BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Home Health Care Services--Tighter Fiscal Controls Needed

The cost of home health care services under Medicare has spiraled in recent years--$786 million is projected for fiscal year 1979. The Department of Health, Education, and Welfare has long been aware of the need to contain these costs through limits or guidelines. Failure to do so has resulted in Medicare reimbursing home health agencies for excessive costs.

Five for-profit organizations helped create nonprofit home health agencies and then, without benefit of competition, arranged to provide them management services.

HEW should take action to prevent Medicare from underwriting such practices in the future.

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COMPTROLLER GENERAL OF THE UNITED STATES
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To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the need for improvements in Medicare's cost reimbursement procedures for home health care services and makes recommendations for such improvements.

Medicare reimbursement for home health services varies greatly; in many cases the reimbursement appears to be excessive. We also found evidence of program abuse. Specifically, home health agencies were claiming questionable costs for Medicare reimbursement, and a variety of abuses was noted with the establishment of agencies.

We are sending copies of this report to the Director of the Office of Management and Budget; to the Secretary of Health, Education, and Welfare; and to other interested parties.

Elmer B. Staats

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

HOME HEALTH CARE SERVICES--
TIGHTER FISCAL CONTROLS NEEDED

D I G E S T

GAO found wide variances and inadequacies in Medicare's reimbursement procedures for home health care. For example, the costs reimbursed for a skilled nursing visit in high-cost metropolitan areas ranged from $14.43 to $42.72. For home health aide visits, the costs varied from $6.69 to $34.72. (See p. 6.)

There were also wide cost variances for performing particular activities or functions and for individual cost elements. For example, the management and clerical costs for two home health agencies in Louisiana that were comparable in size were $291,400 and $129,000--a difference of $162,400. (See p. 8.)

A comparison of two agencies in Florida showed wide variances in personnel salaries. The administrator of a nonprofit agency was paid $36,400, as compared to $17,745 for the administrator of a visiting nurse association. The salaries for the controllers of the two agencies were $20,010 and $14,447, and for the nursing directors, $20,800 and $12,567. (See p. 8.)

The Department of Health, Education, and Welfare (HEW) has been aware for years of the need to limit reimbursement for excessive home health costs, but just recently has it taken positive action. In March 1979 HEW published proposed cost limits by type of home health visit; i.e., skilled nursing, home health aide, etc. HEW should also develop limits for individual costs or groups of costs. (See p. 18.)

QUESTIONABLE COSTS CLAIMED

HEW should take several other specific actions to tighten Medicare reimbursement:

--Establish stronger control over salaries and fringe benefits claimed for reimbursement. (See p. 25.)

--Take additional measures to assure that costs claimed are properly documented. (See p. 19.)

--Clarify and strengthen program instructions concerning the specific types of promotional activities that are allowable for Medicare reimbursement. (See p. 22.)

Concerning the latter, Medicare allows reimbursement for promotional and educational expenses of a general nature but disallows patient solicitation costs. There is an extremely fine line between these types of costs and, accordingly, clarification is needed.

GAO also noted that some agencies were claiming costs which were unrelated to patient care. For example, one agency claimed a trip to European countries for the purpose of observing the European home health care programs. (See p. 19.)

INCREASING NUMBERS OF NONPROFIT HOME HEALTH AGENCIES

The number of nonprofit home health agencies has grown significantly in recent years. One reason is because of the efforts of some for-profit organizations which assist in the establishment of such agencies and subsequently do business with them. GAO identified five such organizations that have assisted in establishing and/or providing management assistance to at least 78 nonprofit home health agencies.

Given the circumstances under which these agencies are created, GAO believes there is program abuse. For example:

--The newly created agencies obtain services from the for-profit organizations without the benefit of competition.

--The contracts of two for-profit organizations were for an excessive period of time; i.e., 35 years and 29 years.

--Some for-profit organizations used facilities of the nonprofit agencies to conduct their business at the expense of the Medicare program. (See pp. 32 and 34.)

--Some services under the contracts may be unnecessary for providing home health services.

--Frequent examples of self-dealing were noted between the for-profit organizations and the home health agencies.

Entering into costly service contracts for 35 or 29 years is hardly indicative of prudent management. To prevent Medicare from underwriting such practices in the future, home health agencies should be required to obtain prior approval for contracts which exceed a specified cost and/or whose term exceeds a specified period of time.

AGENCY COMMENTS

For the most part HEW agreed with GAO's recommendations and said that action was planned or underway to address the problems noted. (See p. 43.) Both for-profit organizations and home health agencies, commenting on the questionable costs that were claimed (see ch. 3) and the abuses related to the establishment of agencies (ch. 4)--generally expressed the opinion that they were not violating program regulations.

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ABBREVIATIONS

GAO General Accounting Office

HCFA Health Care Financing Administration

HEW Department of Health, Education, and Welfare

VNA visiting nurse association

CHAPTER 1

INTRODUCTION

Congressional hearings in 1976 and 1977 raised numerous questions about the reasonableness of home health agency costs claimed for Medicare reimbursement. The hearings revealed that private nonprofit and proprietary agencies incurred excessive administrative costs and that the costs for home health visits far exceeded the costs claimed by traditional visiting nurse associations (VNAs). Because of congressional interest in home health care and rapidly rising costs, we wanted to know whether Medicare's cost reimbursement procedures were adequate for assuring that only proper and reasonable payments were being made for home health care.

AUTHORITY AND FUNDING

The Health Insurance for the Aged and Disabled Act (title XVIII of the Social Security Act) made available a broad health insurance program--known as Medicare--for most Americans age 65 and over. The Social Security Amendments of 1972 expanded the program to include certain individuals under 65 who are disabled or have chronic kidney disease.

Medicare provides two insurance protection programs for the aged and disabled--hospital insurance (part A) and supplemental medical insurance (part B). Hospital insurance is generally financed by social security payments from employers, employees, and the self-employed. Medical insurance is a voluntary program financed by general tax funds and monthly premiums collected from participating beneficiaries. Both insurance programs cover medical services provided to eligible beneficiaries in their own homes (home health care).

As of June 30, 1978, 2,612 agencies--1,303 government; 497 VNAs; 308 facility based; and 504 proprietary, private nonprofit, and others--had been certified by Medicare to provide home health care. VNAs predated other home health care organizational forms; essentially, they were community-based agencies which were supported by charity and some patient fees. Government providers consist mostly of county or public health departments. Facility-based agencies are those agencies that are affiliated with a hospital, a skilled nursing facility, or a rehabilitation facility.

There has been a rapid increase in the number of private nonprofit home health agencies. For example, in 1972 Florida had 29 agencies, 2 of which were private nonprofit. By

comparison, as of April 1976 Florida had 83 agencies, 55 of which were private nonprofit agencies that generally served only Medicare patients. In 1972 Medicare paid Florida home health agencies $1.4 million, whereas in 1976 payments totaled more than $32 million.

Medicare home health care outlays nationally have increased from $287 million in fiscal year 1976 to about $607 million for fiscal year 1978; $786 million is estimated for fiscal year 1979. Of the $786 million, $524 million represents estimated payments under part A, while $262 million will be for part B payments.

PROGRAM ADMINISTRATION

The administration of the Medicare home health care program has been delegated by the Secretary of Health, Education, and Welfare (HEW) to the Administrator of the Health Care Financing Administration (HCFA). 1/ HCFA is responsible for operating the program, establishing policy, and developing operating guidelines. HCFA and the Public Health Service are responsible for prescribing standards for home health agencies that participate in Medicare.

