exceptions relate to

the need for strengthening the regulations or related guidelines governing reimbursement in related organization situations, and

the desirability of the Department of Health and Human Services establishing limits on Medicare reimbursement for HHA management and clerical costs.

The related organization regulations are designed to eliminate profits between parties related by ownership and/or control, such as in the situation described in your letter. Concerning management and clerical costs, our prior work has identified excessive costs in these areas, and under section 223 of the Social

Security Amendments of 1972, the Secretary of Health and Human Services has specific authority to establish reimbursement limits for such costs. Although, in line with our recommendation, the Department has established section 223 limits on total costs for home health visits, it has not done so for management and clerical costs.

HCFA believes that the cost data presently being reported by HHAs lack sufficient uniformity to make such limits meaningful. According to HCFA officials, they are trying to solve the data problem by implementing a uniform reporting system as required by the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142).

In addition, the 1982 budget may include significant reductions for audits made by Medicare intermediaries. Although this issue is not directly related to the question of regulatory or legislative change, significant budget cuts in this area can hamper the intermediaries' ability to assess compliance with existing legislation and regulations.

This report is based on work performed at HCFA headquarters in Baltimore, Maryland. Also, we relied heavily on various existing reports prepared by us and HCFA as well as a detailed analysis of existing laws and regulations. Because Medicare accounts for the bulk of Federal expenditures for HHA services, our comments relate primarily to this program. Also, many States have adopted Medicare reimbursement principles for their Medicaid programs. Our specific comments on each of the issues you raised are presented in enclosure I.

We did not obtain agency comments on this report because of the tight time constraints. Also, unless you publicly announce the report's contents earlier, no further distribution will be made until 30 days from its issue date. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

MILTON J. SOCOLAR,
Acting Comptroller General of the United States.

Enclosure.

RESPONSE TO THE SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS' QUERIES ON ABUSES IN THE HOME HEALTH CARE INDUSTRY

A. THE EFFECTIVENESS OF THE COST-REIMBURSEMENT SYSTEM OR PROPOSED ALTERNATIVES

Under Medicare, home health agencies (HHAs), like the other institutional providers (hospitals and nursing homes), are reimbursed retrospectively on the basis of their actual "reasonable" and allowable costs related to patient care (sections 1815(a) and 1861(v) of the Social Security Act). Thus, with few exceptions, the system is open ended, and it has been widely criticized as lacking incentives to providers to be efficient and minimize their costs. Under Medicaid, more and more States are using Medicare's cost-reimbursement system in response to criticisms that unrealistically low Medicaid payment rates had discouraged the use of home health services as a substitute for more costly long-term institutional care.

Despite the trends to more liberal reimbursement, annual Medicaid expenditures for home health services amount to about 1 percent of program payments, or about $250 million—with most of this in New York. In contrast, under Medicare, expenditures for home health services in 1981 are expected to amount to about 3 percent of benefit payments, or about $900 million.

In our view, in addition to the open-ended nature of the system, three problems have emerged that apply not only to HHAs but also to other institutional providers paid under the same retrospective system:

Wide variations in the unit costs of similar services and the related problems in determining whether costs at the higher end of the range are reasonable.

Problems in determining the allowability of costs claimed and their relationship to patient care.

The application of Medicare's "related organization" rule, which basically requires that the reimbursable cost of goods or services furnished to a provider by a related organization be the lower of the actual cost to that organization or the price of comparable goods and services available elsewhere. Organizations generally are considered to be related if they are owned or controlled by the same person or persons.

Variations in costs

Under Medicare reimbursement principles, providers are to be reimbursed for the actual cost of providing quality care, however widely that cost might vary from provider to provider and from time to time for the same provider (42 CFR 405.451). This principle is subject to a limitation where a particular institution's costs are "substantially out of line" with costs of other institutions in the same area that are similar in size, scope of service, utilization, and other relevant factors.

As discussed in our May 1979 report to the Congress,[1] without a definition of what constituted "substantially out of line," Medicare paying agents (intermediaries) found this provision to be virtually unadministrable in establishing upper limits on reimbursable costs—particularly on a retrospective basis.

Section 223 of the Social Security Amendments of 1972 (Public Law 92-603) amended section 1861(v)(1) of the act to provide the Department of Health and Human Services (HHS)[2] with another vehicle for dealing with the problem of the wide variations in costs. Specifically, the law allowed the Secretary of HHS to establish limits: "* * * on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title.

Such reimbursment limits were to be established prospectively, and providers could charge beneficiaries for the difference between the section 223 limits and its rates following public notice by HHS that the particular provider would do so.

HHS initially established section 223 limits in 1974 for hospital inpatient general routine operating costs (42 CFR 405.460), and at our recommendation the use of the section 223 authority was expanded to cover the total cost of home health visits in 1979. We also recommended that, where feasible and appropriate, HHS establish section 223 reimbursement limits for individual home health care cost elements—such as management and clerical costs—because our work indicated that excessive overhead costs in the form of administrative salaries and management consulting fees have been claimed and reimbursed by Medicare. To date, HHS has not adopted this recommendation.

The Health Care Financing Administration (HCFA) believes that the cost data presently being reported by HHAs lack sufficient uniformity to make such limits meaningful. According to a HCFA official, they are trying to solve the data problem by implementing a uniform reporting system as required by the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142).

Although we believe that existing legislative authority is adequate to implement our proposal, we note that, during the 96th Congress, S. 489 was introduced which would require limits for specific HHA line-item costs, such as transportation, administrative salaries, and fiscal and legal services. This bill was not enacted during that Congress, and in the absence of agency action on this issue, we would support similar legislative initiatives in this Congress.

Allowable costs related to patient care

Medicare principles of reimbursement for provider costs are contained in subpart D to part 405 of title 42 of the Code of Federal Regulations. These regulations include rather detailed rules for such specific elements of cost as interest expense (42 CFR 405.419), bad debts, charity and courtesy allowances (42 CFR 405.420), educational activities (42 CFR 405.421), and research costs (42 CFR 405.422).

In contrast, the regulation governing the costs related to patient care (42 CFR 405, 451) is very general. Although disputes in interpreting this regulation have arisen involving all types of providers, its application has presented special problems in HHA reimbursement because of the competition involved in obtaining patients. A key feature of an HHA's operation is patient referrals from hospitals, doctors, and social workers. This has given rise to the use of full-time employees, described as hospital discharge planners or coordinators, whom we believe were engaged in identifying potential patients and soliciting referrals, which under the program instructions is not allowable for reimbursement.

[1] "Home Health Care Services—Tighter Fiscal Controls Needed" (HRD-79-17, May 15, 1979).

[2] Then the Department of Health, Education, and Welfare.

Another problem is promotional gifts (pens, letter openers, etc.) that have been provided to doctors and other sources of patient referrals and charged to Medicare. Because the regulation (42 CFR 405.451(b)(2)) defines necessary and proper costs as "costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities," identifying and disallowing such promotional costs has been difficult. Although HCFA has issued various program instructions to clarify the types of promotional activities that represent allowable costs, we believe that, as long as the regulation is general the instructions will be difficult to implement or enforce. On the other hand, it has been argued that too rigidly drawn regulations facilitate the identification of "loopholes" and thus are equally difficult to enforce. We believe that currently this is a very "gray" area in which we can offer no easy solutions.

Costs to related organizations

The regulations governing transactions between providers and related organizations (including HHAs and "front" organizations) are embodied in 42 CFR 405.427. Also, implementing program instructions are contained in chapter 10 of Medicare's Provider Reimbursement Manual.

The underlying principle for transactions between related parties is as follows: "Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere."

Essentially, this provision is designed to eliminate profits for Medicare reimbursement purposes between parties considered to be related.

The regulations also provide for an exception to the above rule if all of four certain conditions are met to the intermediary's satisfaction. The conditions are that (1) the supplying party is a bona fide separate organization, (2) a substantial part of its business is transacted with organizations not related to the provider, (3) there is an open competitive market for the services or supplies in question, and (4) the services or supplies are those commonly obtained by the type of provider from other organizations and are not those ordinarily furnished directly to patients by that type of provider.

The regulations and manual instructions have changed little since November 1966 and June 1969, respectively; nonetheless, they have been the subject of considerable debate and controversy. A common complaint has been that many terms need to be defined more precisely; for example, "bona fide separate organization," "open, competitive market," and "control." At the same time, attempts to make the regulations more specific have been opposed because of concerns that more rigid regulations would arbitrarily hinder legitimate transactions.

On April 20, 1981, HCFA requested comments from us, and others, on a proposed change to the related organization provisions of the Provider Reimbursement Manual. Basically, the proposal clarifies many of the manual provisions and sets out more examples of what constitutes a related organization transaction. Our general reaction is that the proposed change is a significant improvement.

In related organization determinations, the burden of proof generally falls with the Medicare intermediary; that is, the intermediary must provide substantive evidence that the provider and party in question are related by common ownership or control.[3] We believe that the burden of proof should be shifted to the provider when certain criteria are met. For example, if the administrator of an HHA (or hospital or skilled nursing facility) is related to a top officer of a supplying organization, the agency and the organization would be presumed to be related for Medicare reimbursement purposes. Another example would be subcontracts between an HHA and an organization that was instrumental in organizing it and/or getting it certified for Medicare participation. In such situations, therefore, the provider would be required to disclose such a relationship and dem-

[3] Under the exception rule (42 CFR 405.427(d)), the burden of proof is on the provider that the four conditions are met.

onstrate to the intermediary's satisfaction that such a relationship does not constitute a related organization arrangement under Medicare reimbursement principles.

Subcontracting abuses by HHA's

We believe that overall the provisions of the Medicare law and regulations provide sufficient authority to adequately control abusive subcontracting by HHAs, especially with the recent provisions added by Public Law 96–499, approved December 5, 1980.

Section 930(p) of Public Law 96–499 added to the Medicare law section 1861(v)(1)(H), which prohibits the Secretary from recognizing, as allowable costs, HHA costs related to subcontracts that are more than 5 years in duration or that base payments under the contract on a percentage of the HHA's revenues or claims for reimbursement. We have identified and reported on a number of instances in which contracts were excessively long and/or percentage of revenue type contracts between providers and both related and nonrelated organizations have resulted in inflated Medicare and Medicaid costs. We have recommeneded that percentage contracts be prohibited under both programs. We found problems with such contracts not only with HHAs,[4] but also with nursing homes,[5] hospitals,[6] prepaid health plans,[7] and Medicaid insuring agreements.[8] The provision in Public Law 96–499 only covers HHAs.

Section 952 of Public Law 96–499 added section 1861(v)(1)(I), which requires Medicare providers to include in their subcontracts with others a provision giving HHS and us access to the subcontractor's books and records necessary to identify the nature and extent of the costs incurred by the provider under the subcontract. This provision should assure that the Government has available the books and records necessary to determine the reasonableness of costs associated with both arm's-length and non-arm's-length transactions.

Public Law 96–499 also gives the Secretary authority to establish bonding requirements for HHAs which we believe will help HHS recover cost disallowances, including those attributable to subcontract abuses. This provision is discussed on page 10.

Alternative reimbursement mechanism

Besides proposals to establish tighter section 223 limits for HHAs, we are not aware of any proposals to change the Medicare reimbursement mechanisms for HHAs. A principal alternative reimbursement method for over types of providers is a prospective payment system, under which the rate of payment is established before the fact and retroactive adjustments generally are not made.

We believe a prospective system would be harder to use for HHAs because of the lack of a uniform unit of service on which to base the rate. For hospitals and nursing homes, a day of inpatient care is a common unit of service used in prospective payment systems. However, for HHAs the unit of service is a visit, which can vary in duration between the various types of visits, including variations in traveling time.[9]

Also, establishing prospective rates on a per-visit basis (or on a patient served basis) could be subject to manipulation and would give HHAs incentives that could lower the quality of care provided. For example, to maximize revenues, HHAs would have an incentive to decrease the duration of visits in order to increase the total number of visits. A decrease in the length of visits in turn could compromise the quality of care provided.

B. THE EFFECTIVENESS OF INTERMEDIARY AUDIT COVERAGE

A good measure of the effectiveness of intermediary audits is their cost/benefit ratio: that is, the relationship between the cost of the audit and the savings or

[4] See note 1.
[5] "Problems in Auditing Medicaid Nursing Home Chains" (HRD–78–158, Jan. 9, 1979).
[6] Report to the Administrator of HCFA on hospital management services contracts (June 30, 1980).
[7] "Relationship Between Nonprofit Prepaid Health Plans With California Medicaid Contracts and For Profit Entities Affiliated With Them" (HRD–77–4, Nov. 1, 1976).
[8] "Medicaid Insurance Contracts—Problems in Procuring, Administering, and Monitoring" (HRD–77–106, Jan. 23, 1978).
[9] Although this unit of service is used in establishing section 223 limits, such limits are the maximum amount to be considered reasonable and thus are not the sole basis for payment.

disallowances resulting from it. While HCFA does not specifically monitor the cost/benefit of HHA audits, over the last few years the cost/benefit ratio for all types of Medicare providers (hospitals, skilled nursing facilities, and HHAs) has been about $4 saved for every $1 spent.

Although the effectiveness of intermediary audits is an important issue, an equally important and recurring issue is the adequacy of audit coverage. To minimize Medicare administrative costs, many provider cost reports are settled or accepted without field audits. For example, for provider cost reporting years ended in 1978, about 60 percent of the HHA cost reports were settled without a field audit. A major concern with settling cost reports without such an audit is that providers can be reimbursed for significant unallowable costs. It is difficult to identify such unallowable costs by reviewing a cost report without also field auditing the provider.

An example of the potential shortcomings of not field auditing is demonstrated by a January 1981 HCFA Bureau of Quality Control report on eight large HHAs in southern California. The cost years audited by the Bureau for six of the HHAs had been settled by the intermediaries without the benefit of field audits, and for these agencies, the Bureau recommended[10] overall cost adjustments of $366,319. Most of the adjustments involved related organization transactions ($121,901) and salary adjustments ($97,551). The recommended related organization adjustments involved transactions for rent, durable medical equipment, accounting and billing services, and consultation. The salary adjustments involved unreasonable salary costs and the lack of documentation to show that the salaries claimed were in fact paid.

Adjustments of the magnitude listed above are not likely to be representative of the level of unallowable costs that could be identified at other agencies; however, they do demonstrate the potential benefits of field audits and the potential risks of settling cost reports without such audits.

For fiscal year 1982, significant cuts in the HCFA budget for intermediary audits are under consideration. On March 12, 1981, HCFA told intermediary representatives that plans were being considered to reduce the 1982 budget for provider field audits by $19 million, about a 67-percent reduction over the fiscal year 1981 funding level. We believe cuts of this magnitude could hamper the intermediaries' ability to assess compliance with existing legislation and regulations.

C. THE EFFECTIVENESS OF OVERSIGHT AND ADMINISTRATION BY HCFA

The operation of the Medicare program is highly decentralized; day-to-day program responsibility is delegated under contract to Blue Cross and Blue Shield plans and commercial insurance companies (intermediaries and carriers) located throughout the country. HCFA's role largely involves providing national policy direction to the program and assuring that its contractors perform as required.

HCFA oversees the program's administration in several ways. Ten regional offices are responsible for monitoring the performance of the contractors in their regions, and many contractors have on-site HCFA representatives. Also, all contractors are required to routinely provide information on various aspects of program operations, including the cost and timeliness of claims processing, the timeliness and results of provider audits, the disposition of beneficiary inquiries, and the amount of and reasons for claim denials. Finally, HCFA is to formally evaluate each of its contractors annually. These evaluations cover the principal aspects of their operations, such as claims processing, beneficiary services, and fiscal administration.

How well HCFA monitors the program's administration is difficult to say; however, we believe the agency has set up reasonable systems to fulfill this responsibility. We have issued two reports since 1979 which touch on how HCFA administers Medicare's home health program. Your letter noted one of them: "Home Health Care Services—Tighter Fiscal Controls Needed" (HRD–79–17, May 15, 1979). Another report (copy enclosed) discusses our evaluation of HCFA's 1980 proposed home health care limits established under section 223 of the Social Security Amendments of 1972. The report (HRD–80–84, May 8, 1980) points out various problems with the data base and methodology used to develop the limits.

[10] The Bureau's recommendations are not necessarily final. Intermediaries are responsible for making final determinations, which are also subject to appeal by providers.

D. THE MEANS BY WHICH DISALLOWANCES CAN BE RECOVERED BY THE FEDERAL GOVERNMENT WITHOUT RENDERING INSOLVENT THE BONA FIDE HHAS

The Medicare program can recover overpayments from HHAs in three basic ways:

By a lump-sum payment from the HHA at the time of the cost report settlement.

Through a repayment schedule under which the HHA makes periodic payments until the overpayment is repaid.

Through offset by reduction or suspension of future payments for services rendered to program beneficiaries until the overpayment has been recaptured.

These methods of recovering overpayments assume that the HHA has or can obtain the funds necessary to make the repayments or can continue to operate at reduced revenue levels. We believe that it is unreasonable to assume that nonprofit HHAs with a high proportion of Medicare utilization will have the reserves necessary to repay significant overpayments or the ability to continue to operate if their Medicare payments are reduced substantially below the level of their costs.

The primary options available to the Government to collect overpayments from bankrupt or insolvent nonprofit HHAs are:

Attaching the HHA's assets, which are normally of nominal value (e.g., office furniture and equipment).

Demonstrating that the directors and/or officers of the corporation abused its tax-exempt status for their personal enrichment—which enables the Government to proceed against the assets of the directors and/or officers involved.

The ability to recoup overpayments from a proprietary HHA would depend on the HHA's financial condition. Recovery from insolvent proprietary HHAs would be undertaken by the Government following the normal bankruptcy and contract law procedures.

In our view, the ability to collect overpayments from HHAs, particularly nonprofits, depends heavily on the extent of their reliance on the Medicare program for revenues. A nonprofit HHA with 100-percent Medicare utilization would have great difficulty continuing operations if Medicare funding was interrupted. A nonprofit HHA that received revenues from other sources and/or received philanthropic support might have less difficulty. A proprietary chain that is part of a diversified corporation might encounter little difficulty.

A recently enacted provision of the Omnibus Reconciliation Act of 1980 could decrease the likelihood of an HHA becoming insolvent when it has to repay overpayments. Section 930(n) of the act added to the Medicare law section 1861(o)(7), which authorizes the Secretary of HHS to require HHAs to be bonded or to establish escrow accounts to protect the Government's financial interest. When this provision is implemented through regulation, it could both protect the Government from losses resulting from overpayments that HHAs cannot repay and protect HHAs from insolvency when they must repay identified overpayments.

E. THE MEANS BY WHICH THE FEDERAL GOVERNMENT CAN TERMINATE IRRESPONSIBLE HHA'S FROM PARTICIPATION IN FEDERAL PROGRAMS

Several authorities are available to the Government to terminate irresponsible HHA's.

Under the Social Security Act, providers, including HHAs, are required to disclose to HHS the identity of any person who has an ownership or controlling interest in the provider or who is an agent or managing employee of the provider and has been convicted of a criminal offense against any of the three programs (section 1126). HHS or the applicable State agency can preclude or terminate program participation by the provider if such an individual is associated with it (42 CFR 420.204). Failure to disclose such situations is grounds for termination (42 CFR 489.53(a)(1)).

Providers, including HHAs, are also required to disclose to HHS, and to the States for Medicaid and title XX purposes, information on persons with ownership in or control over them (section 1124). If an HHA fails to disclose this information, it can be terminated (42 CFR 420.206(c)).

Furthermore, providers, including HHAs, are required to disclose upon request information on the ownership of a subcontractor with which the provider had

business transaction aggregating $25,000 (during the previous 12 months) and any significant transactions between the provider and any wholly owned supplier or other subcontractor during the 5-year period ending on the date of the request (section 1866(b)). Failure to disclose this information is grounds for termination (42 CFR 489.53(a)(9)).

Under Medicare (42 CFR 489–53), an HHA may also be terminated if it

is not in substantial compliance with the requirements of the Medicare law or regulations or its provider agreement with Medicare,

does not meet the Medicare conditions of participation for HHAs,

fails to provide information to HHS necessary to determine if payments are or were due under Medicare and the amount of the payment due,

refuses to permit HHS or its agents to examine its financial or other records necessary to verify information furnished as a basis for Medicare payments,

knowingly and willfully makes or causes to be made any false statement or misrepresentation of a material fact in an application or request for payment under Medicare,

submits or causes to be submitted requests for payment under Medicare of amounts for items and services substantially in excess of the costs incurred by it in providing such items or services,

furnishes items or services that HHS has determined to be substantially in excess of the needs of individuals or of a quality below professionally recognized standards of health care, or

fails to comply with the civil rights requirements contained in the regulations.

Under Medicaid, the States can establish the grounds for terminating providers (except for those required by Federal law discussed at the beginning of this section).

Chairman ROTH. I would ask that each of you take approximately 5 to 10 minutes, if you could, to summarize your findings and recommendations. Mr. Manikas, do you want to begin.

Mr. MANIKAS. Thank you, Mr. Chairman. Can you hear me?

Chairman ROTH. You have to speak right into the mike.

Mr. MANIKAS. On behalf of the BGA, I appreciate the opportunity to testify here today on the Federal home health care program. It has performed a very important role in improving the lives of millions of chronically disabled persons, and we are eager to do what we can in helping to remedy some of the problems in the program's operation.

As the BGA indicated in its letter to the subcommittee, we believe that many of the provider-related abuses that have occurred in this program and in other areas of medicare-medicaid financed health care are closely related to the program's design. In short, how we pay for and deliver in-home services seems to invite abuse.

Under the present system, providers exercise enormous discretion in determining what services will be delivered and at what price. There are few incentives to control costs and the system is extremely difficult to monitor for fraud and abuse.

Several proposals have been made to refashion the way the Nation finances long-term care services. For example, a new title XXI has been proposed, S. 861, which amends the Social Security Act. That bill provides for 10 statewide demonstration programs which experiment in different ways to provide community-based care to elderly and disabled individuals. Certainly this kind of experimentation is greatly needed.

The BGA's investigation of financial abuses in home health programs suggests that future reform experiment should focus on two problems.

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1 OF 2

First, the cost reimbursement system. Several different alternatives to this payment mechanism should be explored, including prospective budgeting and use of vouchers for the purchase of in-home services.

The second problem concerns utilization. Under the present system, in large measure the providers determine both whether a potential beneficiary is eligible to receive services and the level of services to be received. For example, the number of home health visits that are conducted is determined by the provider.

Decisions like this should not be made by providers who have an economic stake in their outcome. The proposed new title XXI, for example, establishes an independent team to assess and screen potential beneficiaries. That might be the kind of reform you want to consider.

Mr. Chairman, the BGA, aided by the University of Chicago's Center for the Study of Welfare Policy, has prepared a document for the subcommittee that examines several approaches to reform in more detail. We will provide the subcommittee with the report in the next few days.

[At this point, Senator Cohen entered the hearing room.]

Mr. MANIKAS. Reforms concerning how in-home and community-based services are financed require some experimentation and extensive debate. However, in the context of the present program, there are several interim reforms we believe should be considered.

We have 10 recommendations. I won't read them all, but let me highlight some of them. One of the most important ones is in regard to audits. We are recommending that the number of field audits focusing on home health agencies be increased and that they focus not on the size of the agency and the size of the population the agency serves but rather that this be triggered by utilization rates and how much an agency is spending; for example what percentage of their income they are spending on subcontracting, and contracting for consulting or legal service. We would also suggest that medicare payment for all promotional gifts to hospitals, hospital personnel and others who supply home health agencies with services be prohibited. We are suggesting that a coordinated audit program be implemented that focuses on home health services provided under titles XVIII. XIX, and XX. One of the problems that we have encountered relates to duplicate billings, particularly under titles XIX and XX. A coordinated program would be designed to determine whether duplicative billing is taking place.

The conditions of participation of home health agencies should be strengthened to increase the ties between agencies and local communities. There are virtually no regulations in the conditions of participation in regard to advisory boards. Oftentimes they are dominated by agency personnel and sometimes by family members. That would be a relatively easy problem, I think, to correct.

You might even try something like requiring that the agency contract with local citizen groups to monitor the quality of care that is being provided. There are a number of groups and local communities that have a specialized interest in care for the elderly. This approach might be one way to provide for the kind of accountability mechanism that is presently lacking.

Another recommendation relates to providing a centralized source of information in regard to home health agencies. It seems that it would be a relatively easy matter to require State agencies, for example, to collect data on the various home health agencies operating in geographical areas and distribute that kind of information to beneficiaries so they can make the wisest choice in regard to what kind of agencies and services are available.

We have over 10 rather specific recommendations here that I have submitted to the committee and I will be glad to answer any questions in regard to the proposals we have made. Thank you, Mr. Chairman.

I want again to tell you we appreciate being able to testify today. We will be glad to help all we can.

Chairman ROTH. Thank you. I thought, Senator Cohen, what we might do is let all four testify.

Senator COHEN. Fine.

Chairman ROTH. Next I would call upon Mr. Ahart, who is Director of the Human Resources Division and GAO. Mr. Ahart.

Mr. AHART. Thank you, Mr. Chairman. I am pleased to be here this morning to discuss the adequacy of the present legislation and regulations relating to the home health care industry.