HCFA administers the home health care program with the assistance of public and private organizations that serve as fiscal intermediaries. There were about 80 such intermediaries as of December 1977 who, among other things, are responsible for: (1) making reasonable payments for services provided by home health agencies, (2) serving as a channel of communication between home health agencies and HCFA, and (3) assisting in establishing and applying safeguards against the unnecessary use of program services.

Home health agencies can also deal directly with the Federal Government. This function is carried out by the Division of Direct Reimbursement of HCFA's Medicare Bureau. As of June 1978 the Division acted as intermediary for about 380 home health agencies.

The Social Security Act requires that Medicare payments to home health agencies be based on the lesser of reasonable costs or customary charges. While agencies are paid during the year based on estimated costs, final settlements are

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1/Before the establishment of HCFA in March 1977, the program was administered by the then Bureau of Health Insurance of the Social Security Administration.

limited to those costs found by fiscal intermediaries to be proper, reasonable, and related to patient care. The agency's annual cost report is the basis for determining an agency's allowable costs for furnishing services and determining the share of those costs which are attributable to Medicare. The agency's report is subject to a desk review and field audit by the fiscal intermediaries.

PROGRAM BENEFITS AND ELIGIBILITY REQUIREMENTS

Home health care is health care prescribed by a physician and provided to persons in their homes. Medicare home health care services include

--part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

--physical, occupational, or speech therapy;

--medical social services, which include services necessary for assisting the patient and his/her family with adjusting to social and emotional conditions related to the patient's health problem;

--part-time or intermittent services from a home health aide which include helping the patient to bathe and care for the mouth, skin, and hair; to the bathroom and in and out of bed; to take self-administered medications ordered by a physician; and to exercise; and

--medical supplies (other than drugs and other medications) and equipment.

To be eligible for home health coverage under Medicare, a person must essentially be confined to his/her residence, be under a physician's care, and need part-time or intermittent skilled nursing care and/or physical or speech therapy. The need for such care must be prescribed by a physician, and the services furnished must be provided by a participating home health agency (either directly or through other arrangements) in accordance with the physician's treatment plan. To qualify for home health care benefits under part A, a person must have been in a hospital for at least 3 consecutive days before receiving home care. Home care must be for an illness for which the person received services as an inpatient and must be provided within a year after hospitalization or after

a covered stay in a skilled nursing home following such hospitalization. Under part A, a person's coverage is limited to 100 home care visits a year after the start of one spell of illness and before the beginning of another. 1/

A person may qualify for home health care benefits under part B without prior hospitalization, provided certain conditions are met. In such cases a person is limited to 100 home care visits in any one calendar year. While the beneficiary is still required to pay the first $60 each year for care provided under part B, the Social Security Amendments of 1972 eliminated the 20-percent coinsurance requirement for home health care.

SCOPE OF REVIEW

Detailed audit work was conducted at 11 home health agencies--8 in Florida and 3 in Louisiana. (See app. I.) As part of our review of these agencies, we performed selected tests of financial records to verify that the costs claimed for Medicare reimbursement were in fact incurred, allowable, reasonable, and properly reported. In addition to the detailed work at these 11 agencies, we did a limited amount of work at other home health agencies. This work was done primarily in connection with our examination of the practices employed by certain for-profit organizations which were involved in establishing home health agencies.

In selecting agencies for a detailed audit, we considered such factors as agency type, location, and size, and the types and amounts of costs claimed for Medicare reimbursement. The review focused on proprietary and private nonprofit agencies because congressional hearings indicated abuses by these types of agencies. We did not select any agencies that were under investigation by HEW or the Department of Justice at the time our review began.

We also reviewed audit procedures, guidelines, and techniques used by four fiscal intermediaries to settle home health agency cost reports. These intermediaries are Blue Cross and Aetna in Florida, Blue Cross in Louisiana, and HCFA's Division of Direct Reimbursement. We also did a limited amount of work at four other intermediaries in California, Maryland, and Illinois.

1/A new spell of illness begins if a beneficiary is rehospitalized after having been out of a hospital or a skilled nursing home for at least 60 consecutive days.

We examined HEW audit guidance and other instructions provided to the intermediaries. We also interviewed HEW, intermediary, and home health agency officials responsible for administering the program.

We requested comments on this report from the 11 home health agencies reviewed in detail, the for-profit organizations involved in the establishment of agencies, and HEW. With the exception of four home health agencies, all parties provided written comments. These comments have been considered in finalizing this report.

CHAPTER 2

HOME HEALTH CARE COSTS VARY GREATLY

The cost of providing home health care varies greatly throughout the country. For example, for the eight agencies we reviewed in Florida the average cost claimed for a home health visit in fiscal year 1976 ranged from $16.61 to $33.26. Wide variances in unit costs can be explained by a number of factors, and they frequently are a function of utilization. But we have found that a major reason for the variances is that some agencies incur excessive administrative and clerical costs and may be overstaffed.

Medicare essentially allows reimbursement for all costs claimed by home health agencies so long as the costs are found to be related to patient care, reasonable, and not substantially out of line with comparable agencies. In past years these terms have not been defined, but in March 1979 HCFA published in the Federal Register proposed reimbursement limits for home health services by type of visit.

A NATIONWIDE PROBLEM

The amount of Medicare reimbursement for home health care varies widely across the country. Examples of such variances are the costs reimbursed for home health care in high-cost metropolitan areas such as Miami, Boston, New York, Chicago, Las Vegas, and Los Angeles. The table below summarizes the range of these variances.

Range of Medicare Reimbursement for Home Health Care in High-Cost Metropolitan Areas by Type of Visit and Agency Workload for Fiscal Year 1976 (note a)

Type of visit	Agency workload (visits made) 1-4,999	5,000-9,999	10,000-19,999	20,000+
Physical therapy:				
high	$57.42	$63.20	$40.26	$52.92
low	9.18	10.00	9.63	12.29
Skilled nursing:				
high	79.19	55.62	35.00	42.72
low	4.56	5.79	8.95	14.43
Home health aide:				
high	33.27	30.54	31.25	34.72
low	3.41	5.44	4.85	6.69

a/Cost reporting periods ending on or before June 30, 1976.

MANAGEMENT AND CLERICAL COSTS

We noted wide variances in the costs of performing various management and clerical activities. As shown by the following table, the costs had little or no relationship to the number of patients served or visits made:

Average Management and Clerical Costs
By Patients Served and Visits Made--
Fiscal year 1976

Agency (note a)	Cost	Patients served	Visits made	Average cost: By patients served	Average cost: By visits made
Florida:					
Dade County	$310,400	2,009	46,670	$154.50	$6.65
Home Health	299,100	1,000	42,626	299.10	7.02
Hollywood	246,700	697	27,440	353.95	8.99
Bay Area	226,400	2,277	56,020	99.43	4.04
Broward County VNA	132,600	2,104	40,844	63.02	3.25
Pinellas County	118,600	892	23,503	132.96	5.05
Medi-Health	107,600	710	20,926	151.55	5.14
Hillsborough VNA	47,600	1,442	22,251	33.01	2.14
Louisiana:					
HHS/Louisiana	291,400	905	43,212	321.99	6.74
Capitol	212,600	704	33,109	301.99	6.42
Golden Age	129,000	1,006	46,699	128.23	2.76

a/See appendix I for the complete agency name.

During fiscal year 1976 Dade County, a nonprofit Medicare only provider, had 16 full-time equivalent administrative and clerical employees that received over $208,000 in wages and benefits. During this same period, the agency also purchased substantial administrative services from other organizations. Purchased services included $60,948 for management, accounting, and data processing services, $39,868 for typing services, and $1,620 for board meeting expenses--bringing total management and clerical costs to about $310,400, the highest of all the agencies reviewed. By comparison, the Broward County VNA--which is about 20 miles away--served about the same number of patients and made about the same number of visits, but it incurred approximately $132,600 in similar administrative costs--a difference of $177,800 from Dade County.

Management and clerical costs at the agencies reviewed in Louisiana also varied widely, even though they provided similar services, were located in the Baton Rouge/New Orleans area, and served about the same number of patients. In fiscal year 1976 Home Health Services of Louisiana (HHS/Louisiana) had 21 management and clerical employees that received over $189,000 in salaries and other benefits. During this period the agency also spent $70,858 for management consulting, accounting, and data processing services, $23,489 for typing services, $5,443 for legal assistance, and $2,633 for board meeting expenses; bringing total administrative costs to about $291,400. Management and clerical costs by patients served and visits made averaged $321.99 and $6.74, respectively.

By comparison, management and clerical costs incurred by Golden Age in fiscal year 1976 averaged $128.23 for each patient served and $2.76 for each visit made. Golden Age had only seven management and clerical employees; they received about $107,800, and the agency spent less than $21,200 for purchased administrative services. Golden Age incurred about $129,000 in administrative costs--$162,400 less than the amount incurred by HHS/Louisiana.

Commenting on our report, Home Health and HHS/Louisiana provided many reasons why their costs were higher. They also stated that our analysis did not consider many factors, particularly the quality of care.

We agree that the quality of care delivered by a home health agency would affect the cost of such care delivered, and we believe an agency should spend whatever it considers necessary to deliver high-quality care. But we believe there is a limit as to what the Medicare program should reimburse for such services. Further, under our proposal (p. 15) agencies are free to spend whatever they consider necessary for providing these services, and they are free to collect from the beneficiaries those costs which Medicare will not reimburse. If beneficiaries are convinced that the extra cost is worthwhile, we would expect that they would be agreeable to paying the extra cost.

Salaries

Wide cost variances can also be illustrated by comparing individual cost elements. For example, at Home Health (Florida), the salaries for key officials far exceeded the salaries paid by the Broward County VNA, even though the number of visits made were about the same and the Broward County VNA served twice as many patients as Home Health. The salaries paid for selected positions are:

	Salaries paid by	
	Home Health	Broward VNA
Administrator	$36,400	$17,745
Controller	20,010	14,447
Nursing director	20,800	12,567

Unlike the VNA administrators, who are governed by independent boards, the private nonprofit administrators are essentially free to provide whatever salaries and fringe benefits they choose. Commenting on these salary variances, the Home Health administrator stated that no guidelines were available to assist him with determining a reasonable salary. This problem is discussed on page 11 of this report.

Physician services

Home health agencies employ or contract with local physicians to assist with agency administration and other activities. We found that annual costs for physician services varied significantly by agency, and those agencies that had physician employees on staff (8 of the 11 we reviewed) claimed substantially more costs than those agencies that obtained medical advice on a consulting basis.

For program participation, Medicare requires that skilled nursing and other therapeutic services be under the supervision and direction of a full-time physician, a registered nurse, or a similar qualified individual that participates in all activities relevant to the professional services provided, including developing personnel qualification requirements and supervising agency employees. Medicare also requires that home health agencies establish and maintain an advisory group of professional personnel; this group is to include a licensed physician who approves and regularly reviews the agency's policies regarding the performance of skilled nursing and other therapeutic services. Physician charges for such services as training and counseling employees concerning a specific patient have also been recognized by the Medicare Bureau as reimbursable expenses.

Officials at those agencies that had physician employees claimed that their physicians or medical directors (1) provided medical advice as needed, (2) evaluated care and utilization, and (3) consulted with attending physicians. The agencies did not have records that specifically documented physician activities; however, we found that the medical directors did not work full time and did not visit patients,

and all of the agencies had nursing directors or supervisors that could have performed the daily supervisory services required by Medicare. Medical director salaries and fringe benefits ranged from $6,305 to $42,200.

The costs of physician services claimed in fiscal year 1976 by agencies not having staff physicians ranged from $1,200 to $1,575--significantly less than those costs claimed by agencies having medical directors. The administrator at an agency that did not have a staff physician or a medical director stated that a staff physician was not needed, but such an individual would be effective with obtaining patient referrals. Also, the executive director of a VNA stated that she seldom needed physician assistance; she estimated that the agency needed only about 9 hours of physician consultation in 1976.

Since some agencies managed without them, we question whether agencies need physicians on their staffs. It would appear that what need there is for physician services can be satisfied more economically on a consulting or fee-for-service basis.

An intermediary official stated that medical directors in home health agencies are used as sales representatives to maximize home health services in the community. He added that there is no need for a medical director in a home health agency and that no patient-physician relationship exists between a patient served by an agency and the agency's medical director. Officials from Chicago's Medicare region generally agreed that home health agencies do not need medical directors, and that those who do have medical directors use them to help increase patient referrals.

Bay Area and HHS/Louisiana commented on the use of medical directors after reviewing our report. Both said that their medical directors were responsible for few referrals and that they were needed and performing a valuable service.

In April 1978--after the completion of our fieldwork--HCFA issued Intermediary Letter 78-16. The letter, in part, addresses the compensation paid to medical directors by home health agencies and requires that agencies specifically document the services they provide and the hours they work. We believe this action should help curtail unnecessary expenditures in this area.

AGENCY STAFFING VARIES GREATLY

Some agencies have substantially more employees than others, and many nonprofit agencies appear to have too many

management and clerical employees. (See p. 7.) Agency administrators are essentially free to organize and staff their agencies as they choose.

The number of field employees--the nurses, physical therapists, aides, and others that make home visits--varies greatly from one agency to another, and the number of employees bears little or no relationship to the number of patients served or visits made. For example, in fiscal year 1976 one agency we visited made more than 38,000 visits (excluding contract visits) with a full-time equivalent field staff of 30 registered nurses and home health aides. In contrast, another agency which provided similar types of visits in the same area made about the same number of visits with a full-time equivalent field staff of 60 people. Each field employee at the first agency averaged about 1,270 visits during the year, while employees from the latter agency averaged only about 650 visits.

The above data are difficult to interpret, but they do raise questions about (1) an agency's efficiency and employee productivity, (2) the quality of care, and (3) utilization. For example, the wide variances in the average number of visits by employees could indicate that one agency's employees are more efficient or productive than another's. It could also indicate that one agency's caseload is too high, thereby possibly adversely affecting the quality of care.

COST LIMITS ARE NEEDED

The Medicare Bureau and HEW have been aware for a long time of the need to contain home health care costs through establishing cost limits or cost guidelines, but they have failed to act effectively. This failure has resulted in Medicare reimbursing home health agencies for excessive costs for home health care.

An old problem

The original Medicare regulations provided that intermediaries were not to reimburse costs which were substantially out of line with comparable providers. Also, in August 1969 the Medicare Bureau issued Intermediary Letter No. 393: "Identifying unreasonable costs--application of the 'prudent buyer' concept." 1/ The letter provided intermediaries some general guidance on how to identify reasonable costs. The letter also pointed out that the Bureau expected

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1/Reasonable costs were discussed genrally; home health costs were not specifically mentioned.

the intermediaries to "have in operation effective means for detecting and investigating situations in which costs seem to be excessive."