Overall, with two exceptions, we believe existing legislation and regulations, including the new authority provided by the Omnibus Reconciliation Act of last year, give HCFA sufficient authority to address the subcommittee's concerns. The exceptions relate to the need for strengthening the regulations or related guidelines governing reimbursement in related organizations and the desirability of the department establishing limits on medicare reimbursement for home health care agencies for management and clerical costs.

Under medicare's cost reimbursement, institutional providers are reimbursed retrospectively on the basis of their actual reasonable and allowable costs. This system has been widely criticized as lacking incentives to hold down costs. In addition to the open-ended nature of the system, several problems have emerged. One particular problem is the wide cost variation among home health agencies. Under the system, the providers are paid the actual cost of providing quality care subject to a limitation where a particular provider's costs are substantially out of line.

As we reported in our May 1979 report, medicare intermediaries have found this provision almost impossible to administer.

Section 223 of the 1972 social security amendments authorizes the Secretary to establish limits on the overall cost or costs of specific items and services or groups of items and services. The Department initially established limits in 1974 for hospital in-patient routine operating costs and in 1979 at our recommendation to cover the total cost of home health visits. The Department has not adopted our further recommendation for limits for individual cost elements, such as management and clerical costs. HCFA believes that available cost data lacks sufficient uniformity to make such limits meaningful. It is trying to solve this problem by implementing a uniform reporting system as required by the 1977 medicare-medicaid amendments.

Although we believe that existing authority is adequate during the 96th Congress legislation was introduced which would require limits

for specific costs. We would support similar legislative initiatives in this Congress.

Another problem with the reimbursement system is the difficulty of applying the regulation governing which costs are related to patient care and which are not. An example is whether certain costs are for patient solicitation, which is not an allowable cost, or with maintaining good relations with the medical community, which is an allowable cost. As long as the regulation remains general, it will be difficult to implement. If it is drawn too rigidly it will give rise to loopholes equally different to enforce. I am afraid we don't have any easy solution to offer for this kind of a problem.

Another problem with the system is application of the regulations designed to eliminate profits between parties related by ownership or control. A common complaint has been that many terms need to be defined more precisely. On the other hand, more specifics have been opposed because of concerns of arbitrarily hindering legitimate transactions.

Last month, HCFA requested comments from us as well as others on a proposed change to the related organization guidelines which we think would be an improvement, but we think further change is needed. Unless a provider is applying for an exception to the related organization regulation, the medicare intermediary presently has the burden of showing that the provider and party in question are related. In practice this is very difficult and time consuming. We believe the burden of proof should be shifted to the provider when certain criteria are met: For example, where the administrator of an agency is related to the top officer of a supply organization or where there are subcontracts between an agency and an organization that was instrumental in organizing the agency in the first place. In these kinds of situations we think the provider should be required to disclose the relationship and show that it does not constitute a related organization arrangement.

To overcome the problems with medicare's reimbursement system, some have advocated that an alternative reimbursement system be established. Principally, a prospective system under which the rate payment is established before the fact and retroactive adjustments generally are not made.

We believe a prospective system would be hard to use for home health agencies because of the lack of a uniform unit of service upon which to base the rate. The basic unit of service in these agencies is a visit and that can vary significantly in terms of duration and costs and travel time that is involved in making it.

Also prospective rates on a per visit or per patient base could be subject to manipulation and would give agencies incentives that could lower the quality of care.

The second area that you outlined for us is the effectiveness of intermediary audit coverage.

To minimize administrative costs, many provider cost reports are settled without field audits. For the cost reporting year ended in 1978, about 60 percent of the home health agency reports were settled without field audit. A major concern with this practice is that it is difficult

to identify unallowable costs without field audits. In fiscal 1982, significant costs in the budget for intermediary audits are under consideration—about 67 percent of the fiscal year 1981 level. Cuts of this magnitude could hamper the intermediary's ability to assess the compliance with existing legislation and regulations.

The next issue is the quality of HCFA oversight. This question is difficult to answer. We have issued two reports since 1979 which touch on how well HCFA administers medicare's home health care program and we have suggested areas for improvement. Overall, we believe the agency has set up reasonable systems to fulfill its responsibility.

The question of the ability to collect overpayments depends heavily on the extent to which the agencies rely on medicare for revenues. A nonprofit agency with 100-percent medicare utilization would have great difficulty continuing operations if medicare funding is interrupted. The provision of the Omnibus Reconciliation Act of 1980 which authorizes the Secretary to require home health agencies to be bonded or to establish escrow accounts to protect the Government's interest could protect the Government and also protect agencies from insolvency.

The last issue you asked us to comment on is the means by which the Government can terminate irresponsible home health agencies. In summary and not going into detail, we believe that there is sufficient authority already on the books to allow for termination where that is warranted. Thank you, Mr. Chairman.

Chairman ROTH. Thank you. Mr. Hall.

Mr. HALL. I am Hadley Hall, president of the National Association of Home Health Agencies. We request that the advanced testimony delivered on Monday of this week be incorporated in the record as well as the full text of today's statement.

The letter from the Better Government Association of April 27, 1981, is especially perceptive, concise and to the point and I recommend a very careful review of BGA's comments, especially the two points on page 3 of the latter.

In my 18 years of involvement with the same employer in the same community, I believe it is the best statement of its type that I have reviewed. The patients served by some care organizations are needy and vulnerable. The providers are nearly always concerned, honest, fair and responsible. The abuses described are those of a few and are of long standing. The stories on television of last week and in years past are not new. The responsibility for correcting these problems belong to all of us. All aspects of the home care program can be faulted. Medicare, medicaid, and title XX.

Some providers have clearly taken advantage of the program. Some intermediaries have failed to perform conscientiously. The employees of some intermediaries should be in jail. The Department's record is inconsistent at best and some of its employees should be held accountable if not put in jail. Law enforcement agencies have rarely shown an interest in pursuing so-called low yield fraud cases or an understanding of the programs. But the largest measure of responsibility, I believe, and the one most frequently ignored belongs to Congress. Most of the problems we have identified are locked into the process and parameters of the programs Congress has established.

The most important solution in our view are the following:

One, it is clear from previous testimony and especially yesterday that there is confusion about community based, nonprofit agencies and privately controlled and owned not-for-profit companies. A letter is submitted for the record to assist in clarifying this matter.

Two, public employees at the Federal, regional, State, and local levels have not been held accountable. Employees of Government and the intermediaries who gave Peter Gottliner, Flora Souza, and others, clean bills of health continue to be employed. Congress and State legislators have requested reports on home care that have been rejected as unresponsive, yet no civil servants have been terminated or disciplined for not being responsive to the requests of elected officials.

Employees of fiscal intermediaries have not been disciplined for allowing fraudulent and unreasonable practices to take place and to continue as we heard yesterday and in 1977.

When some individuals of very high status are suspected of improper conduct, they are not disciplined or fired. They are moved to other jobs at equal salaries while they complete the seniority needed to be fully retired.

Congress must hold Federal and State civil servants and the employees of fiscal intermediaries accountable for the public trust placed in them for the handling of Federal dollars.

Three, consumers of home care services financed by medicare, medicaid, title XX, and several other Government programs do not know the charges the Government pays on their behalf. It is ironic that the Government does not require that fiscal intermediaries send a copy of the bill they are paying on behalf of the recipients. In home health care we have a system similar to a department store sending a banker bill on behalf of the customer and the banker pays it without verification or authorization.

Some members of the Government may mislead you by confusing the reports of services utilized under medicare with a copy of a bill that would be understandable to a reasonable person and received in a timely manner.

Four, anyone of almost any background, reputation, experience, and no bank account can participate in Government programs of long-term care such as nursing homes and home health companies without personal or financial risk of any kind. This is not true for private enterprise or for charitable organizations.

As long as the unscrupulous can participate without true capital investment, there will be future hearings of these kinds in the years to come. There should be training, educational, financial, and experience requirements before an individual can open a company to sell home health services to the public, whether financed by Government or private funds.

And five, the current reimbursement systems in medicare, medicaid, title XX, and others, require that all providers subsidize these programs or become bankrupt. Eventually this Government policy means the destruction and elimination of community programs such as the visiting nurses associations and United Way agencies. Congress did not intend this and Congress does not expect the space and highway programs to be subsidized by cake sales and charity fundraising. It should not be required for home health.

Such reimbursement policies encourage what David Brinkley referred to as "The liars, the cheats, and the thieves."

We appreciate, Senators, the opportunity to participate in these hearings and we commend you for the special interest you have demonstrated. We hope that this interest will be maintained long enough to insure positive changes in the programs, problems, and issues these hearings have emphasized. To that end may I respectfully suggest that you hold followup hearings 6 months from now with representatives of the Government, fiscal intermediaries, the Inspector General, providers, and others to assess the progress made.

Today there is plenty of blame to go around. There will be no long-term solution to these and other problems until Congress recognizes this fact and restructures the many fragmented programs and processes. The National Association of Home Health Agencies and its members will do all it can to help in this effort. We request that the letter and the balance of the prepared oral testimony be included in your record.

Chairman ROTH. So ordered, without objection.

[The letter will follow the prepared statement of Mr. Hall.]

Chairman ROTH. Finally, Mr. Reck?

Mr. RECK. Thank you, Mr. Chairman.

My name is Ronald Reck, administrator of home health services of Allegheny County, Pittsburgh, Pa., and president of the American Federation of Home Health Agencies. I am very pleased to have this opportunity to present testimony to this subcommittee regarding home health care.

The American Federation of Home Health Agencies is a national trade association representing primarily private and nonprofit and proprietary home health agencies across the United States. We represent the small business, free enterprise aspect of the home health industry. Formed in September 1980 for the purpose of presenting a carefully reasoned picture of the private sector of the home health industry to the Congress and the Health Care Financing Administration (HCFA). It is our belief that constructive input on behalf of the private segment of the industry had been noticeably lacking in the past. The American Federation represents a greater percentage of the private sector than any other national organization representing the home health industry.

We would like to make clear at the outset that our organization does not condone or in any way support fraud or abuse conduct by the agencies within this industry.

We are as interested as your subcommittee in eliminating the onus placed upon our entire industry by the actions of a few individuals. Organizations whose fraudulent conduct has been proved should be omitted from the Federal program pursuant to existing procedures and pursued with the full force of the law.

We also believe the subcommittee should investigate the activities and the actions of the fiscal intermediaries who are obligated by contract with implementing the program. There have been patterns of abuse and incompetence on the part of the intermediaries which have, in some cases, actually led to charges of abuse against home health agencies. In some cases the agency may be accused of abusive practices

which were initially overlooked or verbally approved by the intermediary. It is also a frequent tactic of intermediary representatives to issue a notice of program reimbursement detailing fiscal disallowances to a provider and later reopen that notice to significantly raise the questioned reimbursement amount when a provider has filed a notice of appeal.

In essence, this is retaliation by the fiscal intermediary for the provider's exercise of his constitutional and statutorily created rights. In other cases, an intermediary representative has threatened to shut down a home health agency or to suggest to the agency that while they will not be shut down, they will be made to suffer financial hardship for an extended period of time.

It should also be noted that many of the problems in the industry have surfaced after the intermediary has failed to do his job. The system may likewise be subjected to abuse if an intermediary has failed to timely notify a home health agency that has been kept in the dark or where the rules have been changed and applied retroactively.

Unfortunately, for the home health agency the intermediary has a method of covering up their incompetence by retroactively seeking repayment to the medicare program. And I cite a case that is coming before the PRRB, on which a decision has not been made and that is one that was located in 1976 and 1977 here in Washington, D.C. It was a private, nonprofit home health agency which was supposedly driven out of business by the program. There was no fraud or abuse actions held against that agency, by the way.

We think this subcommittee should recommend a method of holding the intermediary accountable for their arbitrary and incompetent actions.

It is AFHHA's position that related organizations are not and should not in themselves be precluded from participation in the program. If a related organization is providing a necessary service, and if the cost of the service is reasonable and fair in the marketplace, and if the existence of the related organizations is known to the program then they should be allowed to participate in the program. In some cases the prices paid to the related organization may be less than those in the marketplace.

In other cases the services offered may not be readily available. And I speak to yesterday somebody making a comment on the fact that home health agencies subcontract with other service agencies. Depending on nursing shortage or home health agency shortage or physical therapy shortage, there is a need for home health agencies in certain communities to subcontract for special services and again that would be based on availability, need, and/or costs.

Senator COHEN. What were the special services that you saw on that board yesterday that were required to be contracted out that they couldn't have done themselves?

Mr. RECK. I wouldn't want to associate myself or the organization with that particular case.

Senator COHEN. That is what my comment was directed to.

Mr. RECK. What I am saying is there is a need for home health agencies to subcontract in certain instances and that would be based on availability or the need to supply services.

Senator COHEN. I will come back to that.

Mr. RECK. In response to your letter, effectiveness of the cost reimbursement system or other proposed alternatives, the American Federation of Home Health Agencies believes that the present cost reimbursement system is a very poor system which easily lends itself to abuse. We are proposing today a reimbursement system on a prospective basis with profit incentives in mind, designed specifically for home health agencies. Such a system would reward business efficiency, maintain and enhance the quality in the system, eliminate retroactive denials, eliminate the provider reimbursement preview board for home health agencies, eliminate some HCFA and intermediary's bureaucracy and reduce overall costs to the program.

These cost savings we are working on in committee within the American Federation and will be glad to share with the subcommittee at a later date.

Many ways have been proposed for determining the method of payment for an agency. Under such a system our recommendation is that a set payment per visit be provided to each home health agency in a specific geographic area. Each agency would be allowed to conduct their business up to this per visit payment amount and a percentage of the difference between their costs and the payment would be returned to them as profit. An important function of this profit motive is to weed out inefficient agencies, as with all small and large businesses in the country.

The existence of related organizations would be irrelevant under such a system. Such a system would be more free-enterprise oriented because it would promote efficiency rather than encourage waste.

We realize the fraudulent agency who wished to bill for unperformed visits could be a problem, as would the agency which sought to reduce the quality of care provided. To deal with such practices we are proposing the creation of a quality control system we will refer to as SPO, which stands for structure, process, and outcome. We will delve into SPO in more detail in questions and answers.

Item B.—Effectiveness of the intermediary audit coverage.

AFHHA's concern in this area is twofold: First, we would like to see uniform and consistent application of policy and procedure by the intermediary in conducting their audits, and second, we would like to see some accountability on the part of the intermediary where improper disallowances are made.

Many problems created by the audit coverage could be eliminated by proper prior notification to each home health agency regarding any intermediary letters and other policies that are issued to the intermediary.

We also believe that a notice of program reimbursement should be required to be issued within 6 months of the filing of the cost report by the home health agency. Once the notice of program reimbursement has been issued, if it is issued, then the cost should not be reopened again for any case with the exception of fraud.

Item C.—Effectiveness of oversight and administration of the program by HCFA.

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Fiscal intermediaries have tremendous discretion in administering the medicare home health benefits. In much the same way that the home health agency is responsible to the intermediary for its performance, so too the intermediary should be accountable to HCFA for its performance. In our opinion, such oversight has been lacking in the past.

HCFA could require the intermediary to perform full scope audits at least once every 2 years on all types of home health agencies it oversees.

In the past, such audits have had an approximately 4 to 1 recovery-to-cost ratio, thereby justifying any additional administrative expense.

Item D.—Means by which disallowances can be recovered by the Federal Government without rendering insolvent the bona fide home health agency.

As noted earlier, we believe that a notice of program reimbursement should not be issued after 6 months following a final cost report and that a finalized cost report not be allowed to be reopened with exception of cases involving fraud. Under those circumstances, the intermediary would be required to do a more thorough audit at the time of the first review of the cost report.

Cases have occurred in which during a desk audit, which is the initial review, an auditor made notes in the margin regarding an expense. Three years later the cost report was reopened simply based on the 3-year-old notes in the margin. If the problem existed initially, it should have been dealt with after the first review. An agency should not be left hanging on the intermediary's whim for 3 years.

Item E.—Means by which the Federal Government may terminate irresponsible home health agencies from participating in federally funded home health programs.

You have requested our specific comment on the means by which the Federal Government may terminate the irresponsible home health agency from participating in federally funded home health programs. Our initial problem is your use of the term "irresponsible" as the touch stone for termination from the medicare programs. Fraudulent and intentionally abusive home health agencies should be terminated from the program. The term "irresponsible" is an inappropriate term to apply.

AFHHA does not defend the fraudulent operator. We do defend the honest owner who has been wrongfully tainted by the actions of a few, or who has been accused of abusing the program due to ignorance related to poor or nonexistent advice from the intermediary, or who has been retroactively disallowed based upon an unknown and uncommunicated change in policy or interpretation.

Senator COHEN. Forget about fraudulent and abusive home health agencies for a moment. What about the home health agency that is just incompetent as a business and as a responsible agency, as far as conducting the purpose of the home health care program itself?

Mr. RECK. We believe that the honest, that the——

Senator COHEN. You could be honest but incompetent, can't you?

Mr. RECK. Yes.

Senator COHEN. Would you recommend that we as a Federal policy terminate continued funding for those home health agencies that are purely incompetent but honest?

Mr. RECK. I would say that you should terminate them after they have been given the chance to become competent. I think that the auditing procedures would make aware those incompetencies that could be corrected over a period of time and that an agency should not necessarily be closed down because of an administrator's incompetency.

Senator COHEN. Because of their own incompetency?

Mr. RECK. Again I am saying the administrator's incompetency and I would mean that to be that the agency should not be closed, it could be providing a very proper service in the community and needed. So if the intermediary could instruct properly, and that is part of the intermediary's job, what the policies and procedures are, I believe, not necessarily all of them, I believe the administrator should know what they are when they get into the business of home health care.

Senator COHEN. Shouldn't an agency that is put together and hires the administrator be held accountable, too?

Mr. RECK. Yes.

Senator COHEN. You shift the whole responsibility over to the intermediaries. What about the home health care responsibility?

Mr. RECK. I believe it goes with the disallowance program.

Senator COHEN. If they hire incompetent people, they are bound with that. Shouldn't they be?

Mr. RECK. I do not condone incompetency, if that is what you are saying.

Senator COHEN. I think if you were trying to narrow it down to fraudulent and abusive, you ought to have incompetent in there as well.

Mr. RECK. Existing laws can readily terminate home health agencies from the medicare program if they are enforced. AFHHA believes that the home health agency program is overregulated and underpoliced. Each State is responsible for seeing that home health agencies who are participating in the medicare program annually have met their conditions of participation.

Fiscal intermediaries are responsible through contractual arrangement with the Federal Government in seeing that home health providers are in compliance with existing requirements. The subcommittee should, however, keep in mind that termination is the ultimate sanction and should be very carefully used.

AFHHA believes that the entire medicare program needs to be reformed but, specifically, our concern today is with the existing problems emanating from the hodge-podge of illogical laws and regulations affecting the home health industry.

We offer our assistance to your subcommittee in developing recommendations which we hope will address the problems raised during these hearings.

Thank you.

Chairman ROTH. Senator Cohen?

Senator COHEN. Thank you, Mr. Chairman.

Perhaps I would start with Mr. Ahart, initially.

You indicated with some exceptions that you feel the various laws that are currently on the books already provide HHS and HCFA with sufficient authority to act in the areas of fraud and abuse in home health care. Is that correct?

Mr. AHART. That is correct.

Senator COHEN. I refer specifically to section 223 of the social security amendments of 1972, which allows HHS to put reimbursable limits on management and clerical costs, since the evidence shows that medicare has been paying excessive costs in these areas. I also refer to section 930(n) of the Omnibus Reconciliation Act of 1980, which would authorize home health agencies to either be bonded or establish escrow accounts. This should help to protect the Government's financial interest.

Mr. AHART. That is correct.

Senator COHEN. The problem is that it is not the law as such. Is that also correct?

Mr. AHART. Which point is not the law, Senator Cohen? I am not sure I understand you.

Senator COHEN. These really haven't been translated into regulation form. You have the authority.

Mr. AHART. I am talking about the adequacy of the legislative authority.

Senator COHEN. The authority is there.

Mr. AHART. The authority is there. There is need for work on establishing limits, using section 223 authority to establish limits on those areas of costs that have been troublesome. Also, we think there is a need, as I pointed out in my statement, to shift the burden of proof on the related organization question where certain criteria are met, such as some appearance of possible relatedness, to the provider to disclose what relationship exists.

Senator COHEN. Stop right there. I can't tell from here whether those charts show that, but I have a copy of the chart that shows the transactions we dealt with yesterday. How would any change in law have prevented all that from taking place? We already had a situation. I am referring specifically now to the conditions for an exception to the provisions of medicare's Provider Reimbursement Manual which are designed to eliminate profits between related organizations. One such condition is that the supplying party is a bonafide separate organization. That was not the case yesterday, clearly.

Another condition is that a substantial part of the provider's business is transacted with organizations not related to the provider. That was clearly not the case yesterday. A third condition is that there is an open, competitive market for services and supplies in question. I assume there would have been open competition. A fourth condition is that the services or supplies are those commonly obtained by the type of provider from other organizations, not those ordinarily furnished directly to the patients by that type of provider.

Wasn't the law sufficient in this case to prevent that kind of abuse already?

Mr. AHART. It would have been if everybody had known the facts. What we are suggesting is that in that kind of a situation, if there is some indication that the principal involved is instrumental in organizing these other agencies, then the burden of proof should be shifted to that principal. The principal, first of all, would have to disclose the relationship and then demonstrate that it is not a related organization arrangement. Obviously this kind of demonstration would not have been made in this situation.

Senator COHEN. Assuming that is the law that currently is not translated into the regulatory form, would that have prevented that case history? You have a calculated attempt to lie, to alter records, to destroy records, to have a shifting of employees from one company to another, and management has total interrelated control. How would the law have prevented that case, where you have a calculated wrongdoing?

Mr. AHART. First of all I don't think you can write a law which will prevent all instances of calculated wrongdoing.

Senator COHEN. Had the law been applied as it is currently on the books, that would have made this conduct illegal as it currently stands, would it not?

Mr. AHART. It is now, but the burden of proof in this kind of a situation, since there was no exception applied for, was with the intermediary to go out and uncover and prove that the related organization arrangement existed.

What we are suggesting is that the burden of proof be shifted. The provider would have to first of all disclose the relationship and then demonstrate that it is not a related organization arrangement. So it is a burden problem. It is a very difficult task for the intermediary, to identify and investigate these investigations. However, if you can shift that burden, that is put the burden of proof on the provider to show it is not going on, we think that would help.

Senator COHEN. Does that require a legislative change?

Mr. AHART. I would have to check on that, but quite possibly it could be done by regulation.

Senator COHEN. Couldn't it be done under existing authority as it is currently written?

Mr. AHART. It could possibly be done under the existing authority but I want to check that first to see whether or not a legislative change may in fact be needed. I will submit this information for the record.

We think HHS has adequate authority to require that providers and parties in question establish that they are not related organizations. However, we recognize that questions may arise as to the nature and extent of the burden to be placed on these organizations. To allay such concerns, we think legislation would be helpful to put to rest any lingering doubts regarding burden of proof in related organization determinations.

Senator COHEN. Let's go to the second part about escrow accounts involved. Is that permissible now under the existing authority?

Mr. AHART. Under the Omnibus Reconciliation Act which was passed last year, there is authority to do that and when it is implemented, it should have a good effect.

Senator COHEN. Have you seen any indication from HHS that they intend to do that?

Mr. AHART. I think in response to this subcommittee they have indicated they are working on that. As to what conditions they will require, bonding or the establishment of escrow accounts, but I don't have specific personal knowledge of where they stand on it.

Senator COHEN. You also indicated that there were proposals last year for limiting specific items such as transportation, legal services, and clerical help. I think there were three members of this subcom-

mittee that cosponsored a bill last year to that effect, but it was not adopted. However, the question I have is, Do you feel we have to have a law, or could that be done by regulation?

Mr. AHART. We think the authority is adequate for the Secretary to do that. We would support legislation which would require it.

Senator COHEN. Any reason why it is not being done, in your opinion?

Mr. AHART. The story that we have is that the data they have to work with is presently insufficient to do a good job of establishing those limits. They are trying to improve on that through the uniform cost-reporting system. Presumably if they become satisfied and the data is adequate they would go ahead. It is a difficult thing to do but we think it can be done and they ought to go forward with it.

Senator COHEN. Let me turn to Mr. Hall and Mr. Reck. You both heard Mr. Ahart testify that one of the problems of medicare's cost reimbursement system is in determining which costs are related to patient care and which are not. The regulation governing the issue is very general, that as long as the regulation is general, it is going to be difficult to implement or enforce. And the converse side of that particular point is that if you make the regulation too tight, too rigidly drawn, then that facilitates the creation of other kinds of loopholes and makes for difficulties in enforcement. So we are left in a gray area.

One, do you agree with that assessment; two, what can we do to make it either black or white?

Mr. RECK. You are speaking on the bonding and escrow?

Senator COHEN. No.

Mr. RECK. With respect to reimbursement.

Senator COHEN. Right.

Mr. RECK. On prospective reimbursement, AFHHA doesn't agree with the position that it would be difficult to administer a prospective reimbursement for lack of a uniform unit. As I mentioned in my testimony, we feel that the visit would be a common denominator. If I may use the example, home health agencies utilize visits as parameters for determining their budgets, staffing patterns and productivity, cost reporting, industry comparisons, payment for contractual staffing, certificate of need requirements and accounts receivable, to mention a few.

Fiscal intermediaries use the visit as a parameter for determining reasonableness of cost of home health agencies, home health agencies' waiver of liability, establishing statistical ICDA diagnostic screening, PIP reports or PIP interim payments and preparing comparability studies of their own of a group of providers for whom they act as fiscal intermediaries. The Health Care Financing Administration uses the visit as a common denominator for determining the national home health industry comparison reports that they come out with, for subcontracting reimbursement guidelines and as a basis for a data bank, and for reimbursement to the fiscal intermediaries for services to the Federal Government under contractual arrangements. Finally, also they use—that is, HCFA—uses the visit as a common denominator for budget projections to the Congress.

So we don't agree that the visit could not be used as a common denominator. It could be used.

Mr. HALL. I do not agree.

Chairman ROTH. You say you do or do not?

Mr. HALL. I do not. I agree with GAO it would be very difficult to administer. We saw it in testimony yesterday in 1977, that visits can be manipulated in terms of length and in terms of number.

Not only that, but you have the problem of recidivism, that is, they go off the care for a month, get shifted to another agency and then you have the fourth problem of how long do they stay on the service, getting more visits than they need for longer times at each visit. A car is a car is a car, that doesn't necessarily mean that a Cadillac and a Pinto are the same. They may both get you there at the same time, but they are different elements.

Mr. RECK. If I may finish.

Mr. HALL. I am sorry. I didn't realize you hadn't finished.

Senator COHEN. Maybe it is more of a basis for disagreement.

Mr. RECK. We have a remedy that goes along with the fact as using the visit as a common denominator. I mentioned that also in my testimony.

The American Federation of Home Health Agencies believes that when using the home health visit as a common denominator, quality control can be assured through the three-phase program that I previously mentioned.

Those three phases are the structure or the overall review of the agency structure, the process, a review of the process of providing the care and the outcome and assessment of the actual fiscal status of the patient.

Our committee, the American Federations Committee, is currently developing business practice guidelines for our AFHHA membership and also developing this SPO which we would go further into.

This quality control program could be implemented through the present conditions of participation within the medicare program. If each State is required to have qualified surveyors with this type of specific criteria and standards for evaluating the agency's performance then prospective reimbursement can work under a visit common denominator.

Senator COHEN. That was not the issue I raised whether it is prospective or retrospective, but rather the issue of costs pertaining to patient care and how you distinguish between those pertaining to patient care and those that are unrelated to patient care.

Mr. Hall, did you want to add further?

Mr. HALL. Yes; I do.

Senator COHEN. Let me come back. The problem I have is as I look at this system, Mr. Reck, you seem to put the blame back to the intermediaries, and there is cause for shifting some of that blame to the intermediary. But as I look at this chart, I don't see that there is any incentive anywhere along the way from those subcontractors to the home health agencies to the intermediaries all the way back to the system, even to Congress, as you point out. Where is the incentive to exercise fiscal discipline? I don't see that incentive. Certainly Blue Cross/Blue Shield could take a look at it, and say, well, that looks reasonable, and then pass the bill on to the Federal Government. We pass it on to our constituents by increasing the debt. We increase the debt, which contributes to inflation.

So where in this whole system are there incentives for controlling costs? Where are they? I think you said there is enough blame to go around for everybody, and not simply for the home health agency to point the finger back to the intermediary, and say that they are the guys. Then the intermediary says we are limited in staff, we can only conduct 1,149 audits at a cost of $3.3 million. We cannot do everything. Maybe we will have to build up our bureaucracy here of auditors, then pass that bill back onto the Federal Government.

Where is the discipline going to come from?

Mr. HALL. If I may, I think we have to recognize the fact that the discipline has to come from honest providers doing the very best they know how. That is true of schoolteachers, it is true of physicians, it is true of Congressmen. It sounds like a simple solution and it is very difficult.

Senator COHEN. We now face $1 trillion national debt.

Mr. HALL. We are going to face a higher debt if we don't do something to keep the people out of nursing homes and institutions. This may not be the panacea, but it is one method.

Senator COHEN. Let me just take disagreement with you here. I am a supporter of home health care. I do not support it as an alternative to the nursing home care. The difficulty is that a large portion of the people who are in nursing homes are there because they have no alternative. I think home health care provides an alternative. It is not going to reduce costs to the Federal Government in the short term, although maybe in the long term, many, many year after we are gone from this institution. What it will do is free those beds up in the nursing homes for people who will need them, and you will extend the kind of home health care to people who will survive with dignity. But the costs ultimately go to the Federal Government. Even though you can reduce costs on a per-patient basis, the overall cost is not going to come down until we come to a society which puts the emphasis on preventive care.

But ultimately I think we are making false promises to a lot of people by suggesting we are going to reduce the bill to the Federal Treasury and to the taxpayer by going the home health route.

I don't think that is the case.

Mr. HALL. I agree. I think it was Congressman Waxman who said, "We can't put a cap on the aging." We are trying to put a cap under 225 on costs and the way that has been interpreted is the cost per visit and it is my contention that that is what gets us into a great deal of difficulty. Because you can put the cap on the visit or a candy bar or a can of corn and the can gets smaller or the quality gets less, or whatever. I think we have to look at costs in terms of total. That means the number of units of costs being utilized over what length of time and whether or not there is recidivism. This is as true in home health care as it is in jails or hospital stays. I am afraid that the cost caps as we are currently interpreting them, putting a cap on a unit of service, is going to be much more costly because the natural inclination under a reimbursement system that requires you to subsidize it or go broke is bound to occur.

I don't see any alternative. I think we have to examine the question of what do we mean by costs and compared to what?

Senator COHEN. I know I am treading on your time, Mr. Chairman. Where does that leave Congress? What is your role now? We pass the law, you set up a Health Care Financing Administration which in turn relies upon the intermediaries, who in turn provide the money to the home health agencies, who in turn, in some cases of necessity or by design, insidious design, subcontract it out.

What is the congressional role?

What kind of guidelines should we be insisting upon? The laws apparently are broad enough to allow a number of stringent conditions to be implemented, but what do we do?

Mr. HALL. I think the fact the law is broad enough is not alone enough. Presidents, Vice Presidents, Congressmen, people in private industry are held accountable, are fired. I know of nobody in the fiscal intermediary or the Government that has been fired for this situation. That has been longstanding. That could have been picked up early in 1977 at the latest. Yet nobody responsible is on the carpet even here. We will hear later this morning from somebody that had no knowledge of it.

But somebody there in the Fiscal Intermediaries and in HCFA was responsible as they were in the *Sousa* case in 1977.

Those cases were of 5-year standing then. Godhaner is just barely coming to jail on the criminal charge, not on the civil penalty of a misunderstanding on his income tax. Congress is going to, I believe, have to hold some people responsible. Darn it, if I don't do my job, the people at the United Way kick my body out. They hire somebody that will.

We have people in HCFA that have been around for years that have responsibility. And I think, darn it, you should insist on it.

The people sometimes testifying before you have no more responsibility for the day-to-day situations like that than a man in the Moon. Let's get them here. I don't mean to—that is the way I feel.

Senator COHEN. I don't disagree with you. I was on the floor yesterday on an entirely unrelated matter dealing with fraud and waste in the Defense Department and I recommended, for example, that if one agency of the Government, say HUD, finds that a contractor is a fraud, a liar, embezzler, a cheat, or simply irresponsible, that phrase, irresponsible, and is debarred by that agency from doing business for a period of 3 years, that that debarment ought to be given presumptive validity to every other agency, including the Defense Department.

It is not the case today because a contractor who is debarred from doing business with HUD could be debarred for 3 years, walk across the street, get a contract for military construction on some base under the Defense Department.

So the beat goes on and on and on and we don't insist upon it, it is actually resisted by the Department of Defense.

Mr. HALL. That was exactly what happened in the *Godhaner* and *Sousa* cases, they switched from medicare to medicaid to title XX. If we don't watch it, we will be holding hearings under the Administration on Aging Act.

Senator COHEN. I have exceeded my time.

Thank you, Mr. Chairman.

Chairman ROTH. Thank you.

I have to confess I am still troubled because I don't see anything said yet that persuades me that we are going to create the kind of system that will avoid the kind of problem we face today.

I would like to ask Mr. Ahart a question. The Government is involved in all types of procurement. It seems to me basically they fall into two categories, competition or cost reimbursement; is that correct?

Mr. AHART. That is a little bit of an oversimplification but I think that it is adequate for our purposes here.

Chairman ROTH. Yes; it is oversimplified. Another witness has talked about competition. Does competition offer any potential, any aspect to this kind of a program?

Mr. AHART. I think when you get in the health field generally, competition, in an economic sense, is very difficult to achieve. Most of us do not shop around when we deal with the health care system. We generally have our family doctor or a specific outpatient clinic that we visit when we get sick; we don't shop around for price and quality.

Chairman ROTH. We are not talking about the family doctor. I am not an expert, but as I understand the program, whatever care is given is subject to requirements of the patient's physician. I think that is basic to the program.

But let me just go to that program. You keep talking about the complexity of the kind of home aid we are having. Is this as complex as we make out?

Basically, isn't the kind of service that is being provided a nurse or a nurse's aid, or some kind of physical therapy?

Mr. AHART. Basically that is the case.

Chairman ROTH. We are not providing doctor care.

Mr. AHART. It is care under the supervision of a physician and as you pointed out, it can be comprised of a number of things. It may be a patient who cannot self-administer medication and needs to be visited one, two, or three times a week for that.

Chairman ROTH. We are still providing a relatively—I don't want to oversimplify—but a relatively simple kind of service to the patient at home who for one reason or another needs some kind of medical assistance. Is this an extraordinarily difficult kind of service we are providing here?

Mr. AHART. No; I don't think so. I think where the complexity comes in, Mr. Chairman, is how do you administer and how do you control? You have a person, first of all, who is not paying for his or her own care. Also, you have the care being provided under the supervision of a physician but you need to give, I think, some latitude to the home health agency in making sure they do meet the needs of that patient.

Chairman ROTH. That is the very point I am getting at while there is a multitude of services, it is still within a relatively narrow area of medical aid. I say, again, you provide either a nurse or a nurse's aid or some kind of physical therapy, isn't that essentially what you are providing? What else do you provide?

Mr. HALL. I think you have covered it, Senator. I think there is an absolute need for competition and for alternatives to patients so that they do not have to be stuck with a single organization any more than we are stuck with a single bank or a single hospital.

One of the problems that comes in, however, is when you allow anybody to go into any community and open up a home health agency.

Chairman ROTH. I am not addressing that question right now. I would like to keep on the narrow focus of what kind of system we are providing. It seems to me, at least as I listen to the testimony, that where the difficulty comes in is the multiplicity. What you are dealing with is many small providers scattered throughout the country. If you look at the Department of Defense, to go to your illustration, they are purchasing all kinds of things from services to extraordinarily complex weapons. The problems are there, as we all know. At the same time, the complexity of what they are dealing with from a procurement point of view is much more difficult than here.

What I am trying to say, it seems to me, the basic procurement—I don't like to use the term "procurement" because we are talking about health services and it sounds too cold—but essentially you are dealing with a relatively narrow range of simple health services being provided to the patient at home who cannot get out.

One of the areas I have great difficulty with is why we can't—I want to go back to the question of competition, but if we are going to the question of reimbursement—I do not understand why it is not possible to develop some fairly comprehensive reimbursement standards. I know the providers are never going to like them any more than the defense contractors like the restrictions on the ASBR. But I can't understand why we say it is not possible to describe the cost reimbursement items fairly accurately and in fairness to the providers. Why is that so difficult if I understood your testimony?

Mr. AHART. It is simple, but it is very complex in that each patient requires a different type of service even though they are from the same range of services.

Also, when you are talking about visiting, you are talking about transportation and this can vary significantly.

Chairman ROTH. I am not talking about fraud, I am just talking about trying to determine basically what each provider has and subcontractor spent. Because, again, we talk about mileage. There is nothing unique about mileage in this service. All you have to do is look at the $8 billion we are paying for transportation. That is something we deal with every day. Somebody might defraud us after we found out yesterday they submitted fraudulent requests for reimbursement, but that is not particularly difficult.

Let me go to the kind of assistance we are giving them. Is there a great variety of the kind of assistance and equipment they take with them? Is that impossible to spell out?

Mr. AHART. It is when you talk about the prospective rate reimbursement. If you try to put that on a per visit basis, you have a lot of variation, depending on the location of the patient and what their needs are. There is a lot of variability between visits so we could not come up in our judgment with a rate that said $40 a visit is a good rate and pay $40 for every visit. There is a lot of variability involved.

I think it would cause more problems than it would solve.

As far as the principles that you seem to be leaning to in terms of what is the cost and so on, I think those are already there. We do reimburse the agencies on the basis of actual reasonable costs.

Chairman ROTH. Do we spell out the costs like we do in ASBR?

Mr. AHART. Those are pretty well spelled out. You do get the problem of distinguishing between costs which are for things which are related to patient care and costs which are not. That is a very fuzzy area, as I pointed out in my statement.

For example, on solicitation of patients, that is an unallowable cost, but at the same time you are expected to stay on good terms with the medical community and you incur some costs in doing that.

How do you draw the line in a very precise sort of way between what is soliciting business and what is trying to maintain good relations with the medical community? I don't know of any clear formula by which you can do that. It is a judgmental thing given the fact and circumstances of a particular case.

Senator COHEN. What does that mean, good relations with the medical community?

Mr. AHART. I think you might have to turn to someone other than me to spell out the specifics of that. Obviously if the doctors are to prescribe the care, there needs to be some kind of rapport between the local medical community and the people who are providing the home health services. What kind of contacts would be appropriate to that, I think, is the kind of question I am getting to. It is a very difficult distinction to make. Certainly giving gifts every Christmas I would not think would be in that ball park, or going in and freely providing hospital discharge planning.

Senator COHEN. What you are basically talking about is reassuring the medical community you are not trying to get their particular business by going out in the home health care field and not bringing people to hospitals. Is that what it amounts to?

Mr. AHART. That may be part of it.

Chairman ROTH. I would point out that in some of the mail we have received, GAO stated there was an apparent need for defining allowable costs. Apparently there is too much variation among regions.

Let me go, if I can, to Mr. Manikas and get his reaction, both to the question as to whether there is a place for competition in this area and, second, to get his comments on cost reimbursement.

Mr. MANIKAS. One of the reasons we made the recommendation in regard to the use of vouchers was for that very purpose, to see whether we could introduce a measure of price competition into the field. There are demonstration projects being conducted around the country right now that use vouchers, the purpose being to generate greater competition among providers within a particular area.

To do that, you need various safeguards because you don't want to damage some of the providers like VNA's that do not have a competitive edge. But the thought is that it can be done. However, you might need a relaitvely complicated mechanism.

For example, if you were going to use vouchers, you might also want to do that in conjunction with the use of some case managers that might be connected with a State agency that would help elderly people select what providers would be providing the service.

If there are a number of providers out there all trying to provide the same service, some people would need help, in terms of making a selection as to what service they need and who can best provide it.

In any case, that is one proposal that has been made. In regard to reasonable costs, it seems to us that everybody has agreed that the concept was so nebulous as to be largely useless. Providers told us, for example, that reasonable cost simply did not mean anything.

On the NBC program that was broadcast last week, one provider said that everything was negotiable. You don't have to worry about reasonable cost because you are going to negotiate everything with the intermediary anyway. It seems that some sort of cost control mechanism has to be designed into the system, either in terms of price competition or in terms of budgeting. We urge the committee to look in that direction.

Chairman ROTH. I go back to the comment that Senator Cohen made, when you go to cost reimbursement, you have no incentive. I have to underscore what he said. It seems to me there is no incentive at any level of this particular program to try to keep costs reasonable. It is all very well to say it depends on honest people and I think that is true of anything we do, but I don't find some of the references you make particularly relevant. I think you have to have within the system some incentives to insure that people are going to keep costs down or they are going to get out of control. That has been time and again true of Government programs, starting with World War I; you can go back that far, costs plus percentage.

Mr. MANIKAS. That is exactly what we are saying. Something has to be designed into the system, either in terms of prefixed budgets or in terms of price competition that would help control costs.

Chairman ROTH. Now when we talk about prospective reimbursements, are we really talking negotiated contracts; is that another name for that?

Mr. AHART. One way would be a rate negotiated with the provider based on the costs experienced by the provider.

Chairman ROTH. On the what?

Mr. AHART. On the experienced cost of the provider.

Chairman ROTH. Are you suggesting it would be based on his costs?

Mr. AHART. Yes, it could be on a provider-by-provider basis.

Chairman ROTH. I will be candid, I don't understand that. Why couldn't it be based upon the experience of HCFA or at least an intermediary in that area? Why would we base those costs on the costs of the particular provider?

I must say if I were a provider, I would like that. Do you have any comment on that, Mr. Manikas?

Mr. MANIKAS. I am sorry—could you repeat that, please?

Chairman ROTH. Going back to cost reimbursement or the form of the contract. One method is to negotiate the rates ahead of time, which I suppose is a form of prospective reimbursement. But I would think that I would negotiate these kinds of agreements, not on the basis of the cost of that provider, but on the experience of either the intermediary or the HCFA itself as to what are reasonable costs for that kind of service.

Mr. MANIKAS. You can take a mean, for example. You can look at the cost experience of agencies within a certain geographical area and base a negotiated rate with a certain cost inflation factor, I suppose, and establish some subsequent year's budget. Negotiated rates

are something that ought to be considered as well. There are a wide variety of mechanisms that can be used, I think, with relatively little experience with any of those.

Hopefully, with the new title XXI, for example, we will experiment with at least three different kinds of reimbursement mechanisms. They are talking about fee schedules, capitation, and negotiated rates. Perhaps we will have a better record of experience over the next couple of years in order to have an evaluation.

Chairman ROTH. I will make just one final comment. As I look at some of these regulations, common ownership exists when an individual or individuals possess significant equity. Control exists where an individual or organization has the power directly or indirectly significantly to influence the policies of institutions. I can see from the testimony yesterday the vagueness of the regulations would provide the kind of problems we are dealing with.

Senator COHEN. Mr. Chairman, could I ask a couple more questions?

Chairman ROTH. Sure.

Senator COHEN. I would like to come back to this issue of simplicity the chairman raised before. But frankly, I do not know what function the home health agency serves. I have to agree with what you said about the ludicrous situation that we have where the company we had yesterday has a capital structure financing of about $2,000 and can secure several million dollars from the Federal Government in reimbursement costs. Is there some point in time when we can come back to the simplicity of the issue, some limitation on what a home health agency can legitimately contract out? In other words, is it simply a broker? Can it simply be a brokerage house where you put an organization together and then we can go over here to Northrad to get consulting services, then we can go to Chicago Home Care to get nursing assistance, then we can go to Oaklawn Physical Therapy to get some crutches. Is there some limitation to say you have to be a legitimate home health care agency and you have to provide these services and can't contract that out to somebody else? My problem is the more you contract out, the more complex it becomes, the less easy it is to follow the audit trail of items.

Is there some basic element that a home health agency should provide within itself?

Mr. HALL. I believe so, sir, and I think the law spells that out adequately. It is not enforced and the exception has become the rule in cases like this.

Senator COHEN. I want to come back to Mr. Manikas. In terms of the intermediaries and, I think, Mr. Reck and Mr. Hall raised this point about the responsibility and irresponsibility of intermediaries.

Do you know whether any of the intermediaries involved in this case Blue Cross and Aetna, felt these organizations qualified under the exception?

Mr. MANIKAS. Under the exceptions?

Senator COHEN. The exceptions to the rule in medicare's "Provider Reimbursement Manual" which eliminates profits between so-called "related organizations."

Mr. MANIKAS. Are you referring to the control?

Senator COHEN [presiding]. One, the supplying party is a bona fide supplying organization; two, a separate party whose business is transacted with organizations not related to the provider; three, an open competitive market for the services or supplies; four, services or supplies are those commonly obtained by the type of provider. Those are the four conditions. I want to know, do we have any evidence that either Aetna or Blue Cross was aware that the subcontractors, Chicago Home Care, Northrad, or Midwest qualified for that exception?

Mr. MANIKAS. They probably ought to have because if you went out into the field and talked to a number of people, you would find that the control aspect of Mr. Morrisroe and the five health care agencies were fairly apparent. The problem is that if you do a desk audit, the relationships are not going to turn up on paper. You have to go out into the field and talk to people. With Mr. Morrisroe, that was not done. It is difficult. You have to understand most of the relationships are based on verbal agreements, not legally enforcible agreements that turn up on contracts.

Senator COHEN. I guess the basic question I am asking in a very complicated way, to try to get a simple answer, I guess, is that if you contract out all these services, what function does the home health agency serve?

Mr. MANIKAS. Presumably the reason for allowing that kind of subcontracting to take place was to generate more agencies.

When the program started, as I understand it, there were no existing home health agencies. So an organization would begin and perhaps would not be equipped to perform all the services that were mandated by law and would have to contract out. The purpose of allowing subcontracting is to get more providers into the field. Perhaps the time is long past where we should allow that to continue. There may still be areas in the country, for example, rural areas, in which you might have to go to a subcontractor arrangement because the services would not otherwise be available. In a large metropolitan area, it seems to me you can require that an agency not subcontract out, or if they are going to subcontract, you can require prior approval of the subcontract or require competitive bidding on some of the contracts.

There are a number of mechanisms you can use in regard to subcontracts.

Senator COHEN. Part of the problem that at least occurred to me yesterday is that you can have the unscrupulous type that sets up a not-for-profit home health care agency and then subcontracts out for profit using the not-for-profit as cover, basically, when, in fact, it might be better just to say you have for-profit home health agencies.

I think the attitude is changing about this. At one time there was this notion that being for profit is inconsistent with health care. There was a real bias against that, against allowing any profit company to participate in Federal programs, in health care. I don't think that is the case today but at one time that was the situation. So you have a manipulation of a not-for-profit service and the scurrilous attempt to undermine that, by giving an appearance of being charitably inclined and not providing a profit for this particular service. You give the for-profit company a black eye in the process.

It just seems to me that we have allowed this system to get out of hand, that you have set up a shell which serves no real function, other than say you are a home health agency and contract it all out. It gets so

complicated, you have other contracts interrelated and pretty soon it is so fuzzy that Blue Cross/Blue Shield raises the question, time goes by, I guess they raised a question here. This goes on throughout Government. I go to my own rural State with its small communities. People would come to me frustrated and say, "I have been down to Washington. I applied for a $50,000 grant application and it was practically turned down in my face." It would have to be at least a million-dollar grant application before they look at this. We have this emphasis on bigness.

If you have a big grant application, we will look at it. If it is little, we will ignore it. If you have a big grant program in agencies, then you are rewarded. The bigger you are, the more people, the more office space needed, the more personnel, the higher the position. We tend to reward those who create empires and bureaucracy. This is something that is throughout our Government. I don't know how we can do it, but we have got to have some incentive for people who save money. We will get Bill Proxmire to give a Golden Scrooge award, something. We have to reverse the emphasis of rewarding people in our system for spending money. That is what the chairman and I both agree on, there seems to be no real incentives for people to save money, just pass the bill onto the Federal Treasury and it is paid out. It keeps going on without that kind of accountability. Maybe it will take what you suggest, some real discipline in firing people, at a minimum, to somehow hold people responsible. There doesn't seem to be much responsibility. We call you to come to us and tell us how we can be helpful and you tell us it's a gray area. You have to be careful you don't overregulate or get too specific.

We are sort of left hanging, frankly, as to what to do about it. The laws are adequate but they are not really being transformed into a profit regulatory mechanism. I am not sure what we are going to do as a result of these hearings, frankly.

I am going to take a break to go vote. I will declare a 5-minute recess.

[Brief recess.]

[Senator present at time of recess: Senator Cohen.]

Chairman ROTH [presiding]. The committee will be in order.

Because of the lateness of the hour, I think we have to proceed to the next panel. I want to thank each of the gentlemen who appear on the first panel for their contribution and testimony. I still am concerned that we don't seem to be able to structure a system that I think can strongly prevent, I think that is the word we want, fraud and waste and still provide the kind of service we want to give to the senior citizens who need assistance.

Thank you, gentlemen.

[The prepared statements of Mr. Manikas, Mr. Ahart, Mr. Hall, and Mr. Reck follow:]

PREPARED STATEMENT BY PETER M. MANIKAS LEGISATIVE COUNSEL FOR THE BETTER GOVERNMENT ASSOCIATION

Mr. Chairman, I appreciate the opportunity to testify here today on behalf of the Better Government Association (BGA). The Federal home health program has performed an important role in improving the lives of millions of chronically disabled persons. We are certainly eager to do what we can in helping to remedy some of the problems involved in the program's operation.

As the BGA indicated in its letter to the subcommittee dated April 27, 1981, we believe that many of the provider-related financial abuses that have emerged in this program and in other areas of medicare/medicaid financed health care are closely related to the program's design. In short, how we pay for and deliver in-home services seems to invite abuse.

Under the present system, providers exercise enormous discretion in determining what services will be delivered and at what price. There are few incentives to control costs and the system is extremely difficult to monitor for fraud and abuse.

Several proposals have been made to re-fashion the way the Nation finances long-term care services. For example, a new title XXI has been proposed which amends the Social Security Act (S. 861). That bill provides for 10 statewide demonstration programs which experiment with different ways to provide community-based care to elderly and disabled individuals. Certainly this kind of experimentation is greatly needed.