Intermediaries historically have had difficulty in applying the reasonable cost concept. Their difficulties are summed up in an intermediary position paper dated December 18, 1969, which was submitted to the Assistant Bureau Director for Intermediary Operations. 1/ The paper states that the "suggestion that a limitation be placed on reasonable costs where such costs are found to be out of line is so undefined and indefinite that a determination cannot be made." The intermediaries' position was that:

> "* * * in the absence of the receipt of prior authoritative written instructions, the intermediaries will make settlement on the basis of full actual experienced costs less all items specifically prohibited by the regulations."

Major problems specifically with home health costs were brought to the Medicare Bureau's attention in 1971. By letter dated May 18, 1971, the Bureau's representative in HEW's Dallas Regional Office advised the Bureau Director of the need for a national policy on reasonable costs for home health agencies:

> "We have been aware for some time of a need for a national policy to guide intermediaries in establishing reasonable costs for home health agencies. It is obvious that many private, non-profit home health agencies are abusing the cost reimbursement provision of the program. To our knowledge the only control over the imprudent, if not irresponsible, financial management of these agencies is determining actual costs are not the reasonable cost."

The regional representative went on to discuss the difficulty faced by intermediaries in trying to apply the principle of reasonable cost:

> "Recently, Texas Blue Cross balked at paying, in the final settlement, some costs purely because they were unreasonable. For example, two agencies which proved actual costs of over $40 per

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1/Reasonable costs were discussed generally; home health costs were not specifically mentioned.

visit were held to $20 in the final cost settlement. However, the manager of Texas' provider audit department told members of our staff that he found himself in an uncomfortable position in cutting back these costs because none of his colleagues in other states were doing it. We suspect that he is correct. So we find ourselves in a somewhat temerarious position in encouraging him to negotiate for lower cost settlements with these agencies when there are no guidelines for him to follow."

The letter also pointed out that in most agencies high costs were attributable to such factors as (1) a large staff, (2) excess administrative staff and high administrative expenses, and (3) high salaries for administrators. In closing his letter, the representative stated:

"We feel that there is an urgent need for national recognition of the reasonable cost issue for home health agencies, and that policies be issued immediately to alleviate this situation."

The Medicare Bureau responded to the Dallas Regional representative by letter dated July 15, 1971:

"We recognize the need for more definitive guidelines for controlling excessive costs in home health agencies. We have been considering additional policies that may be used for determining reasonable costs, but other priorities have delayed any final issuance."

The Bureau also stated that it was going to look into the feasibility of setting salary limits for administrators:

"Your suggestion that salaries of administrators of private, non-profit agencies be limited to the range being paid administrators of VNA's and public agencies in a State is a good one. We will look into the feasibility of this suggestion. However, discretion for its use remains solely with the intermediary which has complete responsibility for determining reasonable costs. Of course, where guidelines in themselves are inadequate the intermediary may use any information at its disposal as a basis for limiting reimbursement of excessive costs."

On October 19, 1971, Medicare Bureau officials met with Blue Cross Association representatives 1/ to discuss a variety of problems. A summary report of the meeting disclosed that, except for certain circumstances, Blue Cross plans were reimbursing incurred costs rather than reasonable costs. 2/ The minutes also noted that the Medicare Bureau's Office of Program Operations planned to "discuss with BCA [the Blue Cross Association] their failure to make reasonable cost determinations as required by law and intermediary contract." However, as far as we could determine the matter was not pursued.

The Social Security Amendments of 1972 became law on October 30, 1972. Section 223 of the law gave the Secretary of HEW specific authority to set cost limits. Specifically, the law allows the Secretary 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." 3/

Data collection of home health agency costs was started in 1973. In April 1974 and again in August 1974, two proposals for implementing section 223 cost limits for home health visits were developed within the Medicare Bureau's Office of Policy. According to Bureau officials, however, the initiative was stopped because the setting of section 223 limits was considered to be contrary to HEW's policy of promoting the use of home health care.

1/In dealing with institutional providers such as hospitals, nursing homes, and home health agencies, the Blue Cross Association is the prime Medicare contractor; the Association in turn subcontracts with individual Blue Cross plans throughout the country.

2/The report addressed reasonable costs in general and not home health costs specifically.

3/It should be noted that under section 223, limits on reimbursable costs are set prospectively and, following public notice by HEW, providers are authorized to charge beneficiaries for the costs or items of service substantially in excess of, or more expensive than, those that are determined to be necessary in the efficient delivery of needed health services.

In September 1977, in an issue/recommendation paper submitted to the Medicare Bureau's Office of Program Policy, HCFA officials from Atlanta, Chicago, Dallas, and Kansas City stated that, except for physical therapy services obtained under contract, 1/ the intermediaries had no specific guidelines to apply when determining the reasonableness of various cost components. Accordingly, they recommended that specific guidelines be established for intermediary use when evaluating the reasonableness of certain operating costs, including: administrative salaries, pensions, office space, furniture and equipment, and transportation; and consulting, billing, and legal services.

More recently, the Division of Direct Reimbursement has developed average-cost-per-visit guidelines 2/ for three types of home health care visits--skilled nursing, home health aides, and physical therapy. The guidelines were developed to help identify those costs considered to be substantially out of line. For each type of visit, the Division of Direct Reimbursement computed 40 separate guidelines; 3/ the guideline to be applied depends on the agency's location and size. The guidelines have been approved by the Medicare Bureau and are to be used for the Division of Direct Reimbursement's providers for all cost reporting periods commencing on or after July 1, 1978.

On July 14, 1978, we met with the Administrator of HCFA and discussed the results of our review. We told him that we believed section 223 limits should be developed with the approach followed by the Division of Direct Reimbursement; that is, to develop cost limits by type of visit. We also told the Administrator that we believed section 223 limits should be developed for certain individual cost elements or groups of cost elements, such as management and clerical costs. The development of limits for individual cost elements or groups of elements would provide further assurance that Medicare will reimburse only reasonable costs; further,

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1/Physical therapy limits were established to implement section 251(c) of the Social Security Amendments of 1972.

2/Guidelines can be developed by individual intermediaries and are applied after the fact. In contrast, section 223 cost limits would be developed by HEW and applied prospectively through publication in the Federal Register.

3/The Division was not able to compute guidelines for all locations and all size facilities because of the lack of data.

the legislative history of section 223 shows that the establishment of such limits for cost elements that are most susceptible to abuse was clearly contemplated.

On August 10, 1978, in testimony before the Subcommittee on Oversight, House Committee on Ways and Means, the Administrator of HCFA stated that HCFA planned to publish in the Federal Register a notice of proposed rulemaking that would establish section 223 limits on overall home health care costs. The Administrator also said that HCFA was going to study the feasibility of establishing a limit on compensation for home health agency administrators. On March 7, 1979, HCFA published in the Federal Register proposed reimbursement limits for home health services, by type of visit.

Significant savings likely

As mentioned earlier, the Division of Direct Reimbursement developed guidelines to help identify those costs that are considered to be substantially out of line. In estimating the potential effect of applying the guidelines to its then 300 providers, the Division estimated that about $300,000 would have been disallowed in fiscal year 1976. Projected nationally, the Division estimated disallowances to be about $13.5 million if the guidelines were applied to all home health providers.