The BGA's investigation of financial abuses in the home health program suggests that future reform experiments should focus on two problems:

1. The Cost Reimbursement System—Several different alternatives to this payment mechanism should be explored including: prospective budgeting; tax incentives to encourage family members to care for their elderly and disabled relatives; the use of vouchers for the purchase of in-home services.

2. Determining Eligibility and Utilization—Under the present system providers in large measure determine both whether a potential beneficiary is eligible to receive services and the level of services to be received—for example, the number of home health visits needed.

These decisions should not be made by providers who have an economic stake in their outcome. (The proposed new title XXI (S. 861), for example, establishes an independent team to assess and screen potential beneficiaries.)

Mr. Chairman, the BGA, with the assistance of the University of Chicago's Center for the study of welfare policy has prepared a document for the subcommittee that discusses several approaches to reform in more detail. We will provide the subcommittee with that report in the next few days.

Reforms concerning how in-home and community-based services are financed require some experimentation and extensive debate. However, in the context of the present program there are several interim reforms that we believe should be considered:

1. To better control costs and prevent fraud and abuse:

Increase the number of field audits focusing on those home health agencies which spend a specified percentage of their income (for example, over 5 percent) on certain ancillary services such as management, consulting and legal services. Home health agencies that have high utilization rates should also receive special scrutiny.

Prohibit medicare payments for all promotional gifts to doctors, hospital personnel and others who supply home health agencies with services.

Explore the use of the civil section of the False Claims Act to recapture misappropriated medicare funds.

Provide for a coordinated auditing program of in-home services delivered under titles XVIII, XIX and XX. The purpose of this reform is to identify duplicate billings for services rendered under different programs. The problem related primarily to services under titles XIX and XX whose in-home personal services overlap and are sometimes indistinguishable from one another.

Review medicare regulations to determine if such terms as "related organizations" and "costs related to patient care" can be more precisely defined.

2. To increase program accountability:

The medicare program's conditions of participation for home health agencies should be strengthened to increase the ties between home health agencies and the local community. Home health agency advisory boards should not be dominated by agency personnel and should include more members from local community groups.

HCFA or appropriate state agencies should contract with citizens groups who have experience with serving elderly and disabled persons to monitor home health agency performance and file reports which would be available for public inspection.

3. To improve service delivery and the quality of care:

HCFA or appropriate state agencies should implement a program for regularly interviewing program beneficiaries to better assess the quality of care.

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Very little is known about the actual care that is delivered, although the few reports that are available indicate that clients are generally satisfied with the program.

A central source, perhaps a state or local agency, should collect and distribute information on the availability of in-home services in a specified geographical area. Clients need to be better informed concerning their options for long-term care.

Medicare's conditions of participation could be upgraded to strengthen the requirements for in-service training for home health aides and other personnel. This should not include licensure or precertification requirements which might only lead to over-professionalization and increased costs.

I want to thank the subcommittee again for inviting the BGA to testify today. If we can provide any additional information or assistance concerning this BGA project to you, we will be pleased to do so.

PREPARED STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION

Mr. Chairman and members of the permanent subcommittee, we are pleased to be here to present our views on the adequacy of present legislation and regulations to prevent profiteering in the home health care industry.

Our testimony today summarizes our April 24, 1981, report to the permanent subcommittee and, as requested, our views are provided in the context of the following five issues:

1. The effectiveness of the cost-reimbursement system or proposed alternatives.
2. The effectiveness of intermediary (medicare paying agent) audit coverage.
3. The effectiveness of oversight and administration by the Health Care Financing Administration.
4. The means by which disallowances can be recovered by the Federal Government without rendering insolvent bona fide home health agencies.
5. The means by which the Federal Government may terminate irresponsible agencies from participation in federally funded home health programs.

Overall with two exceptions, we believe the existing legislation and regulations (including the new authorities provided by the Omnibus Reconciliation Act of 1980—Public Law 96-499) give the Health Care Financing Administration (HCFA) sufficient authority to address the permanent subcommittee's concerns. The exceptions relate to

the need for strengthening the regulations or related guidelines governing reimbursement in related organization situations and

the desirability of the Department of Health and Human Services (HHS) establishing limits on medicare reimbursement for home health agency (HHA) management and clerical costs.

Federal funding for home health services is provided under several legislative authorities; however, our comments relate primarily to the medicare program. This program accounts for the bulk of Federal expenditures for home health services and its reimbursement principles have been adopted by many States in their medicaid programs.

MEDICARE'S COST REIMBURSEMENT SYSTEM

The first issue we will address is medicare's cost reimbursement system. HHAs, like the other institutional providers (hospitals and nursing homes), are reimbursed retrospectively on the basis of their actual reasonable and allowable costs to provide patient care. With few exceptions, the system is open ended and it has been widely criticized as lacking incentives to providers to be efficient and minimize their costs. In our view, in addition to the open ended nature of the system, several problems have emerged that apply not only to HHAs but also to other institutional providers paid under the same retrospective system.

One particular problem is the wide variation among HHAs in the cost of providing services. Under medicare reimbursement principles, providers are paid the actual cost of providing quality care, however widely that cost might vary from provider to provider. This principle is subject to a limitation where a particular provider's costs are "substantially out of line" with costs of other providers in the same area that are similar in size, scope of service, utilization,

and other relevent factors. As discussed in our May 1979 report on medicare's home health program,[1] without a definition of what constituted "substantially out of line," medicare intermediaries found this provision to be virtually unadministrable in establishing upper limits on reimburseable costs—particularly on a retrospective basis.

Section 223 of the Social Security Amendments of 1972 amended the Social Security Act to provide HHS with another vehicle for dealing with the problem of the wide variations in costs. Specifically, the law allowed the Secretary of HHS to establish limits: "* * * on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title."

Such reimbursement limits were to be established before the fact and providers could charge beneficiaries for the difference between the section 223 limits and its rates following public notice by HHS that the particular provider would do so.

HHS initially established section 223 limits in 1974 for hospital inpatient general routine operating costs and at our recommendation the use of the section 223 authority was expanded to cover the total cost of home health visits in 1979. We also recommended that, where feasible and appropriate, HHS establish section 223 reimbursement limits for individual home health care cost elements—such as management and clerical costs—because our work indicated that excessive overhead costs in the form of administrative salaries and management consulting fees have been claimed and reimbursed by medicare. To date, HHS has not adopted this recommendation.

HCFA believes that the cost data presently being reported by HHAs lack sufficient uniformity to make such limits meaningful. According to a HCFA official, HCFA is trying to solve the data problem by implementing a uniform reporting system as required by the medicare-medicaid Anti-Fraud and Abuse Amendments of 1977.

Although we believe that existing legislative authority is adequate to implement our proposal, we note that, during the 96th Congress, S. 489 was introduced which would require limits for specific HHA line-item costs, such as transportation, administrative salaries, and fiscal and legal services. This bill was not enacted during that Congress and, in the absence of agency action on this issue, we would support similar legislative initiatives in this Congress.

Another problem with medicare's cost reimbursement system is determining which costs are related to patient care and which are not. The regulation governing this issue is very general and a number of problems have arisen with HHA costs. An example is whether certain HHA costs represent unallowable patient solicitation activities or whether they represent allowable costs of maintaining good relations with the medical community. We believe that, as long as the regulation is general, the instructions expanding on it will be difficult to implement or enforce. On the other hand, it has been argued that too rigidly drawn regulations facilitate the identification of "loopholes" and, thus, are equally difficult to enforce. We believe that currently this is a very "gray" area in which we can offer no easy solution.

An additional problem with the reimbursement system is the application of the regulations for related organization transactions. The regulations governing transactions between providers and organizations considered to be related by ownership or control are designed to eliminate profits between the parties involved. The regulations, however, also provide for an exception if all of four certain conditions are met to the intermediary's satisfaction. The conditions are that (1) the supplying party is a bona fide separate organization, (2) a substantial part of its business is transacted with organizations not related to the provider, (3) there is an open competitive market for the services or supplies in question, and (4) the services or supplies are those commonly obtained by the type of provider from other organizations and are not those ordinarily furnished directly to patients by that type of provider.

A common complaint about the related organization regulation and guidelines has been that many terms need to be defined more precisely; for example, "bona

[1] "Home Health Care Services—Tighter Fiscal Controls Needed" (HRD-79-17, May 15, 1979).

fide separate organization," "open, competitive market," and "control." At the same time, attempts to make the regulations more specific have been opposed because of concerns that more rigid regulations would arbitrarily hinder legitimate transactions.

On April 20, 1981, HCFA requested comments from us, and others, on a proposed change to the related organization provisions of Medicare's Provider Reimbursement Manual. Basically, the proposal clarifies many of the manual provisions and sets out more examples of what constitutes a related organization transaction. Our general reaction is that the proposed change is an improvement.

In related organization determinations, unless the provider is applying for an exception, the burden of proof falls with the medicare intermediary; that is, the intermediary must provide substantive evidence that the provider and party in question are related by common ownership or control. In practice, proving that parties are related, particularly through control, is very difficult and time-consuming. We believe, therefore, that this burden of proof should be shifted to the provider when certain criteria are met.

For example, if the administrator of an HHA (or hospital or skilled nursing facility) is related to a top officer of a supplying organization, the agency and the organization would be presumed to be related for medicare reimbursement purposes. Another example would be subcontracts between an agency and an organization that was instrumental in organizing the provider and/or getting it certified for medicare participation. In such situations, therefore, the provider would be required to disclose such a relationship and demonstrate to the intermediary's satisfaction that such a relationship does not constitute a related organization arrangement under medicare reimbursement principles.

To overcome the problems with medicare's cost reimbursement system, some have advocated that an alternative reimbursement system be established. A principal alternative reimbursement system method for other types of providers is a prospective payment system, under which the rate of payment is established before the fact and retroactive adjustments generally are not made.

We believe a prospective system would be harder to use for HHAs because of the lack of a uniform unit of service on which to base the rate. For hospitals and nursing homes, a day of inpatient care is a common unit of service. However, for HHAs the unit of service is a visit, which can vary significantly in duration including variations in traveling time.[2]

Also, establishing prospective rates on a per-visit basis (or on a patient served basis) could be subject to manipulation and would give HHAs incentives that could lower the quality of care provided. For example, to maximize revenues, HHAs would have an incentive to decrease the duration of visits in order to increase the total number of visits. A decrease in the length of visits in turn could compromise the quality of care provided.

EFFECTIVENESS OF INTERMEDIARY AUDIT COVERAGE

The second major area we will discuss is the effectiveness of intermediary audit coverage.

To minimize medicare administrative costs, many providers cost reports are settled or accepted without field audits. For example, for provider cost reporting years ended in 1978, about 60 percent of the HHA cost reports were settled without a field audit. A major concern with settling cost reports without such an audit is that providers can be reimbursed for significant unallowable costs. It is difficult to identify unallowable costs by reviewing a cost report without also field auditing the provider.

For fiscal year 1982, significant cuts in the HCFA budget for intermediary audits are under consideration. On March 12, 1981, HCFA told intermediary representatives that plans were being considered to reduce the 1982 budget for provider field audits by $19 million, about a 67-percent reduction over the fiscal year 1981 funding level. We believe cuts of this magnitude could hamper the intermediaries' ability to assess compliance with existing legislation and regulations.

[2] Although this unit of service is used in establishing section 223 limits, such limits are the maximum amount to be considered reasonable and thus are not the sole basis for payment.

HCFA OVERSIGHT

The question of how well HCFA monitors the program's administration is difficult to answer; however, we believe the agency has set up reasonable systems to fulfill this responsibility. Also, we have issued two reports since 1979 which touch on how well HCFA administers medicare's home health program. One report we have already mentioned is our May 15, 1979, report which is entitled "Home Health Care Services—Tighter Fiscal Controls Needed" (HRD-79-17). The other report—a copy of which was forwarded to the subcommittee earlier—discusses our evaluation of HCFA's 1980 proposed home health care limits established under section 223 of the Social Security Amendments of 1972. The report—HRD-80-84, May 8, 1980—points out various problems with the data base and methodology used to develop the limits.

RECOVERY OF OVERPAYMENTS

In our view, the ability to collect overpayments from HHAs, particularly nonprofits, depends heavily on the extent of their reliance on the medicare program for revenues. A nonprofit agency with 100-percent medicare utilization would have great difficulty continuing operations if medicare funding was interrupted. A nonprofit agency that received revenues from other sources and/or received philanthropic support might have less difficulty. A proprietary chain that is part of a diversified corporation might encounter little difficulty.

With regard to the recovery of overpayments from bankrupt or insolvent HHA's, for non-profit agencies the Government has two primary options:

Attach the agency's assets, which are normally of nominal value (e.g., office furniture and equipment).

Demonstrate that the directors and/or officers of the corporation abused its tax-exempt status for their personal enrichment—which enables the Government to proceed against the assets of the directors and/or officers involved.

For proprietary agencies, recovery would be undertaken by the Government following the normal bankruptcy and contract law procedures.

A recently enacted provisions of the Omnibus Reconciliation Act of 1980 could decrease the likelihood of an HHA becoming insolvent when it has to repay overpayments. Section 930(n) of the act authorizes the Secretary of HHS to require HHA's to be bonded or to establish escrow accounts to protect the Government's financial interest. When this provision is implemented through regulation, it could both protect the Government from losses resulting from overpayments that agencies cannot repay and protect agencies from insolvency when they must repay identified overpayments.

TERMINATING IRRESPONSIBLE HHA'S

The last issue we will address is the means by which the Federal Government can terminate irresponsible HHA's, and in summary, we believe there is sufficient authority already on the books.

Under medicare, for example, an HHA may be terminated for a number of reasons, including if it—

Does not meet the medicare conditions of participation for HHA's,

Fails to provide information to HHS necessary to determine if payments are or were due under medicare and the amount of the payment due,

Refuses to permit HHS or its agents to examine its financial or other records necessary to verify information furnished as a basis for medicare payments, or

Knowingly and willfully makes or causes to be made any false statement or misrepresentation of a material fact in an application or request for payment under Medicare.

Under medicaid, the States can establish the grounds for terminating providers but must terminate providers in those cases covered by Federal law.

Mr. Chairman, this completes our prepared statement. We would be happy to answer any questions you or other members of the permanent subcommittee may have.

PREPARED STATEMENT OF HADLEY DALE HALL, PRESIDENT, THE NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

Mr. Chairman, my name is Hadley D. Hall. I am the executive director of San Francisco Home Health Services and the president of the National Association of Home Health Agencies. I appreciate the opportunity of being present today to discuss problems in the administration and operation of the Federal home care programs.

In 1972 the Senate Committee on Aging reported that "the arguments for development of Home Health Care networks . . . seem irresistible." Since that time there has been a growing awareness of the importance of home care, recognized in terms of humanity, effectiveness, and cost advantages in avoiding, delaying and decreasing institutionalization.

Unfortunately, while the need for home care has become increasingly apparent, most of the incentives emanating from the government in the intervening years have been directed at restricting service and containing the program.

Among the concerns serving to retard the development of home care are three principal factors—(1) the conflict inherent in a program that bridges three different titles and the Older Americans Act, (2) the inefficiency of current reimbursement mechanisms, and (3) the recurrent allegations of program abuse.

Since 1975 more than 15 congressional hearings have focused in full or in part on the delivery of Home Health Agency services. These hearings included, among others, joint Senate and House Aging Committee hearings in 1975; hearings by the Senate Governmental Affairs Subcommittee on Government Efficiency in 1976 (Chiles); combined House Ways and Means Oversight Subcommittee and Interstate and Foreign Commerce Health Subcommittee hearings in 1977; Ways and Means Oversight Subcommittee hearings in 1978; Senate Finance Committee hearings in 1979; Senate Aging Committee hearings in 1979 (two); and Senate Small Business Committee hearings in 1979.

During the same period, home care has been the focus of three major GAO reports, five field hearings by the Department of Health, Education, and Welfare (in 1976), and a report to Congress (the HR–3 Report mandated by Congress in 1977 and delivered in 1979).

The objective of each of these activities has been to identify and remedy the problems in home care. Several of those investigations reached conclusions identical to those your subcommittee now pursues.

In each case, these activities were followed by a seemingly ceaseless flurry of regulatory reaction attempting to deal with long-standing problems identified and reidentified. Cost caps were imposed, utilization screens and special audit programs developed, an Inspector General was designated and asked to become involved in home care, criminal penalties were stiffened, a unified cost report has been implemented, training for home health aides has been mandated, and there is a movement toward consolidating intermediaries for Home Health Agencies. But the problems have continued.

The National Association of Home Health Agencies (NAHHA) supported the development of unified cost report, the movement toward regional intermediaries and upgraded training requirements for Home Health Aides, NAHHA supported the appointment of the Inspector General and the development of more appropriate criminal statutes. While we have expressed concern that the mechanisms designed might be ineffective or uneconomical, we have supported the objectives of public accountability inherent in the cost caps, utilization screens and audit programs.

The point lost in all of this and the reason the problems continue revolves around the question of fitness and means to ends and the incentives provided by the program. These fundamental issues have not been addressed.

It would be unrealistic to suggest that the problems that afflict home care will ever be entirely eliminated. We must recognize that there will always be those who will try to take advantage of the system. We believe that number to be a small proportion of those in home care; but, the fact of their existence must be recognized with appropriate safeguards and regulations. Our main concern, however, should be to design a system that eliminates the incentives leading to abuse and, instead, reward efficient and effective service.

To be specific our response to the issues presented in your letter of April 14, 1981 is as follows:

THE REIMBURSEMENT SYSTEM

In the transition papers "Mandate for Leadership" prepared for the Reagan administration, Mr. David Winston, Principal Special Assistant to Secretary Richard Schweiker, wrote: "Most health financing experts agree that the present reimbursement system generally employed by medicare (and in many States under medicaid) . . . is a major culprit in encouraging high-priced care and lax control over utilization."

Nowhere is this more true than in home care. NAHHA has repeatedly testified the reimbursement system for Home Health Agencies simply does not work. The process is open ended, needlessly complex, and presents the wrong incentives. Its "reasonable cost" basis is vague and undefined, necessitating volumes of regulations and interpretations. As a result agencies find their income tenuous and unpredictable and their expectations constantly subject to retroactive adjustments. At the same time, program costs have escalated and the total number of Home Health Agency visits increased at the rate of 12 percent a year.

The administration has attempted to control cost by placing limitations on Home Health Agency costs per visit. This approach has only exacerbated the problems inherent in the reimbursement structure by adding to the incentives leading to over-utilization. The critical problem here is that no one has ever defined the term "cost" as it applies to Home Health. Home Health is a flexible, coordinated care system with an installment payment plan. The cost of care is not the component, nor is it in the installment. It is more than a unit charge for an item of service. Cost is the units of service times their costs times the number of units utilized in a given period of time. Length of stay and recidivism are also cost factors.

NAHHA recommends a prospective reimbursement system be developed.—One way this could be approached is with the establishment of a target rate—based on total cost per patient or spell of illness—capturing the agencies' past cost experience multiplied by the units of service. Alternately, the agencies could be requested to prepare and submit a budget—in essence a negotiated rate—which would serve as the basis for reimbursement. In either event, the essential ingredients are that reimbursement be at the rate target which would define cost to the program and expectations to the provider. Costs exceeding the target would not be reimbursed unless warranted by exceptional circumstances. Services delivered at a cost below the target by increased efficiency should be rewarded by allowing the agency to keep a portion of that savings. Retroactive judgments should be eliminated. The reams of regulations spun out of "reasonable cost" could be discarded. The current incentives for running up costs and "front" arrangements of concern to the subcommittee would be eliminated.

We are aware the Department of Health and Human Services has under consideration a process which would lead to a phased in implementation of prospective reimbursement for Home Health Agencies. This system is based on a target rate method utilizing features of the existing cost limits methodolgy.

While the Department has yet to take a formal position on the proposal, at least some members of the administration are pursuaded it is worth pursuing. On April 28, 1981, Mr. Robert D. O'Connor, director, Bureau of Program Policy, in a letter to NAHHA's executive director, Bill Halamandaris indicated: "We believe such a system could effectively control home health costs and would provide direct incentives to the most efficient Home Health Agencies since providers could retain some share of the difference between the target rate and actual costs."

NAHHA has had an opportunity to review the proposal in draft form and would concur. While a number of issues remain to be resolved, none are insurmountable. We believe the proposal could be the basis of an equitable solution. It should be pursued.

In order for this process or any other prospective payment variation to proceed, Congress must act. Under current Medicare legislation, prospectively determined rates are limited to experiments and demonstrations. Legislation is necessary to remove or modify the requirement for retroactive reasonable cost settlements.

We believe the evidence is compelling that Congress should act to remove or modify the reasonable cost requirement as soon as possible. According to the winter issue of the Health Care Financing Review an analysis of prospective reimbursement deomnstrations in the hospital arena indicates these programs have been successful in reducing hospital expenditures per patient day, per

admission, and per capita. Eight of the programs have reduced the rate of increase in expenses by 2-6 percent. Prospective reimbursement would, if anything, be more effective in controlling costs in home health.

Even with an immediate change in law, it is estimated a prospective reimbursement system for Home Health Agencies could not be implemented before 1984. The Department has indicated sufficiently uniform data base will not be available until mid-1983. In the interim, we would encourage the establishment of prospective reimbursement mechanisms on an optional or demonstration basis to test the salient features of the system proposed and guide the transition from retrospective to prospective reimbursement.

PRIVATE NOT-FOR-PROFIT PROVIDERS

Private organizations, distinguished from traditional community agencies, have been the focus of several Home Health Agency investigations. The judgement has been made by the GAO, in the report you forwarded for our consideration, and others that private not-for-profit providers are more likely to abuse the system. But no one has attempted to find or state the reasons.

It is somewhat ironic that private not-for-profit providers have attracted so much of the program's concern since they are almost completely creatures of the medicare program. More than any other provider segment, they react to the pressures of the program and reflect its problems. All other auspices have in some measure a cushion—be it resourses of the community, a hospital host, State or local government or a parent company. Private not-for-profit organizations walk the razor's edge. They are totally dependent on the medicare program and, as such, are the best barometer of its problems.

RELATED ORGANIZATIONS

The program has been concerned about the dealings of related organizations since 1971. The futility of dealing with these problems given the current reimbursement structure is emphasized in several of the administrative Home Health Agency provisions of last year's Budget Reconciliation Act. The fact that Congress found it necessary to legislate 25-year contracts as unreasonable would at first seem to be legislating the obvious. On second thought, it says a good deal about the vagueness of the definitions and the problems inherent in administering "reasonable cost." Little can be gained by following this path much further.

PROGRAMMATIC SHELL GAMES

Beyond the question of self-dealing and front operations within medicare lies a larger concern—the abuse or potential abuse of playing programmatic shell games. NAHHA has repeatedly requested attention be directed at the development of a national home care and long-term care policy with common definitions, reimbursement and eligibility criteria. Congress requested the administration to address these issues in 1977 following the Senate Aging Committee and House Ways and Means Committee hearings covering the activities of several California providers. These individuals found considerable advantage in shifting patients and costs, taking advantage of the cracks between the programs and the gaps in administration and enforcement of medicare, medicaid, social services and the Older Americans Act.

Congress requested these issues be addressed in a comprehensive report (HR-3), the development of a uniform reporting mechanism, consolidation of intermediaries and single cost report encompassing all home care activities. The cost report has been completed and implemented but is restricted to medicare. A draft reporting system has been circulated and withdrawn. Consolidation of intermediaries is under consideration. The home care report was a debacle. But the need is still there. It is reflected in the New York Office of Welfare Inspector General (OWIG) audit included for our review with your letter and in the General Accounting Office (GAO) title XX study completed last year for the Senate Aging Committee.

STANDARDS

A consistent concern has been the adequacy and appropriateness of standards developed for home care. Since standards developed by the industry have yet to be widely accepted or utilized, the medicare conditions of participation are effectively the only standards to which certified agencies subscribe. Most home care

providers do not meet even these rudimentary requirements. Even in States with licensure requirements, more often then not, the licensure law is a virtual duplication of medicare requirements. For these reasons, NAHHA has long maintained that the Conditions must be strengthened. We believe they can be revised to reflect more accurately internal operations, tracking the activities an agency requires for its internal management and at the same time providing the government with a more effective tool with which to evaluate the agency's performance.

EFFECTIVENESS OF OVERSIGHT AND ADMINISTRATION

For a protracted period, there was no apparent concern within the administration for home care or awareness of the specifiity of that program and its needs. There is good evidence one of the continuing problems is the vagueness of many regulations guiding providers and intermediaries. Many of these are related to the reimbursement system and problems previously identified. There is also an argument that the Department has been trapped into the untenable situation of trying to make reasonable and workable a system that is inherently irrational and unworkable.

RECOVERY OF DISALLOWANCES

NAHHA believes that this entire process is ill conceived. There may always be a need to recover inappropriate expenditures or fraudulent claims, but emphasis should be placed on limiting to the extent possible the circumstances where these activities may occur. By addressing the problems fundamental to the reimbursement system, the need for these retroactive activities could be substantially limited. It's the difference between treating causes and the effects.

Within the current structure, the line of recovery that has most consistently been disregarded is the accountability of the intermediary. Consistently in the past, intermediaries have denied responsibility, limiting their role to that of payment. In the field this often translates to a simplistic process of review by comparatively untrained and unskilled people. In some cases, it is clear the intermediary uses the program as a training ground for new employees who are promoted into non-medicare activities of the fiscal intermediary as soon as they acquire basic experience.

NAHHA believes the intermediary should be at least as accountable as the provider.—Many of the problems your subcommittee has identified and most of the related program expenditures have undoubtedly been approved by the local intermediary. In some cases, arrangements and contracts specifically approved by the intermediary have subsequently been contested. When this occurs, by Department or GAO review, the entire burden falls on the provider. We would suggest the intermediary be required to establish an escrow account and that the program be reimbursed from this fund for at least some part of every inappropriate expenditure the intermediary approved.

TERMINATION

NAHHA believes there are adequate provisions in law and regulation in existence.—The simple problem has been getting people to do their jobs. There is no reason why it should have taken 6 years to obtain a conviction in the *Souza* case. The Department can help by defining the regulations with more specificity—i.e., the *Merlo* case—or requesting specific regulatory activity. But ultimately, for the reasons previously mentioned we believe the answer lies in restructuring the program, particularly its reimbursement aspects, and providing a rational, integrated home care system. The best evidence of this need is contained in Deputy Attorney General Charles "Joe" Hynes' testimony before the Senate Finance Committee in May of 1979.

SUMMARY

In summary, all aspects of the home care program can be faulted. Some providers have clearly taken advantage of the program. Some intermediaries have failed to perform conscientiously. The Department's record is inconsistent at best. Law enforcement agencies have rarely shown an interest in pursuing "low-yield" fraud cases. But the largest measure of responsibility, and the one most frequently ignored, belongs to Congress. Most of the problems we have identified are locked into the process and parameters of the program Congress established.

There will be no long range solution to these problems until Congress recognizes this fact and restructures the program and process. This association and its members will do all we can to help in that endeavor.

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES,
Washington, D.C., April 13, 1981.

Hon. WILLIAM V. ROTH, Jr.,
Chairman, Committee on Governmental Affairs, Permanent Subcommittee on Investigations, U.S. Senate, Washington, D.C.

DEAR SENATOR ROTH: At the hearings on Home Health Care on May 13, 1981 there seemed to be confusion in various testimonies about the differences between community based, controlled and supported non-profit Home Health Agencies and privately owned or controlled not-for-profit companies.

Any individual, group or organization can establish a Home Health Agency. When a Home Health Agency is formed, it is under the "auspices" of the sponsor. The Medicare law encourages two kinds of sponsors for Home Health Agency services:

A. Official Home Health Agencies are under the auspices of government.

B. Voluntary Community Organizations such as Visiting Nurse Associations, Easter Seal Societies and hospitals sponsor Home Health Agencies. These Medicare providers are under the auspices of a community group and frequently under their affiliate national organizations, including United Way. Like "official" Home Health Agencies, the voluntary community organizations are tax exempt, although they pay employer-required payroll taxes. Both kinds of Home Health Agencies are subject to the controls of "elected" representatives who operate the organizations in established ways with public sanction, scrutiny and accountability.

C. Other Sponsors of Home Health Agencies:

1. Profit-making Home Health Agencies.—The Medicare statutes "permit" a profit-making organization to participate in the Medicare program, provided the state in which such a Home Health Agency operates also allows profit-making organizations to be licensed as Home Health Agencies. (Amended to allow proprietaries effective 7/1/81.) By withholding permission, a state may prohibit participation by profit-making companies.

Therefore, the Medicare law has encouraged participation by government bodies and traditional tax-exempt voluntary community organizations, and permitted the participation of organizations motivated by profit. Most states were reluctant, or at least slow, to allow participation in Medicare by proprietary, profit-making organizations.

Recent actions by the Department of Health and Human Services and by members of Congress indicate that this historic pattern may be changing so that organizations motivated by profit will be encouraged to participate while the traditional official and voluntary community organizations will be permitted participation.

2. The private not-for-profit organization.—This confusing and discriminating situation (in conjunction with an unwillingness or the inability of other sponsors to provide the needed nad reimbursable services in local communities) led to the development of another kind of sponsor—the private, not-for-profit company. Like proprietary companies, private, not-for-profit organizations are established by individuals, families, partners and corporations but without legal mandates for citizens' sanction, scrutiny, control or accountability, usually associated with official public providers or voluntary community organizations. However, most private, not-for-profit organizations sought and received community participation. Like other kinds of sponsors, the private, not-for-profit companies provide services reimbursed by Medicare.

The emergence of private, not-for-profit companies was not anticipated when the Medicare statutes were implemented by Congress or HHS. This new kind of sponsorship has been most prominent in states which have failed: (a) to include proprietary, profit-making companies in their licensing laws for Home Health Agencies; (b) in states which have not enacted statutes for licensing as permitted in the Medicare legislation; and (c) in areas where public and traditional community groups were unable, unwilling or have failed to provide services.

In summary, there are several kinds of sponsors. Some have been encouraged, other sponsors have been condoned conditionally, and others were not anticipated.

If we can be of any additional help please let us know.

Sincerely yours,

HADLEY D. HALL,
President, NAHHA.

PREPARED STATEMENT OF RONALD B. RECK, PRESIDENT, AMERICAN FEDERATION OF HOME HEALTH AGENCIES

Mr. Chairman and distinguished members of this committee, my name is Ronald Reck, administrator of Home Health Services of Allegheny County, Pittsburgh, Pa., and president of the American Federation of Home Health Agencies (AFHHA). I am very pleased to have this opportunity to present testimony to the subcommittee regarding home health care.

AFHHA is a national trade association representing private and non-profit and proprietary home health agencies across the United States. AFHHA was formed in September of 1980, for the purpose of presenting a carefully reasoned picture of the private sector of the home health industry to the Congress and the Health Care Financing Administration (HCFA). It was our belief that constructive input on behalf of the private segment of the industry had been noticeably lacking in the past. AFHHA represents a greater percentage of the private sector than any other national organization representing the Home Health Industry.

We would like to make clear at the outset that AFHHA does not condone or in any way support fraud or abuse conduct by an agency within this industry. We are as interested as your subcommittee in eliminating the onus placed upon our entire industry by the actions of a few individuals. Organizations whose fraudulent conduct has been proved should be omitted from the Federal program pursuant to existing procedures and pursued with the full force of the law.

We also believe the subcommittee should investigate the activities and actions of the fiscal intermediaries who are obligated by contract with implementing this program. There have been patterns of abuse and incompetence on the part of the intermediaries which have, in some cases, actually led to charges of abuse against home health agencies. In some cases the agency may be accused of abusive practices which were initially overlooked or verbally approved by the intermediary. It is also a frequent tactic of intermediary representatives to issue a notice of program reimbursement detailing fiscal disallowances to a provider and later reopen that notice to significantly raise the questioned reimbursement amount when a provider has filed a notice of appeal. In essence, this is retaliation by the fiscal intermediary for the provider's exercise of his constitutional and statutorily created rights. In other cases, an intermediary representative has threatened to shut down a home health agency or to suggest to the agency that while they will not be shut down, they will be made to suffer financial hardship for an extended period of time.

It should also be noted that many of the problems in the industry have surfaced after the intermediary has failed to do their job. The system may likewise be subjected to abuse if an intermediary has failed to timely notify a home health agency that has been kept in the dark or where the rules have been changed and applied retroactively. Unfortunately, for the home health agency the intermediary has a method of covering up their incompetence by retroactively seeking repayment to the medicare program. We think the subcommittee should recommend a method of holding the intermediary accountable for their arbitrary and incompetent actions.

It is AFHHA's position that related organizations are not and should not in themselves be precluded from participation in the program. If a related organization is providing a necessary service, and if the cost of the service is reasonable and fair in the marketplace and if the existence of the related organization is known to the program then they should be allowed to participate in the program. In some cases the prices paid to the related organization may be less than those in the marketplace. In other cases the services offered may not be readily available.

ITEM A—EFFECTIVENESS OF THE COST REIMBURSEMENT SYSTEM OR OTHER PROPOSAL ALTERNATIVES

AFHHA believes that the present cost reimbursement system is a very poor system which easily lends itself to abuse. We are proposing today a reimbursement system on a prospective basis with profit incentives in mind, designed specifically for home health agencies. Such a system would reward business efficiency, maintain and enhance the quality in the system, eliminate retroactive denials, eliminate the provider reimbursement preview board for home health agencies, eliminate some of the HCFA and intermediary's bureaucracy and reduce overall costs to the program.

Many ways have been proposed for determining the method of payment for an agency. Under such a system our recommendation is that a set payment per visit be provided to each home health agency in a specific geographic area. Each agency would be allowed to conduct their business up to this per visit payment amount and a percentage of the difference between their costs and the payment would be returned to them as profit. An important function of this profit motive is to weed out inefficient agencies.

The existence of related organizations would be irrelevant under such a system. Such a system would be more free enterprise oriented because it would promote efficiency rather than encourage waste.

We realize the fraudulent agency who wished to bill for unperformed visits could be a problem, as would the agency which sought to reduce the quality of care provided. To deal with such practices we are proposing the creation of a quality control system we will refer to as SPO, which stands for structure, process and outcome. We will delve into SPO in more detail in questions and answers.

ITEM B—THE EFFECTIVENESS OF THE INTERMEDIARY AUDIT COVERAGE

AFHHA's concern in this area is twofold: First, we would like to see uniform and consistent application of policy and procedure by the intermediary in conducting their audits, and second, we would like to see some accountability on the part of the intermediary where improper disallowances are made.

Many problems created by the audit coverage could be eliminated by proper prior notification to each home health agency regarding any intermediary letters and other policies that are issued to the intermediary.

We also believe that a notice of program reimbursement should be required to be issued within six months of the filing of the cost report by the home health agency. Once the notice of program reimbursement has been issued, if it is issued, then the cost report should not be reopened again for any case with exception of fraud.

ITEM C—THE EFFECTIVENESS OF OVERSIGHT AND ADMINISTRATION OF THE PROGRAM BY HCFA

Fiscal intermediaries have tremendous discretion in administering the medicare home health benefits. In much the same way that the home health agency is responsible to the intermediary for its performance, so too the intermediary should be accountable to HCFA for its performance. In our opinion, such oversight has been lacking in the past.

HCFA could require the intermediary to perform full scope audits at least once every 2 years on all types of home health agencies it oversees. In the past, such audits have had an approximately 4–1 recovery to cost ratio, thereby justifying any additional administrative expense.

ITEM D—MEANS BY WHICH DISALLOWANCES CAN BE RECOVERED BY THE FEDERAL GOVERNMENT WITHOUT RENDERING INSOLVENT THE BONA FIDE HOME HEALTH AGENCY

As noted earlier, we believe that a notice of program reimbursement should not be issued after 6 months following a final cost report and that a finalized cost report not be allowed to be reopened with exception of cases involving fraud. Under those circumstances, the intermediary would be required to do a more thorough audit at the time of the first review of the cost report. Cases have occurred in which during a "desk audit", which is the initial review, an auditor made notes in the margin regarding an expense. Three years later the cost report was reopened simply based on the 3-year old notes in the margin. If the problem existed initially, it should have been dealt with after the first review. An agency should not be left hanging on the intermediary's whim for 3 years.

ITEM E—THE MEANS BY WHICH THE FEDERAL GOVERNMENT MAY TERMINATE IRRESPONSIBLE HOME HEALTH AGENCIES FROM PARTICIPATING IN FEDERALLY FUNDED HOME HEALTH PROGRAMS

You have requested our specific comment on the means by which the Federal Government may terminate the irresponsible home health agency from participating in federally funded home health programs. Our initial problem is your

use of the term irresponsible as the touch stone for termination from the medicare programs. Fraudulent and intentionally abusive home health agencies should be terminated from the program. The term irresponsible is an inappropriate term to apply.

AFHHA does not defend the fraudulent operator. We do defend the honest owner who has been wrongfully tainted by the actions of a few, or who has been accused of abusing the program due to ignorance related to poor or nonexistent advice from the intermediary, or who has been retroactively disallowed based upon an unknown and uncommunicated change in policy or interpretation.

Existing laws can readily terminate home health agencies from the medicare program if they are enforced. AFHHA believes that the home health agency program is overregulated and under-policed. Each State is responsible for seeing that home health agencies who are participating in the medicare program annually, have meet their conditions of participation. Fiscal intermediaries are responsible through contractual arrangement with the Federal Government in seeing that home health providers are in compliance with existing requirements. The subcommittee should, however, keep in mind that termination is the ultimate sanction and should be very carefully used.

AFHHA believes that the entire medicare program needs to be reformed but, specifically, our concern today is with the existing problems emanating from the hodge-podge of illogical laws and regulations affecting the home health industry.

We offer our assistance to your subcommittee in developing recommendations which we hope will address the problems raised during these hearings.

Chairman ROTH. At this stage I would like to call the next panel, if I could.

Mr. Paul Willging of HCFA and those who accompany him.

Gentlemen, if you would please rise and raise your right hand.

Do you swear the testimony you are about to give before this subcommittee will be the truth, the whole truth and nothing but the truth, so help you God?

Dr. WILLGING. I do.

Mr. KAPPERT. I do.

Mr. BOUXSEIN. I do.

Mr. KELLY. I do.

Chairman ROTH. Mr. Willging, if you want to introduce those that are with you, I would appreciate that. I would point out we do have a copy of your written response to the same five basic issues that were addressed by the earlier panel. I would approciate your summarizing as briefly as you can that response.

Dr. WILLGING. Thank you, Mr. Chairman, I will do that.

TESTIMONY OF PAUL R. WILLGING, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY MARTIN KAPPERT, DIRECTOR, BUREAU OF QUALITY CONTROL; PETER BOUXSEIN, DEPUTY DIRECTOR, BUREAU OF PROGRAM POLICY; EDWARD KELLY, ACTING DIRECTOR, HEALTH STANDARDS AND QUALITY BUREAU

Dr. WILLGING. I will summarize my remarks very briefly and hit upon the five basic areas that you have requested we deal with today.

I would start by suggesting in terms of a few basic statistics the nature of the problems we have with respect to home health care.

While home care represents a relatively small proportion of total program benefits, it is rising dramatically.

In fiscal year 1975, $203 million were spent on medicare home health benefits by the Health Care Financing Administration; in fiscal year 1980, medicare expenditures for home health had risen to $750 million.

We have also seen medicaid program expenditures rising from $70 million in 1975 to $348 million in 1980.

In 1979, 837,000 medicare beneficiaries received home health services. In that same year, there were 358,000 medicaid recipients of home health services. While the proportion of the total program payout is small—approximately 2 percent of the total benefits—home health benefits have quadrupled over the past 5 years. That growth has also been seen in the number of agencies participating in the program.

The areas that you asked us to deal with I will group into five basic concerns: The reimbursement mechanisms we use to fund home health services; the audit procedures and oversight responsibilities of the Health Care Financing Administration; the issue of how to deal with consulting home health agencies; the issue of sanctions, their availability, and how we apply them within the Federal Government; and legislation proposed by the administration.

[At this point Senator Cohen entered the hearing room.]

Dr. WILLGING. I would start generally by responding to the question of whether the Health Care Financing Administration has sufficient authority to deal with the problems of home health agencies. We believe we do have sufficient legislative authority, with one or two exceptions that I will deal with at the conclusion of my remarks.

Let me start with the issue of cost reimbursement systems. There is little doubt and little disagreement that the cost reimbursement approach to dealing with home health expenditures is inadequate. Retrospective cost reimbursement systems, as indicated previously, provided no incentive for effective management.

I was particularly impressed with Senator Cohen's remark that we find somewhere in the system an incentive to exercise fiscal discipline. Such an incentive does not exist in this type of reimbursement system. We believe alternatives to the current cost reimbursement system need to be developed.

We have some growing doubts, however, as to whether a prospective reimbursement system is the answer. We essentially agree with the General Accounting Office that reimbursement reforms will be difficult.

Right now, the administration believes an alternative approach to be considered is a viable competitive strategy, not only for home health agencies but for all providers. It is not enough to simply impose a rigorous, sometimes onerous, sometimes cumbersome regulatory burden on providers as a substitute for cost consciousness and management consciousness.

Some form of competitive strategy must be developed. The Secretary has previously suggested that an administration bill for a competitive health care strategy will be submitted to the Congress this year. I think this is where we need to focus today, not on a prospective reimbursement system.

In the interim, however, until such debate is concluded and hopefully the competitive system is put into place, we can tighten up the reimbursement mechanisms we currently have.

Section 223 limits are now applied to home health agencies. They save us about $35 million per year over what would be expended were

we simply paying all the costs submitted by home health agencies. We are also considering establishment of guidelines on certain administrative costs. I would take some issue with Mr. Ahart, in that we have not rejected the proposal to establish such guidelines. We think we have to have an adequate data base to do so.

The nature of the home health industry is such that agencies vary in business structure.

This agency-to-agency difference was reflected in the design of the cost reports which were used for a number of years by home health agencies. We do have in place, as of last October, a new, more uniform cost-reporting system for home health agencies which will allow us to get a better sense of the exact nature of the costs and how they are distributed.

On the basis of that data, we will be attempting to develop more meaningful guidelines with respect to specific components of HHA costs.

We will also continue to develop and propose instructions to implement the Omnibus Reconciliation Act provisions regarding long-term and incentive contracts.

Moving to the area of HCFA oversight and intermediary audit coverage, there is no question in my mind that we did not do an adequate job a year or so ago in terms of audit coverage. Home care agencies are a different kind of animal than nursing homes or hospitals. The degree to which we were able to audit home health agencies was impeded by the tools we had provided to our intermediaries. We have attempted to make, and I think have made, some changes in that regard.

We have done two or three things I would particularly like to emphasize.

The audit process begins with the cost report review and settlement by the intermediary. All cost reports are reviewed and settled once a year. Based on the review of these cost reports, an intermediary makes a judgment as to where a field audit should be conducted.

As has been indicated previously, about 40 percent of cost reports are field audited. Our problem then is a lack of effective data base to help intermediaries focus those field audits. I think we all agree most home health agencies are responsible and, indeed, many if not most of them are cost conscious. It would not be cost effective to do a field audit on every agency. Clearly it would be cost effective to do an audit on those agencies which the data we have available to us indicates are types where problems seem to be severe.

We will be providing instructions to the intermediaries in the immediate future so they can better rank the data stemming from cost reports to allow them to focus on particular suspected areas of abuse. Accompanying the methodology for data ranking will be revised audit protocols, both in terms of cost and utilization.

We never had an effective mechanism to make sure intermediaries were correctly applying policies, so we developed the cost report evaluation program, which is based on a statistical sample of cost reports, to measure the intermediaries' performance.

Overseeing the entire process will be the program evaluation effort initiated 2 years ago within the Health Care Financing Administration to keep the entire system reasonably honest.

I think we are going to make some dramatic progress in this area. The rate of return for a typical audit has been about $4 for every $1 expended. These new protocols which have now been field tested in a number of States are being used in three of our regions and have increased our rate of return to $8 to $10 for every $1 expended.

There is no question in my mind that we have made progress and continue to make progress with respect to the audit and oversight function.

A problem we have had, however, with home health agencies and the "100 percenters" in particular has been that, as we have been more effective in isolating excessive costs and attempting to recover these funds for the Federal Government and the taxpayer, we have run the risk of driving these agencies into insolvency and losing the entire overpayment.

The Congress has done the program a great service in the Omnibus Reconciliation Act by giving us the authority to require escrow accounts and bonds. I think that will alleviate the problem we have of trying to collect funds while knowing full well that collecting those funds might leave the Federal Government and the American taxpayer holding the bag.

In the area of audit and oversight, we have made considerable progress, although I think more still needs to be done.

[At this point, Senator Nunn entered the hearing room.]

Dr. WILLGING. In terms of the use of sanctions available to us to deal with providers where abuses are found, what we have done is a reasonably good job in excluding providers on quality conditions, that is, providers who fail to meet basic quality standards. To date, over 100 HHA's have either been excluded or voluntarily withdrawn from the program as a result of their inability to meet these standards. What we have not done is apply our same exclusionary authorities in terms of those who abuse the system in terms of cost or utilization.

In the entire history of the program, we have only excluded four HHA's or owner-operators for abuse. I think that is not a very laudible track record. I have instructed staff in the Health Care Financing Administration to increase their emphasis on applying sanctions over the next couple of years. We do have the authority. We quite frankly have not effectively utilized the authority we have.

I would like to move finally to the area of proposed legislation.

[At this point Senator Nunn withdrew from the hearing room.]

Dr. WILLGING. We think there is one piece of legislation which would help us in terms of preventing these abuses and effectively dealing with them more precisely. That is the Department's proposal for a civil money penalty program.

One can find fraud, but the Justice Department, like all departments, has limited resources. The Justice Department, therefore, sets priorities in terms of what cases referred to them are worth prosecuting. Priorities relate both to the ability to prosecute the case and to the size of the dollar loss to the Federal Government.

We would not like to continue to exclude from punishment those providers who have not been accepted by the Justice Department for criminal prosecution. I think if there is still a fairly strong case of blatant abuse or fraudulent activity, the civil money penalty program will help us deal with it.

With the civil money penalty we can also deal with the actual individuals, not simply by excluding the HHA or individual from the program, but by providing a fiscal penalty, something that will hurt, and possibly deter these abuses.

The administration feels that although we are making progress in getting a handle on home health abuse, the problems have not by any means been solved. I think that has been evident over the last few days. We wonder how advisable it is to expand the program while we are still trying to get it under control. That, along with fiscal issues, is the reason for the administration's proposal that the Congress repeal the provisions in the Omnibus Reconciliation Act which took away the 100 visit limitations under medicare parts A and B, and which added occupational therapy as a qualifying benefit for home health services.

That concludes my introductory remarks, Mr. Chairman. I will be happy, along with my colleagues, to address any questions you may have.

Chairman ROTH. Mr. Willging, as I understand it, section 1866 of the Social Security Act provides that a home health agency may be terminated from medicare reimbursement. If that agency submits bills containing costs that are excessive, if that is accurate, why have the five Chicago home health agencies that we have examined not been excluded?

Dr. WILLGING. Mr. Chairman, I would like to make a couple comments about the Chicago issue.

I strongly disagree with the previous comments that a good number of our intermediary personnel or employees should be put in jail because they have not done their jobs.

I would like to emphasize for this committee that as early as 1978, the issues in Chicago were referred by the Health Care Financing Administration to the Justice Department for prosecution. As early as 1978, reductions were begun in terms of the rates paid to these organizations for the very reasons isolated in your chart. We did not feel our beneficiaries were receiving adequate return from the moneys paid to the five home health agencies.

I think the administration has done its job, to some extent, in the case of Chicago. There are, however, two or three things that in hindsight I wish we had also done. I think the minute we began to see repeated cost reports with these inflated costs, we should have used the authority we had to exclude these agencies.

There are probably two reasons we didn't. One is that, in the absence of these escrow and bonding provisions, one has to make a judgment call: Should you try to keep the agency in the program so as to perhaps recoup the dollars—and we are talking about $1 million so far in overpayments in Chicago, but as early as 1978, we were talking about a third of a million dollars—or should you exclude them. Exclusion, of course, means that without an escrow account or bond or attachable assets the Federal Government would have simply lost a third of a million dollars.

In retrospect, I wish we could have seen the future at that time, recognized that we would never get the money back and simply excluded the providers from the program.

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Second—and this perhaps was a misguided concern about turf and intruding in another departments' area of responsibility—we had in 1978 referred these issues to the Justice Department for prosecution, and felt that perhaps until their investigation was completed, we should continue to deal with these providers as providers.

There were mistakes, in retrospect, that we made. I would not operate that way in the future.

Chairman ROTH. I am troubled by your last statement. It is one thing to refer to the Justice Department matters for prosecution, but I cannot see how that is a justification for not taking action to prevent further abuse or fraud of the same provider.

Dr. WILLGING. I think, once again, Mr. Chairman, in retrospect, I would agree with you, but there is the other factor as well. Without escrow and bonding, excluding them at that point, even as early as 1978——

Chairman ROTH. That still doesn't answer the question. I am not only talking about recovery, what has been done in the past, but I am talking about preventing it in the future, further loss to the Federal Government. If you had the facts sufficiently before you that you referred it to the Justice Department, why, in Lord's name, wouldn't you go in and carefully audit the situation and take corrective action, if not outright terminate? The thing that bothers me, and I am not saying specific people should be prosecuted and dismissed because I don't know what the facts are, but certainly there does not appear to be any record of an aggressive attitude on the part of the agency to remove abuses. How many providers have you terminated in this service?

Dr. WILLGING. For issues related to the concerns of this committee, only four.

As I indicated, that is an area where I don't think we have done an adequate job. There are different kinds of corrective action, I suspect. There were things we did do with respect to these five providers. We instituted not the normal annual audit procedure, but a quarterly audit. We have so dramatically reduced the rates paid to these providers, that they have accused us of hounding them with bankruptcy. Some of them started with a rate of $30 per visit. As a result of our audits, we have reduced that rate to as low as $17. Some corrective actions have been taken. I agree that not all corrective action that could have been taken were implemented in Chicago.

Chairman ROTH. Senator Cohen?

Senator COHEN. I appreciate the dilemma you find yourself in, namely, you have a big liability here, three-quarters of a million dollars already that is outstanding with no prospect of getting it back. Let me ask you, what has been the amount of money paid out to those firms since you reported it to the Justice Department for recommendation for prosecution?

Dr. WILLGING. I can go through here and find it or submit it for the record.