To gauge the effect that the Division of Direct Reimbursement's guidelines (and possibly section 223 limits) would have on the home health agencies reviewed, we applied the guidelines to selected high-cost agencies. Also, for comparison purposes we related the amounts that would have been disallowed to those amounts that were questioned by the intermediary auditors. The results are shown below:

Disallowances Per Application of Substantially Out-of-Line Guidelines in Comparison With Intermediary Audit Disallowances for Fiscal Year 1976

State and agency	Overall cost per visit	Disallowances per Guideline	Disallowances per Intermediary audit
Florida:			
Home Health	$33.26	$242,067	$108,389
Pinellas County	27.49	155,746	12,543
Dade County	26.54	11,200	c/23,229
Hollywood	26.27	-	35,830
Louisiana:			
Capitol	27.41	a/188,167	(b)
HHS/Louisiana	27.53	273,667	80,260
Total		$870,847	$260,251

a/Includes skilled nursing visits only.

b/The intermediary had not yet audited Capitol for cost year 1976.

c/Represents preliminary disallowances based on a field audit.

As can be seen from the above table, the application of the substantially out-of-line cost guidelines generally results in a major increase in cost disallowances. Intermediary auditors have stated that they are reluctant to question claimed costs as unreasonable because they have no basis other than their professional judgment. Further, it is important to note that the intermediary audit disallowances noted above include those costs that are considered to be either unreasonable or unallowable. The cost guidelines, or section 223 limits, only address the reasonableness of claimed costs.

CONCLUSIONS

The costs of providing home health care to Medicare beneficiaries varies greatly, and in many cases the costs appear to be excessive. The Medicare Bureau has not adequately addressed this problem, and only recently has HCFA published proposed limits in the Federal Register.

The approach taken by HCFA--limiting Medicare reimbursement by type of visit--is a sound one. Additionally, while

the establishment of such limits is a worthwhile first step, HCFA also needs to set limits for specific cost elements or groups of cost elements.

RECOMMENDATION

We recommend that the Secretary of HEW direct the Administrator of HCFA to develop section 223 cost limits for individual home health care cost elements or groups of elements, such as management and clerical costs, where this is feasible and appropriate.

HEW COMMENTS

Commenting on our report (see app. III), HEW pointed out that on March 7, 1979, a Notice of Proposed Initial Schedule of Limits, by type of home health visit, was published in the Federal Register. Concerning the development of cost limits for individual home health care cost elements or groups of cost elements, HEW said it would study the matter. In this regard, S. 489--which was introduced on February 26, 1979, and cosponsored by 17 Senators--would require the Secretary of HEW to develop guidelines for specific home health agency line item costs. The bill (The Medicare Home Health Amendments of 1979) is designed to curb excessive Medicare payout for such cost items as transportation, administrative salaries, and fiscal and legal services. Further, the bill requires that such limits be in place within 120 days of enactment.

CHAPTER 3

QUESTIONABLE COSTS HAVE BEEN CLAIMED

The agencies visited were claiming certain costs for Medicare reimbursement which appeared questionable:

--Five agencies visited were claiming costs of fairly substantial amounts that were undocumented and/or unrelated to patient care.

--Two agencies claimed excessive costs for office space which involved less-than-arm's-length transactions. 1/

--Many agencies claimed costs that appeared to be for seeking patient referrals.

--Fringe benefits were being claimed without required prior intermediary approval, and the benefits were being reported throughout the cost report.

HCFA needs to emphasize and strengthen program requirements to preclude unallowable costs from being reimbursed under the program.

COSTS WERE UNDOCUMENTED OR UNRELATED TO PATIENT CARE

Medicare specifically provides that costs not related to patient care are not reimbursable and that all costs claimed must be documented. Five agencies visited, however, incurred and claimed fairly substantial costs that were not related to providing patient care and/or were undocumented.

The Hollywood home health agency, for example, claimed costs related to European trips for its president, treasurer, acting administrator, and their wives. The president stated that they visited Europe to observe the European home health care programs. Agency records did not adequately document the trip's actual costs, but they did show that they visited at least 14 different countries.

1/Transactions between related parties or organizations are often described as "less-than-arm's-length" transactions because the parties are presumed to share a common interest in each other's welfare.

We also noted that Hollywood officials claimed Medicare reimbursement for several other trips, including trips to New Orleans, Boston, and New York. The agency did not document the purpose of these trips and, at the time of our visit, agency officials could not tell us how they were related to patient care. Subsequently, however, the president of Hollywood told us that the trips were made in association with home health programs and conferences.

The agency also claimed expenses for local restaurant charges; flowers for various individuals, including the president's wife; a fishing trip and "boat conference;" and membership in a local country club. Agency officials again could not explain how these expenses related to providing patient care but ultimately acknowledged that personal expenses had been claimed for Medicare reimbursement.

At our request, agency officials analyzed the expenses claimed and filed a revised 1976 cost report. The agency administrator stated that agency officials were billed $28,000 and $2,663 for personal expenses paid by the agency in fiscal years 1976 and 1977, respectively. On June 7, 1978, an agency official stated that about $29,500 had been repaid.

Dade County claimed expenses for a forfeited $1,200 down payment to send three employees to a National League of Nursing Workshop that was to be held in Spain. The executive director stated that he and the others decided not to attend the workshop because he subsequently concluded that the program offered little educational value and, therefore, Medicare probably would not reimburse the associated costs. Dade County also claimed at least $9,924 in inadequately documented and unsupported charges for such items as travel, conferences, professional awareness, and staff education.

Undocumented charges claimed by Home Health included at least $2,445 in unexplained local restaurant charges. The agency's administrator stated that the restaurant charges were incurred in connection with occasional informal meetings with members of the staff held during their lunch hour to discuss agency business. He added that, "based upon the existing regulations, the costs are reasonable, prudent, proper, necessary, and related to patient care." The agency also claimed about $750 in moving expenses for an employee who transferred to Capital Home Health Services, Inc. (See p. 32.)

We do not know the total amount of costs claimed that are unrelated to the provision of home health services;

our review of agency supporting documents was limited to randomly selected expenses. It is also important to note that the above examples were identified in cost reporting periods that at the time had not been audited by the intermediaries and, in the normal course of intermediary audits, it would be reasonable to expect that some of these costs would be identified and disallowed. 1/ Nevertheless, our primary concern is that, although the Medicare program has been operating for over 10 years, providers are claiming reimbursement for undocumented costs and costs unrelated to patient care.

OFFICE SPACE

In Florida, we collected data on the amount of office space that agencies had and what they paid for it; again, we found wide variances. Office space for administrative employees ranged from 95 to 417 square feet per person, and costs ranged from $896 to $2,594 per person. Officials at several agencies stated that they had leased space in anticipation of serving more patients; however, the workload increase never materialized.

In two instances, we noted that excessive costs for space involved less-than-arm's-length transactions. Pinellas County leased its office space from a company owned by the agency's certified public accountant who organized the agency. (See app. II, p. 41.) The accountant purchased the building from a former client and increased the agency's monthly rental charge from $1,000 to $3,000. The accountant stated that the $3,000 represented the fair market value for the area.

Although an appraiser subsequently determined that the space (including improvements made) had a rental value of $2,350 a month, the agency's rent was increased to $3,000 8 months before the improvements were completed. These rental charges will allow the accountant to recoup his cost--about $145,000 for building and improvements--in about 4 years. At the time of our visit, the agency administrator acknowledged that the agency had too much space, but stated that she did not make the arrangements, and that she had no authority to seek other facilities without prior approval from the Board of Directors.

1/Examples of costs not identified as unallowable by intermediary auditors are certain costs claimed by Home Health. The auditors did not disallow the $2,445 in unexplained meal charges at a local restaurant or the $750 claimed for the moving expense discussed on page 20.

Commenting on our report, both the home health agency and the accountant stated that the "going rate" for office space in the agency's area was $7.11 per square foot. The rate is based on a General Services Administration survey of office rental rates in the Florida area.

The test of reasonableness for Medicare reimbursement depends on the specific item in question. In this case, the rate of $3,000 per month ($4.86 per square foot)--effective starting in January 1976 and before building improvements were completed--is not reasonable in our opinion, in view of the appraisal rate. The $2,350 per month appraisal dated July 30, 1976--which considered the building remodeling--translates into a rate of only $3.81 per square foot per month. Furthermore, given that the rental fee represented a less-than-arm'slength transaction, the rate of $3.81 could be further reduced to reflect the actual cost for the space, exclusive of any profit for the accountant under Medicare's related organization rule.

Another indication of the unreasonableness of the accounting firm charges is the rate charged a current sublessor. A sublease was let in August 1978 and, according to the agency administrator, 900 square feet were leased for $350 per month--$4.67 per square foot. This rate is less than the accounting firm's rate, even though the sublease rate was agreed to about 2-1/2 years later than the effective date of the firm's rate.

Hollywood subleased part of its office space--approximately 100 square feet--from a professional association partly owned by the principal organizers and managers of Hollywood. During our review, Hollywood was paying $300 a month for this space--more than four times the lease rate charged the professional association by its lessor. Officials agreed that the charges were excessive, and they stated that the rental charge would be adjusted to a more reasonable rate. Hollywood submitted a revised cost report which reduced fiscal year 1976 space rental costs by $2,400.

PATIENT SOLICITATION COSTS

All of the agencies claimed advertising costs of some type during fiscal year 1976. Medicare allows reimbursement for certain advertising expenses and promotional expenses of a general nature; however, reimbursement of expenses which are intended to increase utilization of agency services or involve the solicitation of patients are not permitted.

Most agencies sent brochures to hospitals, physicians, and patients, and purchased advertisements. Additionally, 9 of the 11 home health agencies we visited also employed full-time individuals often described as hospital discharge planners or coordinators.

The Medicare Bureau has concluded that hospitals and skilled nursing facilities are responsible for all patient discharge planning activities and that any costs incurred by a home health agency in performing such services, on a full- or part-time basis, are not reimbursable. 1/ For the most part, agency records did not document the specific activities of these individuals; however, their primary function appeared to be soliciting patient referrals for their respective agencies.

At the time of our visit, officials at Dade County acknowledged that their discharge planners spent considerable time seeking patient referrals. HHS/Louisiana's monthly reports showed that its discharge planners actively solicited patients. The reports also disclosed that the discharge planners screened records of those ready for discharge and generally selected only those eligible for home health care under Medicare.

A representative of a county medical committee explained that keener competition for Medicare patients results as agencies increase in size and number. He stated that, to obtain patients, agency coordinators and discharge planners visit hospitals, scrutinize patient charts, and solicit doctors and social workers for possible referrals.

One VNA official stated that for 3 years VNA has attempted to understand the rationale for employing hospital coordinators/discharge planners by the nonprofit home health agencies. She said that it is VNA's opinion and observation that utilization of an agency discharge planner is a method of soliciting referrals and, thus, the motive for employing such personnel.

1/This position was set forth in a July 1975 memorandum from the Acting Deputy Director, Office of Program Policy, to the Assistant Director, Office of Central Operations. The position was subsequently reaffirmed in an April 1978 intermediary letter.

The VNA nursing director further explained that, since the hospitals had social workers or nurses trained in discharge planning, the services provided by the agency discharge planners duplicated hospital efforts and increased costs. Officials at four of six hospitals we visited in Florida generally agreed that continuity of care could be assured without home health agency employees visiting hospitalized patients, and that the hospital staffs could perform all home care discharge planning activities.

Hospital officials said that the agency discharge planners simply made their jobs easier. An official at one hospital, however, said that agency discharge planners were needed to prepare a plan of treatment, and at another hospital--which did not have a social services department--an official said that the hospital would have to employ another person if it were not for the home health coordinator. Blue Cross of Florida's medical director stated that agency discharge planners are not necessary for continuity of care and that agencies use them primarily as sales representatives.

There is an extremely fine line between program promotion and patient solicitation and, thus, the regulations are difficult to enforce. This is particularly true when a judgment has to be made on the nature of specific activities of such individuals as discharge planners. In these instances, the intermediary basically has to rely on direct observation, which for the most part is impractical, or the perceptions of others who have observed the activities of such individuals first hand.

Three of the seven home health agencies that provided written comments on our report remarked on the use of discharge planners/coordinators. Two agencies said that they were needed and they provided a valuable service. The other agency (Dade County) denied that the agencies' discharge planners engaged in any questionable practices.

Another problem noted with promotional or educational expenses relates to claims for meals and gifts to physicians and hospital social workers. The Provider Reimbursement Manual does not discuss these types of expenses, yet some agencies claimed these costs for Medicare reimbursement. For example

--Home Health claimed about $750 for gifts (candy, backgammon sets, bath crystals, etc.) for physicians and hospital social workers,

--Hollywood claimed about $4,600 for restaurant charges and about $460 for flowers for business promotions and public relations,

--Bay Area claimed about $2,400 for promotional gifts (desk organizers, memorandum pads, etc.) to physicians and others in the health field, and

--Pinellas County claimed about $2,000 for gifts (pens, letter openers, etc.) to physicians and others in the health field.

Home health agencies, commenting on our report, generally did not see anything wrong with giving physicians and hospital social workers gifts such as those listed above and charging them to the Medicare program. In our opinion, since gifts--no matter how small--are not related to patient care, it is questionable whether the Medicare program should be charged for such gifts.

SALARIES AND FRINGE BENEFITS

Intermediaries are required to consider both salary and fringe benefits when evaluating the reasonableness of employees' compensation. The Provider Reimbursement Manual specifically allows for certain types of fringe benefits (such as vacations, sick leave, and health benefits). Additionally, the manual allows reimbursement for other fringe benefits, providing that prior approval is received from the intermediaries.

The intermediaries reviewed generally did not have adequate control over fringe benefits. According to intermediary officials, fringe benefits were not being approved in advance. Also, present provider cost reporting is not sufficiently detailed to enable intermediaries to determine the nature and total amount of the compensation paid to individuals.

Of particular concern are costs that appear to be fringe benefits--e.g., leased cars for administrative personnel, Christmas parties, and Christmas presents--being reported in cost categories throughout the cost report. An examination of selected costs claimed by three high-cost agencies in Florida disclosed that fringe benefits were being reported in nine different sections of the cost report. For example, Hollywood claimed $11,100 for compensation paid to employees for attending advisory meetings under the subcaption "other,"

which was under the caption "other general costs." Home Health claimed about $930 for a Christmas party under the subcaption "stationery and printing." A considerable amount of detailed audit work would be required to arrive at total compensation for employees of these agencies.

Commenting on our report, Home Health's administrator stated that he believed the $930 cost of the Christmas party to be reasonable. He added that, because the party was held in the agency's office, and not in a hotel or a country club, the agency saved over $7,000 for the party. But our issue here is not reasonableness of costs but where the cost of the party was reported.