[The information follows:]

On October 1, 1978, HCFA's Office of Program Integrity referred the five Chicago home health agencies to the Justice Department. During the period of October 1, 1978 through April 30, 1981, the intermediary paid the five HHAs $5,535,101. However, the intermediary has disallowed 15.6 percent of the costs claimed by the five Chicago agencies through audits.

Senator COHEN. It is sort of like the programs we start, Mr. Chairman. We start a program off and find it is a bad program, but the argument is, well, we have three-quarters of a million dollars so we might as well finish it. We end up spending more money finishing the project.

As I understand it, there are claims still pending by the various firms against the HCFA or the Federal Treasury right now, is that correct?

Dr. WILLGING. That is correct, sir.

Senator COHEN. For 1980.

Dr. WILLGING. Let me give you an example. In 1978, which is the first year we began to reduce the payments claimed by these agencies, Midway Visiting Nursing Service claimed $216,000; the amount finally determined to be reasonable by the intermediary was $178,000. HHA Will County claimed $395,000; the amount determined reasonable by the intermediary was $291,000.

That is, as you indicated, Senator, just the first step in the process of conclusively determining unreasonable costs. The home health agency or any provider does have a right to reconsideration by the intermediary. If that reconsideration is not favorable to the provider, the next step is to go to the provider reimbursement review board. Due process can take time. I, as deputy administrator, finally sign off on the decisions by the provider reimbursement review board.

It is only in the last couple of months that the board rendered its decision with respect to a couple of these agencies.

Senator COHEN. The difficulty is when you refer something to the Justice Department and continue to do business, any business with these particular firms. It has been, what, 3 years, since 1978, since you referred this to the Justice Department and it is under consideration for grand jury indictment.

We are talking about a 3-year hiatus period. It may be longer before the case is prosecuted. By the time that appeal runs out to the circuit court or the Supreme Court, you can still be doing business, theoretically. I would hope not in this case, but you could still be doing business with these firms, still paying out.

Dr. WILLGING. I agree with you, Senator. That is also my concern.

Senator COHEN. If it is so severe that you make a recommendation to the Justice Department, should you then have a department policy that you terminate business with those firms?

Dr. WILLGING. My sense is, Senator, that even where we are not talking about suspicions of fraud, but where we have blatantly inflated cost reports, we should perhaps use the exclusionary processes available to us and do it much more quickly.

Chairman ROTH. One of my concerns with respect to the answer you just gave Senator Cohen is that, frankly, I think a lot of the ballooning of costs arise not so much in the outrageous cases, but those where a degree of care and reasonableness can be found. You mentioned that you are going to go in the direction of competition. At the same time, I assume that competition won't be available everywhere, in all communities. Is that true?

Dr. WILLGING. In certain types of benefits, I suspect you may be right, Senator.

Chairman ROTH. So you are really going to have to nevertheless continue at least with some alternate proposals if home care service is going to be available throughout the country.

Dr. WILLGING. That may not necessarily mean that the Federal Government needs to continue using the same set of regulations and oversight responsibilities. The competitive structure, I suspect, would take into account the availability of supply. There is no question that in other sectors of the economy the availability of supply does determine the price.

We would not expect home health services, for example, to be provided in the same way and at the same cost everywhere in the country, but in terms of supply available, the competitive structure would make sure that the programs are gaining the highest quality of benefit for the beneficiaries at the most reasonable price within each community.

Chairman ROTH. If you have real competition, of course, I think that is the best way of at least maintaining costs, but at the same time, I suspect that it is going to be found that that is not going to be realistic, wherever you go.

Dr. Willging, I believe you are familiar with a recent letter from the Department of Justice to the Inspector General at Health and Human Services outlining concerns over the regulatory schemes governing nonprofit home health agencies? According to this letter, the problems noted by the Justice Department have apparently made it extremely difficult for them to prosecute offenders in this area.

In that letter, the Department of Justice is critical and complained about the lack of appropriate regulations covering composition of home health agency boards, salaries of owner-operators, general corporate expenses, costs not directly related to patient care and accounting. What is Health and Human Services doing in response to this criticism?

Dr. WILLGING. I am familiar with the letter, Senator. I am not sure I am competent to speak to the approach that will be taken by the Department since that is within the purview of the Inspector General's Office.

I am very interested, however, in sitting down and chatting with the new Inspector General as to the nature of regulatory changes which might make it simpler or easier to prosecute these offenders. I must admit, on my own reading of that letter—I am not an attorney, much less a prosecuting attorney—I am not sure how a specific regulation, for example, dealing with the composition of the boards of home health agencies would make it easier or more difficult to prosecute. That is probably more as a result of my naivete. I would be most interested in having specifics from our IG.

Senator COHEN. What about allowing a person less travel? Do you think less justification could be made for first-class travel?

Dr. WILLGING. Let's assume we have a regulation that said there will be no first-class travel. Let's also assume the home health agency submits on its cost report a reimbursement for first-class travel. There is no attempt to deceive the Federal Government. We would disallow it.

Let's then assume they file a cost report which hides the first-class travel. They can be prosecuted for filing the falsified cost report whether the false amount is travel, or anything else. That reflects the

nature of my confusion as to what a change in regulations would do to allow Justice to more effectively prosecute.

Once again, not being an attorney, I don't know the answer. I think the most appropriate next step is to sit down with the attorneys in the IG Office to see where we can make changes to make life somewhat more satisfying for the Justice Department.

Senator COHEN. Should the members of the board of directors sign a certificate that the costs incurred are legitimate, reasonable, uninflated under penalties of prosecution?

Dr. WILLGING. I am not sure all that should be required. The current rule is that an officer of an organization or an owner must sign the cost report. We don't allow just anyone in the home health agency to sign it. Whether it would be effective for everyone to sign the cost report, I don't know. Certainly I would want somebody in the agency in a senior position to be accountable.

Chairman ROTH. Are you undertaking studies or attempting to clarify your regulations to give better understanding to your providers as to what is reimburable? Are your current regulations up for review and clarification?

Dr. WILLGING. Yes; in a number of areas we have made progress already. In the area of coverage, 12 specific provisions regarding what is or is not covered as a service are under revision and will be disseminated shortly.

Chairman ROTH. Are you saying services?

Dr. WILLGING. Services, yes, sir.

Chairman ROTH. What about costs?

Dr. WILLGING. In terms of costs, we are proposing to look at some of the areas which have been more problematic: administrative costs, and advertising costs, for example.

We do think that in order to actually apply certain limitations on those costs, we need at least a year or so of experience with the new cost report that has just gone into place. Costs have been provided to us in such a confusing and dissimilar fashion across the country that we had to put a new, more uniform cost report in place. The cost reports using the new forms will be effective for reporting periods beginning October 1, 1980. So we haven't really begun to develop a data base. As soon as we have developed that data base, we will be refining, revising, and changing our approaches to many of these cost elements.

I would like to add, that in terms of comments that you have made, it is sometimes difficult for HHA's to know what is allowable and what isn't allowable. My suspicion is, as I looked at some of these disallowances, that while there are some admittedly gray areas, there are many areas where I find it hard to believe the HHA's would feel there is any question.

When you start using nurses and medical social workers, for instance, to solicit business for the HHA—that is, prohibited. We think most HHA's know that this practice is prohibited. I don't know how much additional refinement is necessary to resolve that issue.

When you start paying for huge advertisements in the yellow pages, and in the newspapers—costs clearly not related to patient care—I am not sure how much more specificity is necessary of if what we are

hearing is simply the fact people don't like to have their costs disallowed and why not blame their discontent on the Federal Government.

Chairman ROTH. What percentage of costs have not been allowed?

Dr. WILLGING. We will have to submit it for the record. The figures have normally been about $5 to $6 for every 1 of audit. Since we are spending about $3½ million in audit, I would have to say it is about $12 to $13 million.

I will be happy to submit that for the record.

[The information follows:]

In fiscal year 1980, our Provider Audit Cost Report shows that intermediaries made decreasing adjustments of 4.3 percent in the reimbursement claimed by home health agencies.

Senator COHEN. What about consulting fees? In other words, I can see where a home health agency might have a need for an accountant to keep books or might have to contract it out. But why would a home health agency need to have a management consultant?

Dr. WILLGING. I suspect there are many areas where they would not need a management consultant and we have seen some of them over the last day or two. I can also see other places where there might be a conceivable and justifiable need for management consultants. HHA's are businesses, either for profit or not for profit. Any business, I assume, is susceptible to increased efficiency. I see cases where management consultants might be useful to an HHA. The result of consulting can be lower costs or better quality care. I suspect one has to look at each case on a case-by-case basis.

Certainly some of the consulting cases in Chicago brought no benefits in terms of costs, and in terms of the program's beneficiaries, limited benefits, if any at all.

Chairman ROTH. I go back to your auditing figures. Some people are using that as grounds for further audit where they are saying we are not catching much of the unreasonable costs because there hasn't been additional auditing. Let me ask you this: You have had authority to require HHA's to be bonded for several months. When are you going to issue regulations on that?

Dr. WILLGING. We hope to have the regulations out in July or August, Senator.

Chairman ROTH. I would just like to underscore one concern. I think the situation is serious and that the need for prompt action in some of these areas is obvious for the good of the program.

How many employees do you have in HCFA?

Dr. WILLGING. Approximately 4,800, sir.

Chairman ROTH. How many?

Dr. WILLGING. 4,800, both central and field staff.

Chairman ROTH. And they administer what programs?

Dr. WILLGING. Both medicare and medicaid, PSRO and the standard and certification programs.

Chairman ROTH. How many millions of dollars in programs is that?

Dr. WILLGING. Our budget this year is around $57 billion, sir. I might point out, although it is tooting our own horn, that the administrative cost of running these programs is approximately 3½ percent of the total payments.

Chairman ROTH. Senator Cohen?

Senator COHEN. Just a couple of other questions. According to the 1981 audit of HCFA, there seems to be few program dollars that are going to be spent in fiscal 1981 on program audits for validation of home health agencies, is that correct?

Dr. WILLGING. That is correct, sir.

Senator COHEN. Why is there a lack of priority being assigned to these reviews, particularly in light of some of the abuses we have heard about?

Dr. WILLGING. I wouldn't characterize it that way, Senator. We are very heavily committed to program validation in the home health agency area.

This commitment is partly as a result of some of the hearings both by this committee and by Congressman Pepper's committee on the House side and partly as a result of the GAO report of 1979.

Our concern was to develop better processes to identify abuses which could be turned over to the intermediaries. As a result of 32 audits done by the Bureau of Quality Control, we did develop both a new data base methodology and revised and much more rigorous audit guides or protocols. We feel that the most appropriate action now is to move these new tools into the intermediary setting so that we can cover all HHA's.

The role of program validation is to identify areas of program abuse, use the authorities we have to develop processes and policies to combat the abuse, and move these new processes into the system on a comprehensive and vigorous basis.

We have enough areas, as you can imagine, of abuse of the medicare program. Quality control will keep itself busy in other areas.

Senator COHEN. The intermediary audit is the first line of defense against the fraud and abuse. How would you explain the fact in the fiscal 1982 budget there is going to be a 60-percent reduction?

Dr. WILLGING. The Health Care Financing Administration, like all departments, is being asked to restrain costs. We are, as you know——

Senator COHEN. But you are getting back $4 for every $1 invested on the audit.

Dr. WILLGING. We have suggested, Senator, this is one of the areas that needs to be looked at as we try to accommodate a fairly major reduction in our contract funding for the intermediaries and carriers. We have not made any final conclusions as to whether audit in fact will be one of the areas to be reduced.

The Administrator of the Health Care Financing administration, Dr. Davis, has made sure that in 1981 there will be no reductions in audits. We are doing a zero-base budget analysis, a $700 million contract budget to see where we could, in fact, drop functions without damaging programs.

We will try as best we can to preserve the bulk of, if not all, the audit function. At this time, I can't say whether we will be able to do it. We are in a tight budget situation right now.

Senator COHEN. It seems to me we have two problems here.

No. 1, the intermediaries conducted only about 1,150 audits of home health agencies. It cost them $3.3 million. The audits recovered some $13.5 million. There seems to be less enthusiastic, regressive auditing procedure on the part of the intermediaries themselves.

I would think that is one problem. The other problem is HCFA itself. I would not want to see a 60-percent reduction in the amount allocated for auditing.

Dr. WILLGING. Nor would I, Senator. As one looks at the cost structure of intermediaries and carriers in the medicare program, most of the costs are incurred for equipment, buildings, and staff. The bulk of the intermediaries' processes cannot under any circumstances be stopped; we have to pay claims. There is, however, a very limited area of special line items where one can absorb decreases in the budget. I would hope that we can keep the reductions in the audit function to a bare minimum. I think to some extent some decreases can be accommodated in that area since we are going to be better able to focus audits.

With the revised protocols, if we can better focus our audits, perhaps we can get a greater impact with the dollars we have.

Senator COHEN. What about the recommendation of shifting the burden of proof to the provider on the reasonableness of the costs?

Dr. WILLGING. In a sense, I think that burden may already be on the provider. The cost report comes in and the provider, by submitting its cost report, is attesting to the fact the costs are reasonable. The intermediary reviews that cost report against its protocols and against its available data. Where it does suggest to the provider that a cost is unreasonable, the provider is responsible for proving it is reasonable.

Moving up to the PRRB, there is a clear statutory requirement that says the burden of proof is on the provider. At that point the provider has to prove it is reasonable.

Senator COHEN. You don't think there has to be any change, then?

Dr. WILLGING. I guess what I am saying is that I am not sure whether that particular change would make an appreciable difference in the way the reasonableness issues are sorted out. What I am saying is in fact, once it gets to the point that the intermediary has isolated some suspect costs, the providers essentially have to show why those costs are justifiable, why they are reasonable.

Senator COHEN. What about the tax-exempt, nonprofit character of a home health agency? We have had quite a bit of evidence that has been abused. One recommendation has been that you place home health care in the hands of private enterprise and eliminate this need between nonprofit and for-profit agencies.

Dr. WILLGING. I would like Mr. Bouxsein to respond to that, but with the enactment of the Omnibus Reconciliation Act, we no longer have an issue as far as HCFA is concerned.

Mr. BOUXSEIN. That is right. I think one of the reasons perhaps that there has been attention focused on the ownership structure of these facilities is because in many of these States, proprietary organizations were not lawfully authorized to participate in the medicare program under statute and regulations prior to the Omnibus Reconciliation Act. People who wanted to participate in the program could do so only by forming a nonprofit organization.

Senator COHEN. What about the suggestion made earlier this morning by Mr. Hall, who indicated that perhaps we should use much greater scrutiny before we allow the licensing of various home health agencies? Does it sound reasonable to have a firm put together with

$2,000 capitalization to then be in a posture of securing several million dollars from the Federal Government in the way of contract services?

Dr. WILLGING. If I understood the discussion and dialog this morning, Senator, it all stemmed from the question as to whether one should be allowed to contract for most of the services where you have in a sense a broker——

Senator COHEN. I raised that question because that is all we had in this case. All it is, is a brokerage house.

Dr. WILLGING. I guess my sense is that I would want to be very careful about suggesting that to the providers because it is not just home health agencies who are heavily involved in subcontracting. I think my primary concerns would be: Is the benefit provided? Is it of adequate quality? Does it meet the needs of the recipient and is the cost reasonable? If it is found by providers to be more reasonable to subcontract in terms of cost, then we have no reason for complaint. I suspect in most cases that is so, with obvious exceptions.

I would not want to tell providers of health care in the country how to conduct their business in terms of structure.

Senator COHEN. But it is a structure that contributes to confusion. If their structure is such that makes the business more complicated, and you cannot trace the reasonableness of the charges, then don't you think we have an obligation to reduce the capacity for creating confusion. Don't you think this is a squid-like process, which shoots ink out that befuddles the auditor?

Dr. WILLGING. I certainly agree that we have to make a choice between two conflicting goods. One is to eliminate the confusion and to some extent ease the burden on people like myself and HCFA staff.

If you look at the history of these programs, attempts at both beneficence and making life easier for the bureaucrat sometimes tend to overburden providers and take away certain flexibilities so that ultimately costs may be higher. In any of our provider groups the vast majority are honest and efficient; but when we make burdensome regulations, they apply to everyone.

Chairman ROTH. Would the Senator yield?

What you have just said, I think, is a matter of real concern. I agree with you that where you have a situation where there is real competition, that you can rely on the private sector to insure that a cost-efficient job may be done. I recognize there may be some problems about the quality of the service which we don't want to overlook.

What bothers me here is that we are in a cost reimbursement situation, where there appears to be no incentives to be efficient. I will be candid. Remembering Mr. Hall's remark, there are difficult decisions to be made, but they have got to be made and we have to put in place some controls that insures the taxpayers' dollars are being well spent.

I understand that you are looking at competition as a new approach, but that will take 1 year and several months. I don't think we can wait indefinitely on some of these questions. There needs to be more of an attitude of aggressiveness in trying to clean up this situation.

I think it is a very serious problem. I think the most serious problem is the one that Senator Cohen made earlier. It is not this horrible

situation we have had in Chicago. It is that we have created a program that provides no incentives for efficiency.

I just don't think we can sit back in the executive branch and say since it is the private sector, it is a matter of their judgment how they do it when the Government is paying the costs.

Dr. WILLGING. I think I would ask questions about the specifics. If I understand Senator Cohen's question or implied question—should we, in fact, prohibit certain kinds of subcontracts—that raise the question of which kinds? Should every home health agency be required to directly provide most of the services, some of the services, which of the services?

Senator COHEN. First, we have to identify what is the nature of the services? They are fairly limited in scope. You are talking about people who can be treated in their homes by either nurses, nurses' aides, medics, or paramedics—a fairly limited range of services.

So is it unreasonable to require someone who wants to get into the business of providing home health care to say if you do that, you have to have the following range of services available, otherwise you shouldn't be in the business?

Dr. WILLGING. The problem is that home health services are not homogeneous—nursing, speech therapy, physical therapy, certain equipment and supply services. To ask a home health agency to be able to participate and provide all of these directly, you raise questions as to which ones you do provide and is it more efficient in a given community, given a certain set of beneficiaries who have different kinds of needs to ask the home health agency to be able to provide all of them directly. There are perhaps some areas where it might be appropriate to say you do have to provide these directly. I think, though, to raise that question is not to imply that we are being less vigorous in terms of what will be available.

When we see contracts, I think we are trying to be much more vigorous in looking at these services, determining whether any benefit was derived from the contract and reducing the reimbursement rate if we ascertain there was no benefit.

Senator COHEN. I still haven't had an answer to my satisfaction about what Midway, Southwest, Oaklawn, and Orland-Tinley did as home health agencies?

Dr. WILLGING. I suspect they did provide the actual home health aid service at a highly inflated cost. At Northrad, I am not sure they did much of anything. Midwest Leasing—I am not familiar with what they did, if anything at all. Midway Therapy——

Senator COHEN. I am talking about the home health agencies.

Dr. WILLGING. What the broker essentially did.

Senator COHEN. That is what I am saying.

Dr. WILLGING. The broker does by regulation have to provide at least one of the major services but I am not sure that is an adequate response, either.

That one service could be very minimal in nature and——

Senator COHEN. What I am concerned about is you have an operation set up with very thin capitalization which provides virtually no service other than maybe one out of four or five services and then contracts it out. I don't know what justification we can have that it is a designated certified home health agency when, in fact, it is simply a shell. I think that kind of situation leads to the very abuses we have seen here. I would be willing to say there are probably a lot more cases like this to be found around the country.

Dr. WILLGING. My response would be, if that is seen to be a viable new approach, in effect, mandated direct service delivery——

Senator COHEN. With some exceptions. Maine might be an exception, for example. In rural Aroostook County, it would be difficult to have all those services provided over approximately 16,000 square miles. There might be some exceptions. I am talking about formulating a Federal policy to try and deal with this clearly abusive situation which I believe personally is repeated time and time again. Maybe it is not the egregious amounts, as Senator Roth suggested earlier, but, as one of the witnesses testified to yesterday, maybe they asked for a $14 increase, and Blue Cross-Blue Shield knocked it down to $7. But multiply 7 times 7,000 visits, and sooner or later it really totals up.

You can get even $2 or $3, again not blatantly excessive, but $2 or $3 added on to the charge times the thousands of visits and then multiply that across the country, then you will have some really serious problems, even though it would not come to your attention because it is no so egregious that you get shocked and say prosecute that agency.

Dr. WILLGING. I think it is certainly worth considering. I suspect I would like to consider the options submitted in previous remarks by the General Accounting Office, and not build in something so specific that it does defeat efficiency.

My sense is that we could direct a great many home health agencies to provide services directly. However, you can still be incompetent and inefficient without necessarily being abusive. The bottom line is the same, the Federal Government pays.

Senator COHEN. But you would be in a better position as auditor or overseer to determine whether someone is doing it incompetently, because there are fewer focal points you have to look at.

Dr. WILLGING. Certainly it would ease our burden.

Senator COHEN. The way in which it is now, HCFA has to depend upon Blue Cross/Blue Shield, Aetna, or whomever who in turn have to look at Midway, Southwest, Oaklawn, who in turn have to look at Chicago Home Care—the more complicated and distant it is, the more complicated it becomes. It becomes very difficult with regard to the credit processes. It is sluggish, not terribly aggressive, and it may take months to determine this particular cost which after all seems not to be unreasonable, so let's OK it.

That is the way the system works.

Dr. WILLGING. I think you are right, the burden in terms of oversight could be reduced.

Chairman ROTH. Let me ask a question. After this Chicago case came to your attention or to HCFA's attention, you of course referred that to the Justice Department. I would assume it became obvious that this technique was a potential for abuse in other areas. What follow-through was there on the part of HCFA with respect to either its internal organization or to investigate and determine whether there are other situations like this one in Chicago?

Dr. WILLGING. We did a number of things induced not only by Chicago but by hearings that have been held by this committee and in the House——

Chairman ROTH. I basically would like to know what your own organization did?

Dr. WILLGING. Our organization developed an expanded in-house audit protocol which we took down primarily to some of the southern jurisdictions and to California where we had a higher number of HHA's that were so-called "100 percenters."

We initiated a variety of other internal actions. A task force was 25 to 30 of them to see, if indeed the abuses were being replicated elsewhere. Indeed, we found they were in some cases. In fact, in the three instances identified in the NBC program, one was in Chicago and the other two were in California, and Mississippi. All of these agencies had been the subject of program validation reports by the Health Care Financing Administration.

Once having found that the problems of abuse were serious elsewhere, not just in Chicago, we began the development of these revised audit protocols, audit guides which we are now prepared, having already field-tested them, to send out to the entire intermediary community.

We initiated a variety of other internal actions. A task force was established within the Health Care Financing Administration to deal exclusively with home health abuse. A number of recommendations were made by the task force to the Administrator, most of them, 80 or 90 percent, have already been implemented or well on the way to complete implementation. A broad array of activities were undertaken, most of which are now coming to fruition.

Chairman ROTH. If I recall it correctly, the Mississippi and Southern California situations came to light roughly at the same time as Chicago?

Dr. WILLGING. Mr. Kappert?

Mr. KAPPERT. The focus in those two States came somewhat later. The actual field work was done in 1980 and the reports were published earlier this year.

I think it is interesting, as Dr. Willging suggests, that in both cases all of our work preceded the BGA work that was shown on the NBC television show. In fact, we had already been in these places, and had documented and taken action on the problems——

Chairman ROTH. You say you have taken action and yet in the Chicago case, several of them are still functioning.

Mr. KAPPERT. I am talking now, Senator, about Mississippi and California.

Chairman ROTH. Did you terminate any of those?

Mr. KAPPERT. In most of those cases, there were several actions suggested, not all of which were for purposes of termination or exclusion.

The first concern is whether the findings show excess payments, the kind as in Chicago, excessive salaries, and so forth. The first action is to have the intermediary go back now and reclaim the excess. Then we address questions of whether or not there is sufficient evidence of abuse and fraud to refer these cases to Justice or for termination.

Chairman ROTH. Do you have any of these nonprofit providers targeted for auditing this year?

Mr. KAPPERT. They will be targeted and audited in the fashion that Dr. Willging has suggested. We do not plan any intensive validation audits. However, we will continue to address the kind of abuse that has been described through our regular audit processes and other material that we put together and furnished to our regional offices for targeting aberrant providers. There is a concentrated effort under way to identify those providers that should be audited and to what depth they should be audited.

Dr. WILLGING. I might add one point, Senator. Although we have not yet been able to isolate the degree to which we will be able to continue the funding of audit activity in 1982, the audit dollars in HHA's have been increasing from $3.3 million in 1980 up to a budgeted $3.9 million in 1981, and that $3.9 million will be spent in 1981.

Beyond that, although medicare's home health benefit is about 2 percent of the total program payments, the audit expenditures for home health are about 6 percent of the dollars we devote to audit. I do not think that is too much. It perhaps could be a little bit more. In terms of the audit function we clearly have focused on home health agencies. They receive three times the normal proportion of audit dollars than they would if you based audit budgets only on the total dollar payment made by service. Clearly that is money well spent in terms of what we have been able to isolate not only in terms of costs but in terms of helping us to develop better audit protocols.

Chairman ROTH. Well, I have to say if I were a provider, I can't say that I think I would be too concerned about the kind of review and checks that the government has imposed. I would say there is a pretty open door. It bothers me that after the discovery, for example, in Chicago, there doesn't seem to be any aggressive action taken with respect to that case. Now I admit that is only one case, but nowhere do I see any what I call aggressive action to correct the situation.