CONCLUSIONS

Home health agencies are often unable to support or document costs claimed for Medicare reimbursement, although having a basis for payment is an elementary and integral part of any reimbursement system. HCFA should reemphasize the basic documentation requirements to providers and routinely test their compliance with the requirements.

From a compliance standpoint, the use of discharge planners and hospital coordinators poses an especially difficult problem for HCFA. Essentially, there is an extremely fine line between program promotion and patient solicitation--the former is reimbursable under Medicare, the latter is not. Program instructions should be clarified on the specific types of promotional activities that are reimbursable (particularly for meals and gifts). Providers should also be required to document the scope and nature of the activities of agency employees who are often designated as discharge planners or hospital coordinators.

Home health agency personnel's salaries and fringe benefits should receive closer scrutiny. Program requirements should be reemphasized to providers, and they should also be required to give a detailed accounting of the compensation they pay their employees.

RECOMMENDATIONS

We recommend that the Secretary of HEW direct the Administrator of HCFA to

--emphasize to providers that costs claimed under Medicare must be documented;

--require intermediaries to routinely test, on a sample basis, provider adherence to the documentation requirements;

--clarify and strengthen program instructions for the specific types of promotional activities that are allowable, and require providers to document the scope and nature of the duties of agency employees often designated as discharge planners or hospital coordinators;

--emphasize to home health providers that prior approval is required for those fringe benefits not otherwise specifically authorized; and

--require that home health agencies provide specific reporting on the salaries and fringe benefits furnished to individual employees.

HEW COMMENTS

HEW said that additional instructions emphasizing the program's documentation requirements will be published in early 1979. Also, additional audit resources will be provided to intermediaries to assure that providers comply with program requirements.

With regard to promotional activities, HEW said that in early 1979 additional instructions will be issued to emphasize and clarify the types of expenses that are reimbursable under the program.

Concerning fringe benefits, HEW said it would issue instructions in early 1979 emphasizing that prior intermediary approval for such benefits is required. Also, HEW said that the uniform method of cost reporting being developed for home health agencies would include provisions for specific reporting for employee salaries and fringe benefits.

CHAPTER 4

PROGRAM ABUSES RELATED TO

ESTABLISHING HOME HEALTH AGENCIES

The number of private nonprofit home health agencies has grown significantly in recent years. A major reason for this increase is the efforts of certain for-profit organizations which help establish such agencies and which subsequently do business with them.

The circumstances under which the home health agencies are created have resulted in program abuse. For example:

--The newly created agencies obtain services from the for-profit organizations without the benefit of competition.

--The service contracts of two for-profit organizations are of excessive duration.

--Some of the services provided under the contracts may be unnecessary for providing home health care services.

--Some home health agencies' facilities are used to conduct business of the for-profit organizations at the expense of the Medicare program.

--Frequent examples of self-dealing were noted between the for-profit organizations and the home health agencies.

HCFA needs to take action to preclude Medicare from underwriting such practices in the future.

ABUSES RELATED TO CREATING AGENCIES

We identified five for-profit organizations that helped establish and provide a variety of management assistance to home health agencies. These five organizations assisted with establishing, or providing assistance to, at least 78 different agencies. We visited 14 of these agencies, 12 of which were owned, or managed, or may have been controlled by the for-profit organization. The exact nature of the relationship between the agencies and the for-profit organizations affects the amount of Medicare reimbursement. If the

agencies and organizations are determined to be "related," for example, then reimbursement for services generally is limited to the cost of the services, exclusive of a profit for the for-profit organization.

Two of these organizations, the services they provide, their relationships with the agencies visited, and the related actions taken by HEW are discussed below. Information on two other for-profit organizations is provided in appendix II. The activities of a fifth organization--which are not discussed in this report--have been referred by HCFA's Office of Program Integrity to the U.S. Attorney for prosecution.

Unihealth Services Corporation

The Unihealth Services Corporation is a for-profit corporation located in New Orleans, Louisiana. Unihealth organized home health agencies and, as part of the Unihealth package, the agencies entered into long-term contracts with Unihealth for accounting, data processing, and other management services. At one time, Unihealth had long-term contracts with as many as 25 agencies; however, Unihealth told us that as of November 1978 it had only 17 clients.

We visited three Unihealth agencies--HHS/Louisiana, Capitol, and Dade County--and each agency had signed a 35-year contract for Unihealth services. 1/ In fiscal year 1976 Unihealth contract costs claimed by these agencies for Medicare reimbursement were $70,858, $52,111, and $59,303, respectively. In addition, one of the principal owners of Unihealth also owned HHS/Louisiana, and he and another Unihealth executive worked for this agency as part-time medical directors. In fiscal year 1976 HHS/Louisiana paid them $24,828 in salaries, automobile allowances, and health and retirement benefits.

The Unihealth contracts provide for four basic types of services--planning, organizational and continuing management, professional consulting, and data processing services.

1/On July 20, 1978, Unihealth forwarded to at least one of its agencies a proposed contract to replace the existing contract; the term of the new contract is 3 years. Further, on November 14, 1978, Unihealth told us that all of its clients received similar proposals.

Unihealth helps the agencies get established in the planning and organizational phase. According to the contract, Unihealth, among other things, (1) assists the agencies with meeting all Federal, State, and local certification requirements, (2) trains agency staff and assists in establishing office facilities, and (3) provides any other assistance the agencies need to qualify as home health care agencies. Unihealth charges a fixed fee of $12,500 for these services. 1/

Once the agencies are certified and begin operations, Unihealth assists with managing the agencies and provides accounting, data processing, professional consultation, and general home health supplies. The contracts, among other things, require Unihealth to

--provide at least three onsite visits during the first 6 months of operation and at least one onsite visit during each 3-month period thereafter, or as necessary;

--establish training programs and annual seminars for agency executives and administrative personnel;

--provide telephone consultation during normal working hours and train all new executive personnel during the term of the agreement;

--provide operating manuals and help develop operating budgets and cash flow projections; and

--provide any other management or consulting service as considered necessary.

For these continuing services, the agencies agree to pay Unihealth a monthly fee of $200 for the first 6 months and $400 for each month thereafter, or a sum equal to 7 percent of the agencies' monthly gross billings or receipts,

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1/The contracts with HHS/Louisiana and Capitol did not include charges for these services.

whichever is greater. 1/ The Unihealth contract also provides that Unihealth will not hold the home health agency liable for payment should Medicare disallow any or all of the fees charged.

A comparison of management and clerical costs incurred by two agencies reviewed in Louisiana shows that the costs for the agencies serviced by Unihealth are significantly higher. For example, in fiscal year 1976 Golden Age incurred management and related costs of about $129,000, of which about $21,000 was for outside legal, accounting, and data processing. By comparison, HHS/Louisiana--located in the same geographic area, serving fewer patients, and mading fewer visits than Golden Age--incurred about $291,400 in similar administrative costs, $99,790 of which was paid for outside services, including $70,858 paid to Unihealth. The administrative cost for each home visit by Golden Age and HHS/Louisiana averaged $2.76 and $6.74, respectively.

Agency officials at Capitol and Dade County stated that they were unhappy with the Unihealth arrangement and that they would like to terminate the contracts. 2/ They acknowledged that Unihealth charges were excessive and that some of Unihealth's services were not needed. The Dade County executive director stated that he would prefer to use a local accounting firm, did not need Unihealth's consulting services, and could purchase supplies cheaper from other sources. Commenting on our report, Unihealth said that the existing contract with Dade County was for a 3-year period and covered only data processing services. The 35-year full-service contract apparently has been terminated.