It is all very fine to say those are difficult questions and we are going to have to wait a year and so forth, and you do have to deal with care. At the same time this Government has been in the procurement of services for many, many years and we should have some expertise and background somewhere in government that would help you people if you don't have it internally to establish some controls. As I see it, there is very little to insure that the government dollar is well-spent, particularly when you are reducing auditing. I find the whole system lacks controls, lacks incentives and has very little followthrough.

I think that is a matter of great concern.

Senator COHEN. I would just like to say, Mr. Chairman, last year Senator Percy was holding hearings on auto theft in this country on the very same subcommittee. What we discovered was a multi-million-dollar industry in this country in terms of stealing automobiles and recycling them elsewhere in this country and elsewhere. Two key elements were testified to by various law enforcement officials. The first was that there was very low profitability of discovery of catching the culprits. It appears to apply here, too, if I were on the other end and were interested in developing a system. I know Senator Percy felt a sense of outrage that anyone would even conceive of stealing money

from the older citizens of this society. But those elements that are in our society really have no conscience, so it doesn't matter whether they are peddling drugs or stealing cars. They don't draw any distinction.

The same elements seem to apply here, and there is very little fear of discovery. If I were interested in milking a system, it is very easy to milk, as we have seen.

I calculate out the probabilities and say, well, the intermediaries conduct 1,100 audits during the course of a year nationwide. What are the probabilities that mine will even be discovered? Very little to begin with.

The second key element is that asume that I am, in fact, discovered. By the time we run the gamut from 1977 to 1978, we are already in 1981, and chances are I can continue to 1985, and maybe longer in the appeal process, and I can still continue to collect. Even if I am prosecuted, I can claim, well, it really wasn't criminal intent. It simply was a misunderstanding as to what reasonableness is.

Finally, the judge imposes a sentence or a fine of several thousand dollars. So then, calculating out the cost-benefit ratio here, I would say the probability of detention is minimal.

Time frame in which to continue operation is 10 years. Ultimate penalty is minor. So it seems to me the system lends itself, just as our criminal system as far as drug abuse and auto theft, to being basically predicated upon a lack of vigorous investigation, a lack of prosecution and ultimately a rather lenient judicial system that will either suspend the sentence, probate the individual, or impose a minor criminal penalty.

It seems to me we have the same thing not only in auto theft, but theft in home health care.

Dr. WILLGING. I tend to agree with you. My concern is the implication that the department is complacent when it comes across issues of this nature.

Senator COHEN. Five——

Dr. WILLGING. Let me lay out both sides of the equation, if I could.

To say we have not been complacent is not to say we didn't do as much as we could. What did we do? We isolated the problem in 1978 and referred it to the Justice Department. We reduced the rates, intensified the audits, demanded repayment by these agencies.

Could we have done more? Of course. I wish we had done more, I wish we had excluded the agencies. I wish we had determined that since we were not going to get the money back anyway, let's get them out of the program.

We developed new guidelines and protocols, developed new data base management. That perhaps is not yet enough. Clearly, where there is any fraud remaining in the program, it is not yet enough. But to suggest, as has been suggested over the course of the last few years, that the Health Care Financing Administration has been complacent does bother me a bit. I don't think we have been complacent. We can do a lot more and will do a lot more.

Senator COHEN. I know there will be a rigorous advocate opposing the 60-percent reduction in the auditing function. I think that is very important.

[The prepared statement of Paul R. Willging follows:]

STATEMENT OF PAUL R. WILLGING, PH. D., DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman, I am Paul Willging, the deputy administrator of the Health Care Financing Administration. With me today on the panel are Martin Kappert, director, Bureau of Quality Control; Peter Bouxsein, deputy director, Bureau of Program Policy, and Edward L. Kelly, acting director, Health Standards and Quality Bureau.

I'd like to emphasize at the outset our commitment to home health care as a humane, cost effective service for people who need care in their home. We must not allow the actions of a few unscrupulous home health agencies to poison the waters for those agencies who are doing so much to help the elderly and disabled.

In my statement, I will focus on some of the problems we in the Health Care Financing Administration have experienced in administering the medicare and medicaid home health benefits. I will touch briefly on the historical perspective of the benefit, the problems that developed and finally the steps that have been taken to overcome the problems. My remarks will focus for the most part on the medicare home health agencies since they are directly reimbursed through a Federal program and are not subject to State-by-State differences in reimbursement and benefits as are home health agencies under medicaid. We are also submitting for the record our response to the subcommittee's letters of April 2 and April 14.

HISTORY

In enacting the home health provisions in 1965, Congress intended these benefits to provide a needed health service, and in many cases, to serve as a lower cost alternative to institutional care. Not only are the costs of care often reduced in a home care environment, but care at home with the help of family members and friends can promote a more positive attitude and lead to faster recovery.

MEDICARE HOME HEALTH BENEFIT

The Congress placed rather tight limits on medicare home health benefits, including strict conditions for eligibility and limits on the number of visits per year. For example, to receive home health care under medicare, a beneficiary must be confined to the home, under the care of a doctor, and need part-time or intermittent skilled nursing care, or physical, or speech therapy. (As of July 1, patients may also receive medicare home health benefits if they need occupational therapy services.)

In addition, coverage of home health services under the hospital insurance part of medicare (part A) requires beneficiaries to have been admitted to a hospital for at least 3 days prior to receiving home health benefits. Under part A, coverage is limited to 100 home care visits in the year following the qualifying stay. (As fo July 1, both the 3-day prior hospital stay and the 100 visit limit will be eliminated.)

Under the supplementary medical insurance part of medicare (part B), benefits are limited to 100 visits in any calendar year. There is no hospital stay requirement for part B. (As of July 1, this visit limit will also be dropped.)

The benefits provided as part of medicare's home health coverage are oriented toward a need for skilled health care. They were not designed to cover services related to assistance in activities of daily living. Medicare home health services include: Intermittent skilled nursing care; physical, speech, or occupational therapy; medical social services; part-time or intermittent services of a home health aide; and medical supplies and appliances.

Medicare home health agencies are required to meet various certification requirements relating to health and safety before they are permitted to participate in the program. Payments for services are made directly to the agencies by fiscal intermediaries, organizations (generally insurance companies) which are under contract with the Health Care Financing Administration to administer medicare at the local level. Payments are based on the "reasonable cost" of providing the services. Reasonable costs are determined at the end of the provider's fiscal year from detailed cost reports submitted by the agency.

MEDICAID HOME HEALTH BENEFIT

While medicare is a uniform Federal program with one set of eligibility standards and benefits which are nationwide in scope, medicaid gives the individual

States broad discretion in establishing eligibility criteria, benefit packages, and reimbursement rates. States are required to provide certain basic services to any recipient who needs medical care in the home. These services include coverage of: nursing; medical supplies; equipment, and appliances; and home health aide services.

In addition to these required services, States have the option of providing coverage for physical, occupational, and speech therapy. All services must be authorized by a physician, incorporated into a written plan of care, and supervised by a professional nurse.

Although home health benefits are a mandatory medicaid service, States have considerable leeway to limit the amount, duration, and scope of home health benefits. Reimbursement for services is at the State's option with about half of the States using a reasonable-cost related rate similar to the medicare rate. Medicaid home health agencies are required to meet medicare certification standards.

EXPENDITURES

Despite the limitations in present law, expenditures for home health services have shown a marked overall increase. In fiscal year 1980 medicare expenditures for home health were about $750 million as compared to $203 million in fiscal year 1975. Medicaid has also seen a rapid expansion, with expenditures for home health increasing from $70 million to $348 million during the same period. In fiscal year 1979, in-home services were used by 837,000 medicare beneficiaries. In fiscal year 1979, 358,000 medicaid recipients received home services.

With HCFA expenditures for home health services quadrupling over the past 5 years, it is important to insure that these expenditures are going to the beneficiaries who need them and are not being siphoned away through abuse and fraud.

PROVIDERS OF HOME CARE

Before the medicare and medicaid programs were established, providers of home health services did not fit into any uniform model. Home care was provided by physicians making house calls, through charitably funded visiting nurse associations, and by 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 little 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.

At the time of enactment, there was little practical experience in applying the concept of home health care as defined by the program. As a result, effective implementation of the benefit in accordance with congressional intent developed slowly. At first, there was a fairly widespread belief among beneficiaries, providers, and the medical profession that any person who needed health services in the home would be entitled to covered home health benefits.

Since medicare coverage guidelines were general and unrefined, varying interpretations by the intermediaries of the precise nature of the benefit added to the confusion. The growth of understanding of the limited nature of the benefit—by the Government, home health agencies, intermediaries, the medical profession and the general public—is reflected in the number of home health agencies who chose to participate in the program.

Initially, there was a significant growth in the number of agencies and amounts disbursed. While part of this increase was due to home health agencies being established in areas which previously had no home care, there was also some overexpansion by existing agencies due to misinterpretation of the scope of coverage.

In 1969, the Social Security Administration—which administered medicare prior to the creation of HCFA—issued instructions to the intermediaries and home health agencies which contained specific guidelines on the level of care that was necessary for coverage of home health services under medicare. As these more precise guidelines were applied, there was a tremendous increase in the number of claims denied after services had been furnished. The application of the new guidelines resulted in a decline of about 21.6 percent in medicare expenditures for home health services over fiscal years 1971 and 1972.

1972 AMENDMENTS

Congressional concern over these denials resulted in the passage of two provisions in the Social Security Amendments of 1972 which were designed to correct the problem. One provision provided a waiver of liability to beneficiaries or home health agencies if they delivered—or received—noncovered care which they could not reasonably have been expected to know would be denied. The waiver of liability provision has adequately corrected the problem of retroactive denials and also forced home health agencies to pay scrupulous attention to coverage guidelines in order to be eligible for this provision. The other provision attempted to set minimum periods of covered care for each illness. This "presumed coverage" provision proved unworkable and was repealed last year.

REIMBURSEMENT PROBLEMS

At the same time that Government, providers, and intermediaries were becoming familiar with the nature of the medicare benefit, they also had to cope with cost reimbursement mechanisms that were not specifically designed for this type of benefit. The private insurance experience base that existed for physician and hospital care was not available to help in structuring a reimbursement system for home health. Further, because home health benefits constituted less than 2 ercent of the combined medicare-medicaid dollar, the same attention was not given to monitoring home health reimbursement as was given to hospital and nursing home reimbursement problems.

However, in the past few years, we have seen both a growth in the sophistication of HHA accounting practices as well as a shift in the types of agencies involved. As an example of this shift, in 1966 when medicare first began certifying HHA's there were 1848 agencies—only 50 were proprietary home health agencies and less than 25 were so-called "private not for profit." By 1981 the number of agencies had grown to a total of 3,076. Of these 250 were proprietary, a fivefold increase; and 534 were private not for profit, a twentyfold increase.

HOME HEALTH ABUSE

Over the past several years we have seen an increasing tendency for business oriented home health agencies—rather than charitable or Government agencies—to enter the home health field. Most of these organizations are legitimately applying sound business practices to the provision of health care in order to receive an appropriate return on their investment. Our responsibility as administrators is to be sure that the payments made are proper and relate to the value of the services rendered.

Concern over growing abuse has focused both congressional and administration attention on the problem. As the subcommittee knows, a number of hearings have been held which specifically addressed the problems of home health abuses:

In September 1976, the Subcommittee on Health and Oversight of the House Committee on Ways and Means held a hearing to collect data on overutilization and misutilization of home health services.

In March 1977, the Senate Special Committee on Aging held a joint hearing with the House Ways and Means Subcommittee on Health and Oversight.

In August 1978 the House Ways and Means Subcommittee on Oversight held a hearing on medicare abuses in the home health care industry.

In August 1979 the Senate Special Committee on Aging held a field hearing in Miami on Abuse of the Medicare Home Health Program.

In addition to these specific hearings, there were other hearings which considered the overall problems of home health and other forms of long-term health care. These hearings tended to focus on the need to expand a desirable benefit to provide more in-home services.

The Department continually monitored the problems of home health agencies, and, where possible, refined guidelines and instructions to both agencies and intermediaries so as to better address these problems.

As a result of these activities and through a strong desire on the part of both the Department and the Congress to improve the administration of the home health benefit, a number of actions, both legislative and regulatory, were taken.

In October of 1977, in recognition of the need for additional legislation to control program fraud and abuse, the Congress passed the Medicare-Medicaid Antifraud and Abuse Amendments—Public Law 95-142—which contained a number of provisions designed to assist the Health Care Financing Adminis-

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tration in preventing abuse of the home health benefit. In addition, last year we were provided with further means of dealing with fraud and abuse through the passage of the "Omnibus Reconciliation Act of 1980"—Public Law 96-499. In 1979, our concern for the problems which were developing led to the creation of a home health task force. This task force consisted of individuals representing the various bureaus and offices of our organization. It was charged with the responsibility of identifying those actions which could be taken to curb home health abuses. A report of the task force activity was prepared and submitted in October 1980 which contained a number of recommendations.

The main recommendations of the task force were to: (1) modify the existing medicare system of retrospective cost-reimbursement and (2) to establish improved systems for assuring the proper utilization of home health services.

To carry out the task force's recommendation concerning improved utilization controls, we have developed intermediary instructions to require the establishment of utilization screens. These screens will identify home health agencies whose billings patterns indicate a strong possibility of overutilization. HHA's identified in this manner will then be subjected to intense onsite field audits. We plan to begin implementation of these utilization monitoring procedures late this year.

The task force report also discussed the effectiveness of special home health audit activities which focused on utilization and reimbursement problems. Particularly referenced were the results of fiscal year 1979-0 home health program validation audits. (Program validation is a HCFA audit effort designed to detect problems with individual providers and also to test the appropriateness of existing program operations and policies.)

We have prepared a chart which reflects the validation audit results on some 24 home health agencies in California, Florida, Mississippi, and Puerto Rico. The chart indicates that over $9 million of overpayments were made to these agencies for such things as unreasonable management fees, salary costs, consulting fees, auto expenses, travel and entertainment expenses and unsupported or noncovered home health visits. These problems have been brought to the attention of our intermediaries for final fiscal adjustment action and, where appropriate, to law enforcement authorities. A copy of this chart is being submitted for the record. Also submitted for the record are copies of the validation review reports.

The task force also highlighted a home health agency data project which resulted in the publication of HHA cost and utilization data on specific agencies. This data was produced to rank home health agencies on the basis of costs, utilization, and the relationship of administrative salary costs to total salary costs. The information, in turn, was supplied to our HCFA Regional Administrators last October for their use in assuring that intermediary audit attention was turned to the home health agencies where the data suggested that either costs or utilization was too high.

In addition to the long-term reforms associated with changing our home health reimbursement methodology, the task force identified several shorter term improvements which are either already completed or now under way. These activities include:

Revised guidelines for intermediary use in judging the acceptability of management contracts.

Clearer delineation of reimbursement rules for "nurse coordinators" who assist in establishing the treatment plan, but who were sometimes engaged in what might be termed patient solicitation.

Development of initial guidelines for assisting in the determination of "reasonable" HHA owner and administrator salaries.

Other efforts under way within HCFA to control program abuses include:

Validation Review of selected providers to identify (a) suspected improper practices. (b) failure on the part of the claims payers to fulfill operating responsibilities, and (c) weaknesses in program policy or implementation which result in monies being inappropriately paid.

A Home Health Agency Cost Report Evaluation Program (HHA-CREP) to measure the quality of intermediaries' actions in reviewing, adjusting, and settling home health agency costs reports.

An Administrative Sanctions Program to protect the medicare and medicaid program by (1) barring from participation an individual who has been convicted of a program-related crime, (2) excluding providers from participation in medicaid and denying medicaid Federal funding to State agencies for providers services because the provider has been found to have defrauded or committed abuses against the medicare program, (3) terminating agreements of providers to participate because the providers have defrauded the program or failed to uphold requirements of the participation agreement, (4) terminating providers from participation in medicare and medicaid because PSRO's have determined that the providers have failed to meet certain obligations relating to quality and necessity of services, and (5) refusing to enter into or renew agreements with providers who are owned, controlled, or managed by persons who have been convicted of program-related crimes.

Contractor and State agency performance evaluation programs to assess the performance of medicare contractors and medicaid State agencies, including whether they are properly identifying, reviewing, investigating and referring for appropriate action cases of suspected fraud and abuse. Also assessed in these reviews is how well program instructions are being implemented in the areas of reimbursement, financial management and claims processing. The overall objective of these programs is to improve contractor and State agency performance through ongoing guidance and assistance focused at any performance weaknesses which may be identified.

Designation of regional intermediaries for freestanding agencies. Consolidating the home health workload under fewer intermediaries will create an environment which can provide greater assurance of accurate payment determinations to home health agencies. The designated regional intermediaries will be able to concentrate and focus their resources better on the special claims processing and audit programs posed by home health agencies.

Excluding costs associated with contracts which are based on either a percentage of the agency's billings or which are for periods longer than 5 years. Manual instructions are now being prepared and we expect to release them to our Office of Issuances in June.

Excluding from participation in the program health care professionals—in addition to physicians and other practitioners—who have been convicted of program-related crimes. Implementation has already been accomplished.

Access to the books and records of subcontractors for services to providers which cost $10,000 or more over a 12-month period in order to verify the nature and extent of the costs of the services. This affects all appropriate contracts entered into after December 5, 1980. Interim instructions will be issued to the intermediaries this summer. Proposed regulations are scheduled to be published in mid-1982.

Establishing a bond or escrow requirement for HHAs which receive all or a substantial portion of their income from the medicare program to assure the availability of funds to repay any overpayments. We have prepared draft regulations which we expect will be sent to the administrator in July. Manual instructions are being developed and will be coordinated for release upon clearance of final regulations.

Prohibiting a physician who has an ownership interest or other financial or contractual relationship with a HHA from certifying the need for care or establishing the plan of treatment for medicare beneficiaries of the HHA. This provision is included in a regulations recodification package that is nearly ready for the administrator's signature. A medicare manual supplement was issued in April, with advance copies mailed to all medicare contractors in February.

Other actions which specifically address home health agency operating costs and utilization include:

An indepth HHA audit and coverage review program which has been developed and implemented in selected geographic areas where problems have been identified, and for agencies with high medicare/medicaid utilization (85 percent or more). The audit guides used in these areas have served as a basis for the development of national audit instructions in both the coverage and fiscal areas.

In the area of fiscal audits, HCFA is in the process of preparing national fiscal audit instructions for intermediaries. The instructions will provide for the type and scope of home health agencies fiscal audits HCFA expects intermediaries to undertake to assure proper program reimbursement of home health agencies.

HCFA will shortly issue an instruction to part A fiscal intermediaries which will require them to rank their HHA's based on utilization of services and provider costs. The intermediary will then perform an onsite review of medical records for: Providers who appear in the top 10 percent of the ranking, providers who do not have favorable waiver presumption, and all new providers. The implementation of the new instructions is planned during the October–December 1981 quarter.

PROPOSED LEGISLATION

In addition to these ongoing efforts, the administration has proposed a number of reforms which require legislation.

A Civil Money Penalty which would permit the Secretary to assess civil penalties against program abusers without resorting to full criminal prosecution. Not only will this enable us to speedily deal with program abuse, but we expect it to have a great deterrent effect on potential abuse;

A "cap" on medicaid matching funds to the States, coupled with additional flexibility in the administration of the benefit, which would encourage States to develop new and innovative approaches to eliminate medicaid waste and abuse of home health funds.

Mr. Chairman, as I have previously mentioned, in recent years we have seen a growing emphasis on the value of home health services. This emphasis has taken the form of recently introduced legislation to expand and improve the benefit. In general, we agree with the thrust of these initiatives—to provide less expensive care in the home setting, as opposed to paying for care in an institution.

However, we continue to believe that any expansion of the home care benefits must be approached with a great deal of caution, because expansion of home care can and does become an added expense to taxpayers when it supplants services already provided by family and friends.

Proponents of home health care usually argue that the services can and do provide an alternative to institutionalization. In December of 1977, the Government Accounting Office issued a report on "Home Health—The Need For A National Policy To Better Provide For The Elderly," in which they concluded, "The true costs of maintaining the elderly and sick in their own homes have been largely hidden because the greatest portion of such costs represent the services provided by families and friends rather than those provided at public expense."

If we expand home care services, particularly if we expand them by reducing or eliminating the present requirement that a patient must need skilled services, there will be a temptation for program beneficiaries and their families to allow a home health worker to come in and provide this care at taxpayer expense. For this reason we are very cautious about any expansions of the home health benefit at this time. The administration is therefore, recommending restoration of the visit limit under medicare parts A and B, as well as the elimination of occupational therapy as a qualifying benefit.

A further reason for our concern is that, despite all past actions, the incidence of home health fraud and abuse remains at an unacceptably high level. We will continue to work with the Congress to make high quality home care services available to our beneficiaries, while at the same time ensuring that those who seek to abuse the program are detected and prosecuted. I will be happy to answer any questions you may have.

POTENTIAL DOLLAR ADJUSTMENT RECOMMENDATIONS FROM MAJOR PROGRAM VALIDATION REVIEWS

Description of findings	Florida	Mississippi	California	Puerto Rico	Total
Reimbursement made to uncertified HHA's (nonallowable)				$5,500,000	$5,500,000
Related organization Costs (nonallowable)		$53,400	$165,190	1,472,000	1,690,590
Salary costs (unsupported, unreasonable)	$98,641	155,908	203,626	69,876	528,051
Management fees (unreasonable, unnecessary)				400,000	400,000
Consulting fees (unreasonable)	164,881			85,169	250,050
Unsupported/medically unnecessary visits		135,082	44,655	60,000	239,737
Pension cost paid after regulatory time limit (nonallowable)				92,609	92,609
Legal/accounting/computer fees (unreasonable)	29,585	15,875	9,372		54,832
Organizational cost (unreasonable)	48,724				48,724
Miscellaneous costs not related to patient care	1,200		43,863		45,063
Auto expenses (nonallowable)	9,272	14,460	17,611	6,648	47,991
Hospital discharge planning (nonallowable)			37,938		37,938
Mandatory employee contribution (nonallowable)				32,115	32,115
Travel and entertainment (nonallowable)		20,628	8,455		29,083
Start-up cost (unreasonable)	26,860				26,860
Life/malpractice insurance (nonallowable)	3,214	546		21,530	25,290
Equity capital			23,834		23,834
Lease (unreasonable)	4,800	7,818			12,618
Depreciation (nonallowable)			3,448		3,448
Medical supplies (erroneously computed)		1,222			1,222
Total adjustments	387,177	404,939	557,992	7,738,947	9,090,550

RESPONSE TO LETTER OF APRIL 14, 1981, FROM SENATOR ROTH

HCFA believes existing legislation and regulations are adequate to address the kinds of abuse in the home health industry outlined in the Subcommittee's letter of April 14. In particular, provisions of the Omnibus Reconciliation Act of 1980, (Public Law 96-499) passed by the Congress and signed into law by the President on December 5, 1980, will help in this endeavor.

Section 930 of Public Law 96-499 contains a provision which requires Medicare home health agencies to meet additional requirements as a Medicare condition of participation, including the establishment of bonding or escrow accounts, which the Secretary finds necessary to minimize financial risk. The same section also includes a provision which prohibits recognition of costs incurred by Medicare home health agencies which are for long-term contracts (those exceeding 5 years) or for which payment is determined based on a percentage arrangement. Both of these provisions should prove valuable tools in working to prevent program abuse.

Section 930 also requires the Secretary to establish regional intermediaries for home health agencies, which we are now doing. These designated intermediaries should develop a more indepth knowledge of HHA operations which will enable attention to be given to questionable subcontractor situations.

Since the inception of the Medicare program, recognition has been given to the potential for self-dealing through "front" operations. The potential for inordinately increasing profits in dealings between related health care providers and supply organizations has been addressed in Medicare regulations since 1966 (42 CFR 405.427). The Medicare principle established by regulation to control reimbursement in such situations states the cost of services, facilities and supplies furnished to a provider (e.g., HHAs) by organizations related to the provider by ownership or control are allowable only at the cost to the related organization. Furthermore, to be allowable, the cost to the related organization cannot exceed the price of comparable services, facilities or supplies that can be purchased elsewhere. An exception to this rule applies where the supplying organization is a bonafide separate organization, a substantial part of its business activity is conducted with unrelated entities and certain other criteria are met.

In order to monitor these types of situations, all providers, including HHAs are required to fully disclose on their annual cost reports, whether any of their supplies, facilities, or services are obtained through related organizations. Application of this related organization reimbursement principle will be further enhanced by recently enacted legislation authorizing access to subcontractor records (section 952 of Public Law 96-499).

The following are answers to your specific questions:

Question A. What is the effectiveness of the cost reimbursement system or proposed alternatives?

Under current statutory requirements all providers of services, including home health agencies, receive reimbursement based on the cost they incur in providing services to program beneficiaries. While this cost-reimbursement system, which provides for estimated interim payments during the year and for final settlement on the basis of a submitted cost report after the close of the fiscal year, prevents providers from receiving excess reimbursement through inflated charges, it does not necessarily provide incentives for providers to contain costs. Furthermore, one notable disadvantage of a retrospective reimbursement system is that costs incurred by a provider during the year for which it receives interim reimbursement may be found to be unallowable or unreasonable in amount by the provider's intermediary, based upon its review of the provider's submitted cost report. This has been particularly acute for home health agencies which are primarily dependent upon Medicare (and Medicaid) for their income and, therefore, have virtually no other resources with which to repay the overpayments.

For the long term, we believe alternatives to the current cost reimbursement system need to be developed to provide incentives for efficiency. The Administration will be proposing comprehensive health financing reforms to promote competition. We anticipate that new reimbursement methodologies will evolve as part of these reforms.

We have taken several steps to tighten up reimbursement under the current cost reimbursement system:

The authority provided under Section 223 of Public Law 92-603 to establish provider cost limits has been used to apply limits to home health agency costs. Currently, home health agencies are subject to prospective limits on overall reimbursable costs. These limits became effective July 1, 1979 and are established

at the 80th percentile of the costs for each service provided to Medicare beneficiaries. The limits are, however, applied to the agency's aggregate cost. Approximately 20 percent of all agencies are impacted by these limits, with a projected reduction in Medicare reimbursement of approximately $35 million.

We are also evaluating the possibility of establishing guidelines on administrative costs. These guidelines will allow fiscal intermediaries to identify those agencies with excessive administrative costs.

Prior to October 1, 1980, agencies were allowed to use any one of four different methods of determining costs and apportioning these costs to the various health care programs. These options made it difficult to compare costs among agencies and to identify high cost areas. In order to refine the cost reporting process, we developed a regulation which requires that HHAs use a single method of cost finding and cost apportionment. This will facilitate identification of excessive costs and implementation of the home health agency cost limits. We devised a new HHA cost report to implement this regulation and put it into use with reporting periods which begin on or after October 1, 1980. This new report greatly standardizes the cost reporting mechanism, and we expect it will give us the capacity to make more accurate cost comparisons among agencies. We cannot, as yet, assess the extent to which the report achieves this purpose, since we will not begin to receive completed reports until the end of this year.

We have developed proposed instructions regarding purchased management and administrative support services. These instructions, which are applicable to all providers, (a) clarify the steps that a prudent and cost-conscious provider should consider when entering into a management contract, and (b) describe the factors which intermediaries are to consider in evaluating the reasonableness of fees paid based on the value of the services rendered.

Furthermore, we are developing proposed instructions to implement Section 930 of Public Law 96-499 which prohibits reimbursement for costs incurred by home health agencies for contracted services where a contract is entered into for a period exceeding 5 years or where payment by the home health agency to the contracting organization is based on a percentage arrangement.

Question B. What is the effectiveness of intermediary audit coverage?

In general, since there is not sufficient budget to audit all providers each year, audit priorities are determined by the potential savings to be derived from the audit effort involved. Since HHAs' costs generally are lower than hospitals' costs, audit efforts have historically been more concentrated in the hospital area.

However, over the past few years, GAO reviews, congressional committee hearings, departmental audit reports and our own monitoring activities have identified several problems in the home health area. These problems have generally been related to HHAs (a) with a large percentage of Medicare utilization (so-called "100 percenters") which have been established as private not-for-profit organizations and (b) within selected geographical areas. We have developed an in-depth audit program for these providers and areas. The program has been put in use in Florida on a test basis. Findings indicate a return of $8 to $10 for every audit dollar spent, as opposed to the usual return of $4 for every audit dollar. Based on those findings, the program was put into use in two additional HCFA regions, and expansion to a third is contemplated.

There are several areas in the country where intensified HHA audits have been undertaken. An example of this is exhibited by the Chicago region where problems had surfaced with regard to "not-for-profit" HHAs, and specifically to a particular group of five of these agencies. Increased funds and manpower have been devoted to auditing these cost reports. The following data obtained from the HCFA Chicago Regional Office bears this out. Data applies to the fiscal years ending in 1979 and 1980.

	Hours [1]
National average of all HHA's	108
All HHA's in Chicago region	90
All not-for-profit HHA's in Chicago metropolitan area	200
5 specific HHA's mentioned within Chicago metropolitan area	500

[1] Average Number of Hours Expended to Settle an HHA Cost Report.

In addition, the Chicago Regional Office, in 1977, had issued memoranda directing its intermediaries to consolidate its HHAs under one manager, only use experienced staff to perform reviews, and intensify its Medicare pre-certification reviews.

Question C. What is the effectiveness of oversight and administration by HCFA?

When the problems began to surface regarding some of the newer home health agencies operated by family sponsored private non-profit organizations, HCFA initiated a more indepth examination of costs incurred by these agencies and claimed for program reimbursement. It was found that, despite the non-profit character of these agencies, they were neither costs conscious nor prudently operated and Medicare became essentially their only source of income.

HCFA has both completed and underway a number of actions which address home health operating costs and utilization. Certification procedures have become more stringent, reimbursement and coverage guidelines have been strengthened and intermediary monitoring of home health operations in both the fiscal and utilization areas have increased dramatically.

An indepth HHA audit and coverage review program has been developed and implemented, both in selected geographic areas where problems have been identified, and for agencies with a high percentage of Medicare patients, i.e., 85 percent or more. Florida, all States and contractors in the Dallas region, and California are involved. In the Chicago region, problems existed with a relatively small number of agencies and significant resources were already committed (and continue to be committed) for the purpose of auditing these agencies. For this reason, a regional, or even a State-wide intensified audit program was not considered necessary or cost effective.

The audit guides used in these areas have served as a basis for the development of national audit guides in both the fiscal and coverage areas. These should provide sufficient instructions to intermediaries regarding the type and scope of fiscal and coverage audits HCFA expects intermediaries to undertake.

Our validation reviews have already disclosed abusive practices which could have been identified and corrected through more effective intermediary practices. For example, we have found that it is a common practice for HHAs to employ and use Medical Social Workers (MSWs) to solicit prospective clients. Medicare reimbursement for services performed by MSWs is limited to those services which are directly related to patient care. This practice can be identified through intermediaries' use of performance guidelines.

Our San Francisco Regional Office has developed performance guidelines for several HHA activities such as the average visits per day of nurses, physical therapists, occupational therapists, and home health aides. These guidelines are used by intermediaries to identify instances which require further investigation.

We also found that HHA administrative salary costs were frequently excessive. In some cases these administrative salary costs constituted over 50 percent of total direct personnel costs. Upon further review it was determined that these excessive administrative salary costs resulted from the fact that many of the administrative positions were unnecessary, since the duties of the positions were not clearly defined and overlapped with the duties of other positions. We are working on the establishment of administrative salary to total personnel costs ratios which would enable intermediaries to focus their attention on those HHAs which establish and maintain unnecessary administrative staff.

There are other areas of the country where intensified HHA audits have been undertaken, apart from the centrally directed reviews. For example, our Kansas City Region directed intermediaries to review a special group of home health agencies with high cost and high utilization to determine whether problems identified elsewhere in the country also exist in that region. Also, in our Chicago region as we stated previously, where problems have surfaced with a particular group of agencies, increased funds and manpower have been devoted to auditing their cost reports.

In the area of coverage, HCFA is close to issuance of an instruction to Part A fiscal intermediaries which will require them to rank their HHA's based on utilization of services and provider costs. The intermediary will then perform an onsite medical records review of providers who appear in the top 10 percent of the ranking, of all providers who do not have favorable waiver of liability presumption, and of all new providers. The purpose of these onsite coverage reviews is to detect fraud and abuse, to detect and correct situations in which providers are mistakenly billed for noncovered care, and to indicate areas in which provider education needs enhancement. The implementation of the new instruction is planned during the October–December 1981 quarter.

Question D. How can disallowances be recovered by the Federal Government without rendering insolvent the bona fide Home Health Agencies?

Medicare overpayments to home health agencies that are 100 percent Medicare cannot be recovered by the Federal Government without rendering the agencies insolvent. Where the agency's patient load consists primarily of Medicare beneficiaries, it cannot be expected to generate revenues in excess of its costs.

The Health Care Financing Administration is currently developing regulations to implement that part of Section 930 of Public Law 96–499 which gives the Secretary authority to impose financial security requirements on home health agencies, including the establishment of bonding or escrow accounts. Once an escrow account or bond is established, the regulation will provide that the funds can only be used in repayment of Medicare overpayments. We do not expect to require all home health agencies to establish a bonding or escrow account. Rather, we are attempting to identify the characteristics which would indicate that an agency is a poor financial risk, and should be required to have a bonding or escrow account.

Question E. How can the Federal Government terminate irresponsible Home Health Agencies from participation in federally funded home health programs?

Section 1862(d) of the Social Security Act provides that the Secretary may exclude from Medicare reimbursement any provider, practitioner, or other supplier of services who has:

(*a*) Knowingly and willfully made or caused to be made any false statement or misrepresentation of a material fact in a request for payment under Medicare or for use in determining the right to payment under Medicare;

(*b*) Furnished items or services that are substantially in excess of the beneficiary's needs or of a quality that does not meet professionally recognized standards of health care; or

(*c*) Submitted or caused to be submitted bills or requests for payment containing charges (or costs) that are substantially in excess of its customary charges (or costs).

Under section 1866(b)(2) of the Social Security Act, a provider agreement may be terminated if it is determined that the provider committed any of the offenses cited in (a) through (c) above. These exclusion/termination authorities have been used by HCFA to exclude from program reimbursement 1 HHA and 2 owners and operators of HHAs.

Public Law 96–499 contains a provision which broadens the Secretary's administrative sanction authorities. Effective December 5, 1980, any owner or operator of an HHA who is convicted of a Title XVIII, XIX, or XX related offense is subject to an immediate exclusion from reimbursement under these programs.

In addition to these sanctions, under the authority contained in Section 1866 (a)(3), the Secretary may refuse to enter into a provider agreement with an HHA if any owner or operator of the HHA has been convicted of a criminal offense related to participation in the Title XVIII, XIX, or XX programs.

These sanction authorities represent a comprehensive set of administrative remedies for dealing with fraudulent and abusive HHA's. These authorities coupled with the financial security authorities also contained in Public Law 96–499 will enable HCFA to effectively deal with these irresponsible HHA's.

You also requested our recommendation as to the means by which abuse involving subcontractors can be eliminated. In conjunction with Section 952 (Access to Books and Records of Subcontractors) of Public Law 96–499, efforts are under way to assure that activities related to the appropriate disclosure of this information are pursued by the Medicare State agencies. This section requires that disclosure be made with respect to the name and address of each person with an ownership or control interest in the HHA or in any subcontractor in which the HHA has a direct or indirect ownership interest totaling 5 percent or more. In addition, if reference to these disclosure requirements is made in the Home Health Agency Conditions of Participation, the contracting HHA would be subject to termination of its agreement with the Secretary if it refused to provide this information or if it knowingly and willfully made, or caused to be made, a false statement with respect to this disclosure.

We are also considering amending the Home Health Agency Conditions of Participating by stipulating the specific management services which may be delegated to another organization or agency. In addition, we are considering requiring that HHA's include in their contracts with other agencies or organizations the names of the persons holding 5 percent or more interest in the subcontractor.

Chairman ROTH. Gentlemen, it is almost 1 o'clock. I appreciate your coming here. I do urge on you that you pursue whatever remedial steps you are going to take as rapidly as possible. I think it is important for the good of the program.

I also want to underscore that we recognize that undoubtedly the vast majority of providers are conscientious public providers. We do not mean to infer from what we have said that all of them are of the type we discussed today. But I have to re-emphasize that I see nowhere in the system the kind of controls and checkpoints that I think are necessary if we are going to maintain reasonable costs unless you are able to create an environment of real competition. Do the latter and provide quality services. I think that is highly desirable. But I do urge the Department and HCFA move as expeditiously as possible. Is it not a time for slow action.

Thank you, gentlemen.

I would like to state for the record that we invited Blue Cross but they were unable to attend. It should be noted that we did receive excellent cooperation from Blue Cross and they have provided the staff a letter which we will include as part of the record.

[The document referred to was marked "Exhibit No. 9" and follows:]

EXHIBIT No. 9

BLUE CROSS, BLUE SHIELD,
Chicago, Ill., May 12, 1981.

S. CASS WEILAND,
Chief Counsel, Governmental Affairs, Permanent Subcommittee on Investigations, Washington, D.C.

DEAR MR. WEILAND: Once again, we appreciate the opportunity to share our ideas with you.

As you requested, we respectfully present a cost-based (and audited) incentive reimbursement concept, for possible experimentation, which may curtail abuse and foster cost containment for Home Health Agencies.

After a careful evaluation, it is our considered judgment that this program has the potential to: minimize tendencies toward fraud and abuse; provide financial incentives to achieve efficient performance; save Medicare significant dollars; spread risk and encourage competition.

We feel that an incentive program would be supported by the Home Health Agency Industry as well as the Health Care Finance Administration.

Any consideration toward an alternative reimbursement approach, we believe, must be simple, easily understood, and conceptually sound.

INCENTIVE PROPOSAL—THE BASIC DESIGN

1. Establish a Target Fixed Rate.—The audited "reasonable cost": of participating HHAs would be used to compute the average cost per common unit. The target rate might be set somewhere between the average "reasonable cost" (after audit) [1] and the "cap" (223 limits). The target rate should be adjusted for inflation.

Adjusted for geographic location and/or other major variables such as HHA size (visit or case volume), "hospital-based" versus "free-standing", etc.

Reimbursement might be established on a common unit, i.e., per visit. Case mix could be considered or studied during a per visit experimental approach.

[1] Adjusted for inflation.

2. *Share.*—After a thorough audit and determination of "reasonable cost", the difference between the target rate and the reasonable actual costs will be compared:

If the target is exceeded	*If actual "reasonable cost" is under target*
Medicare reimbursement in whole, or in part, covers the loss up to a designated "cap" (223 limits).	Medicare shares: For example a percentage such as 50 percent of the gain. This would give the provider additional funds for community service, uncovered by insurance or medicare services, reserves, as a compensation supplement or anything the HHA believes appropriate.

Our proposal, while cost-based, is designed to modify today's system by spreading risk. Incentives for cost containment are provided by the recognition of and sharing in the cost savings achieved by the Home Health Agency.

The success of such an experiment would be dependent upon an improved and clear definition of covered and medically necessary HHA services, as the provider must be fully aware of the rules, if risk is to be properly assumed.

This proposal, under the current law, would require a Medicare waiver for cost reimbursement to cover the incentive of "target rate".

We are pleased to contribute our thoughts for your consideration. If we can be of any further assistance in designing such an experiment, please let me know.

Sincerely yours,

DAN T. GREGORIO,
Director fo Audit—P. R. & A.

Chairman ROTH. Without objection, I would like to have included in the record certain investigative materials obtained by the subcommittee during investigation. These materials are described on this index.

[The index follows:]

INDEX

HOME HEALTH AGENCY INVESTIGATION—INVESTIGATIVE RECORDS

1. Northrad Management Corporation Trial Balance and accountant's books and records for fiscal years ended 9/30/77 and 9/30/78.
2. Selected bank account records of Northrad Management Corporation.
3. Selected corporate records of Northrad Management Corporation.
4. Chicago Home Care Service, Inc., Trial Balance and accountant's books and records for FYE 1/31/79 and 1/31/80.
5. Selected corporate records of Chicago Home Care Service, Inc.
6. Oaklawn Physical Therapy Associates, Inc., Trial Balance and accountant's books and records for FYE 9/30/78 and 9/30/79.
7. Michael Morrisroe, Ltd., Trial Balance and accountant's books and records for FYE 11/30/77 and 11/30/78.
8. Selected Certificates of Deposit and related bank records from Ashland State Bank, Chicago, Illinois; Michigan Avenue National Bank, Chicago, Illinois; and Oceanside Federal Savings, Oceanside, California; concerning the following account holders:
   a. Chicago Home Care Service, Inc.
   b. Northrad Management Corporation.
   c. Oaklawn Physical Therapy Associates, Inc.
   d. Alternative Power Project.
   e. Michael Morrisroe, Jr.
   f. Pat Tinder.
   g. Jo Ann Stevens.
   h. Maureen Flanigan.
   i. Rose Gallagher.
   j. John Kruisec.
   k. Connie Kubicka.
   l. Energy Engineering Development Company.
   m. Quantimetric Publishing Co.

9. Those certain 5 charts testified about during the Home Health Agency Hearings before the Senate Permanent Subcommittee on Investigations on May 13, 1981, entitled as follows:
   Exhibit 1—Home Health Agency Overview.
   Exhibit 2—Utilization Rate.
   Exhibit 3—Nurses Aide Costs.
   Exhibit 4—Income & Disallowances.
   Exhibit 5—Diverted Medicare Funds.
10. Selected corporate records of Alternative Power Projects Partnership including tax returns, bank records and other financial records.

Chairman ROTH. I would also like to include for the record a statement offered by Senator Chiles and a letter from the Department of Justice to the HHS Inspector General which we have alluded to at an earlier time.

[The letter referred to was marked "Exhibit No. 10" and follows:]

EXHIBIT No. 10

U.S. DEPARTMENT OF JUSTICE,
March 23, 1981.

Re Fraud and Abuse Affecting Medicare Program—Home Health Agencies.

Hon. BRIAN MITCHELL,
Acting Inspector General, Department of Health and Human Services, Washington, D.C.

DEAR MR. MITCHELL: For the past several years, the Fraud Section of the Criminal Division of the Department of Justice has been conducting with the assistance of your office an investigation into alleged cost mischarging in the Medicare cost reports submitted by a large home health agency in South Florida. As you know, we have recently decided not to proceed with the prosecution because of a multitude of problems. Based on our experience in this investigation, we have serious concerns regarding the regulatory scheme governing private, non-profit 100 percent Medicare patient organizations. Specifically, we are concerned about the opportunities for fraud and abuse that the current regulatory scheme presents and the resulting difficulty the government has in proving criminal intent and successfully prosecuting individuals who have engaged in various forms of fraud and abuse. We would like to submit, for your consideration, our perception of the most signifificant problems in the existing regulatory scheme and some possible solution to these problems.

PROBLEMS

As you may know, a home health agency (hereinafter HHA) is defined in the Medicare legislation as a private, non-profit organization primarily engaged in providing skilled nursing and/or other therapeutic services which are supervised by a physician or registered nurse. 42 U.S.C. § 1395(o). Operational costs of the HHA are reimbursable if "reasonable" and "related to the care of beneficiaries." 42 C.F.R. 405.451. A major difficulty in prosecuting violators of existing laws and regulations is establishing that costs, submitted for reimbursement, were not "reasonable" or not "related to the care of beneficiaries." Some of the major causes of this difficulty, which also provide, in the first instance, major opportunities for fraud, are discussed below.

1. Composition of Board of Directors.—There are currently no regulations governing the composition of an HHAs board of directors. Consequently, HHAs can become family operations permitting the owners to place members of their family, who have no connection to, or expertise in, the health care industry, on the board. This enables family members to take liberal advantage of "perks"—frequent, first-class air travel from far and distant places, telephone, lavish entertainment, etc., for frequent "board meetings"—all reimbursed as a business expense.

2. Salaries of Owners/Operators.—General regional guidelines have been published for a limited number of areas listing approved salary ranges for operators

of various health entities, including HHAs, by the number of patients served. The salary guidelines are not mandatory, do not contain regional cost ceilings, and, at best, are persuasive without force and effect of law. This permits owners/operators to exercise broad latitude when fixing their annual salaries. Not only is it difficult to prove the salary "unreasonable" in a civil proceeding before a provider reimbursement review board (hereinafter PRRB), but the chance that an excessive salary could become the subject of a criminal proceeding is practically impossible. Our investigation uncovered owner/operators receiving salary increases which were made retroactive to the date of a prior salary increase. There is nothing in the regulatory scheme which specifically prohibits such action and, with family directors on the Board, approval is guaranteed.

3. General Business Expenses.—There are no regulations to govern general corporate expenses. The only applicable statutory standard is whether the expense is reasonable. Thus, without a cost ceiling, the following corporate expenditures have served to inflate the cost of health care:

(*a*) Lavish entertainment of the medical community and/or local community leadership;

(*b*) Luxury cars provided to high-ranking members of HHA staff (other than board members) at the expense of the program; and

(*c*) First-class and/or frequent travel to national industry conferences coupled with first-class accommodations in the conference city.

4. Other Types of Costs.—Our investigations have shown other costs that HHA owners/operators allege to be "related to patient care" which are susceptible to abuse. Again, there are no regulations which invoke a ceiling on costs or directly prohibit these activities. We have seen similar abuses by other providers of Medicare services, but in the investigation we conducted, the following practices clearly and unnecessarily inflated the cost of home health services:

(*a*) Office space rental in luxury buildings coupled with lavish decorating expenditures for improvements of office conditions, including wallpapering, expensive carpeting, installation of private showers and wet bars;

(*b*) Loans and capital advancements of HHA operating funds for personal expenses of owners/operators or their business associates which are characterized by owners as investments on behalf of the corporation; and

(*c*) Payment of handsome fees to consultants (who may be friends or former employees) without adequate proof of need for or performance under the consulting contract.

5. Accounting Procedures.—As previously noted, many HHAs are wholly funded by the Medicare program. Final audit of the annual Medicare Cost Report ordinarily occurs approximately one year after its submission to the intermediary for final adjustment. If the audit disallows certain expenses, there is only one way the Medicare program can recoup the money: reduce the reimbursement rate in the current fiscal year.

It has been our experience that HHAs included large accruals for anticipated computerization, uniform expense, and staff pay increases in the first quarter of the fiscal year in order to generate cash flow. In most instances, there is little, if any proof the HHA intends to pay out the funds claimed as accruals. In fact, the HHA may deliberately create a phony accrual to ensure cash flow during the year. If the accrual is not paid out, the HHA is in an overpaid status for the year. There may be no potential criminal prosecution if the year end cost report does not reflect the phoney accrual expense, but the HHA has had the use of the cash during the year and the Medicare program has no really effective way of recouping the overpayment. The added cash is many times picked up by directors in the form of a bonus or advancement of capital. By the time Medicare disallows the accrual, it is two years from the original disbursement under the program. The disallowance may only be recouped by reducing the reimbursement rate in the year that it is disallowed. Thus, to avoid bankruptcy and/or serious disruption of the provision of health care, the government will attempt to reduce the reimbursement rate to permit the agency to continue while reimbursing the government over a period of years. This creates a situation where the government is never fully reimbursed and the HHA feels compelled to create new accruals to cover the reduction in operating capital. The "accruals," if not paid out, will ultimately become the source of a future disallowance for which the government will again not receive full reimbursement.

POSSIBLE SOLUTIONS

Having set out the most significant problems that have come to our attention, we feel obliged to offer our thoughts or possible solutions to at least some of those problems. There may be solutions better than the ones we suggest below, but at least we will have a starting point for future discussions.

In general, it is our belief that certain minor regulatory changes, if implemented, would enhance the government's ability to prosecute gross abuse of the Medicare program. Apart from developing a design for internal monitoring at the agency level, the following measures would significantly improve the current situation:

1. Regulations could be designed to prohibit certain practices and thereby put owners/operators on notice. The HIM–15, a manual of federal guidelines which explain the regulations, has been found to be merely directory, and it "cannot be proof of the obligation of Providers under the law or under the regulations . . ." *United States* v. *Hospital Monteflores, Inc.*, Criminal No. 76–106, Opinion and Order, May 13, 1977 (D.C.P.R.). Further, the PRRB, the administrative forum which initially hears reimbursement disputes, decides each matter independently; its published decisions contain a caveat that they are not to be used for precedential purposes and that they are limited to the facts of the particular proceeding. This limits the value of PRRB decisions to the criminal prosecutor. A potential defendant can engage in a practice claiming a similar practice was condoned by the PRRB. And yet, where the PRRB disapproves of a practices, a potential defendant may legitimately claim the decision pertained to the facts and circumstances of an individual provider. Thus, regulations, which have the force and effect of law, must specifically prohibit certain practices.

2. The burden of proof with respect to reimbursement claims should be squarely on the HHA/provider of services. The provider should be forced to justify the reasonableness and relation to patient care of each item claimed in order to qualify for reimbursement.

3. The intermediary receiving the annual Medicare Cost Report should be required to keep the original submission together with the envelope in which it was mailed. Retention of the envelope is critical to proof of mail fraud.

4. It should be required that the annual Medicare Cost Report be signed and certified by all top level personnel who provide information for its preparation, including, but not limited to, the Administrator, Treasurer, Controller, Accountant and chief nursing officials. Some consideration might be given to the addition of a certification stating that no kickbacks have been received by or provided to any entity doing business with the HHA. The general certification should also provide notice that false statements will subject the signatory to prosecution under 18 U.S.C. § 1001.

5. With respect to claims for attorney's fees, consideration should be given to limiting reimbursable legal expenses to those actions directly related to the HHA's patient care (e.g., malpractice actions, drafting of employment contracts, etc.). It may also be appropriate, when an action is prosecuted criminally or civilly, to place monies for anticipated legal fees in escrow until the litigation is resolved. The PRRB could later determine whether the Medicare program should bear the financial burden of the legal defense.

I know you share our concerns about fraud and abuse affecting the Medicare program. I hope that our perceptions of existing problems and our suggestions of possible solutions will prove helpful to you and your colleagues. We will be glad to meet with you at your earliest convenience to discuss these matters and to begin to take corrective action.

Sincerely,

JO ANN HARRIS,
Chief, Fraud Section, Criminal Division.

[The statement of Senator Chiles is included with other opening remarks.]

Chairman ROTH. The subcommittee is in recess subject to the call of the chair.

[Whereupon, at 12:40 p.m., the subcommittee was adjourned to the call of the chair.]

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