1/Though the contracts require payment of 7 percent, Unihealth's executive vice president told us that actual charges are now based on a sliding scale--7 percent for the first $30,000 of monthly agency billings to 1 percent of billings in excess of $130,000. Under a provision in proposed legislation (H.R. 5285), as approved by the Senate Finance Committee in August 1978, such percentage arrangements would not be recognized for cost reimbursement under Medicare.

2/It cost one agency more than $70,000 to terminate a similar contract with Unihealth.

We also found that Unihealth had contracts with individuals who--for a percentage of Unihealth fees--actively sought clients for Unihealth. At least 14 agencies had been referred to Unihealth by individuals who had signed contracts to solicit business for Unihealth. We determined that Unihealth agreed to pay two individuals who had referred eight agencies 30 percent of Unihealth's initial organization fees ($12,500 for each agency) and 3 percent for all subsequent amounts received from each agency. Medicare's Provider Reimbursement Manual prohibits reimbursement of salesmen's fees. Unihealth stated in November 1978 that "no individual is receiving funds from Unihealth as a commission for services rendered in referring clients to Unihealth."

During our work at HHS/Louisiana, we noted that the agency had claimed telephone and telegraph costs that were much higher than the costs claimed by the other agencies visited in Louisiana. HHS/Louisiana claimed $26,101, while Capitol and Golden Age claimed $12,803 and $7,686, respectively. Part of the reason for this high cost is that 15 of the phones were Unihealth extensions. Unihealth and HHS/Louisiana are located in the same office building.

Commenting on our report, Unihealth said that we implied "that Home Health of Louisiana was paying for the Unihealth phone bill * * * which was not the case." HHS/Louisiana, however, acknowledged that the agency in fact did pay for the 15 Unihealth extensions, and that the cost was about $100 per month. The agency explained that, in consideration for the fee it paid Unihealth, two full-time employees of Unihealth served as administrator/comptroller and director of nurses; consequently, it was necessary that some of the phones from the agency's switchboard terminate in Unihealth phones. Although this explanation could account for 2 phones, it leaves 13 phones unaccounted for.

Capital Home Health Services, Inc.

Capital Home Health Services, Inc., of Hallandale, Florida, is a for-profit management firm that operates similarly to Unihealth. Capital had long-term management contracts with nine home health agencies as of May 1977.

One Capital agency--Home Health--was managed by Capital's owner and obtained services from other Capital officials. We found that:

--Capital's owner served as Home Health's administrator and president. Home Health paid the administrator salary and fringe benefits of more $43,000 in fiscal year 1976. The agency also furnished him an automobile and paid its operating expenses.

--Capital's president and legal advisor served on the Home Health Board of Directors; he was also on retainer for legal services at Home Health. The agency paid him a retainer fee of $6,000 in fiscal year 1976.

--A CPA who was the vice president at Capital served as the Home Health independent public accountant. Home Health paid his accounting firm $40,000 during fiscal year 1976.

Home Health had a 29-year contract with Capital which provided for essentially the same services as Unihealth's contracts. In fact, Capital's owner stated that he used the Unihealth contract for designing and developing the Capital contract with Home Health. Like Unihealth, Capital charged a fixed fee ($10,000) for organizing home health agencies and its ongoing management charges were either $400 a month for the first 6 months and $800 a month thereafter or a sum equal to 7 percent of the agency's gross billings, whichever was greater. Also like Unihealth, the Capital contract appears to allow Capital to exercise substantial control over or influence in the operations and management of its affiliated agencies. Home Health paid Capital more than $90,000 in fiscal year 1976.

Concerning the accounting services from Capital's vice president, the Home Health administrator stated that he allowed the accounting firm to provide, and get paid for, whatever services it believed necessary, and that he never asked the accounting firm what it charged for its services. He acknowledged that, in retrospect, the accounting fees ($40,000) appeared quite excessive and that in the future the agency would be more selective in the services obtained from this firm. The accounting firm also provided accounting services for at least one other agency organized by Capital.

We also believe that there was a duplication of accounting services. Capital provided, or at least billed for, accounting services throughout the year based on a percentage of gross revenues, even though the agency had paid the accounting firm of Capital's vice president $40,000 for such

services. Also, for about 6 months of the year Home Health had a controller who had previously worked as a home health specialist for Blue Cross of Florida.

Another abuse noted was the use of home health agency space and telephones to further Capital's interest. Commenting on our report, however, both Home Health and Capital denied this and stated that there are separate leases and phone billings for the two organizations.

Capital and Home Health share the same office building floor but are in fact billed separately for the space they lease. Nonetheless, it appears that some of Home Health's space has been used for Capital business. The lease space occupied by Capital consisted of one room which amounted to about 260 square feet and, during our visit, it appeared that the office space was used primarily in connection with data processing for Capital agencies. Home Health leased about 4,700 square feet.

One Capital employee--a former employee of Home Health--occupied an office in Home Health space. Also, both the administrator (Capital's owner) and nursing director of Home Health (who also occupied Home Health space) admitted to spending time on Capital business. In fact, the administrator has a Capital phone on his desk. No adjustment reflecting the use of Home Health space for these purposes was made on the fiscal year 1976 cost report submitted by the agency.

Capital and Home Health are also billed separately for telephone services. Home Health claimed about $27,000 on its cost report for telephone/telegraph services for fiscal year 1976. However, an examination of the toll calls made during a 2-month period in 1976 and charged to Home Health disclosed calls that appear to have been made in connection with Capital activities. About one-third of the 107 long distance calls made during the period and billed to Home Health were made to or from other home health agencies that were served by Capital. We also noted in a letter to a Capital home health agency that the agency was instructed to call a Home Health number in connection with Capital business.

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The general tone of the comments on our report submitted by the four for-profit organizations was one of disagreement. The organizations did not see anything wrong with the way they have operated, and they felt that they were not guilty of any

program abuse. We disagree and believe that the facts as presented above and in appendix II indicate that program abuses have occurred.

ACTIONS BY THE MEDICARE BUREAU AND FISCAL INTERMEDIARIES

Unihealth

The Medicare Bureau and the fiscal intermediaries have initiated some action to evaluate the reasonableness of Unihealth charges, but much more remains to be done.

Initially, the Medicare Bureau considered Unihealth a provider of management services. In 1976, however, the Bureau changed its position and ruled that the contracts between Unihealth and its affiliated agencies were in the nature of franchise agreements. Some of the factors that led to this determination and which were found in the Unihealth contracts were:

--The agency shall purchase Unihealth manuals.

--The agency shall purchase Unihealth business forms.

--Unihealth has the right to examine the agency's books.

--The agency must pay Unihealth a licensing fee.

--The agency may not assign the contract to a new owner without Unihealth's consent.

--The term of the contract is for 35 years.

--The agency is prohibited from establishing another known health agency within 50 miles should the agreement between the provider and Unihealth terminate.

--Unihealth establishes performance standards with which the agency must comply or risk termination of the contract.

Based on this decision, the Medicare Bureau concluded that the reasonableness of Unihealth charges should be determined in accordance with section 2133 of the Provider Reimbursement Manual. This section provides that franchise fees are not patient related and, accordingly, should not be reimbursed. The manual also specifies that the costs of the services provided must be reasonable to be reimbursable.

On November 3, 1976, the Medicare Bureau advised the intermediaries that audit Unihealth agencies that the reasonableness of Unihealth charges should be determined by comparing the charges--by type of service--with charges for similar services provided by other organizations. The Bureau also advised intermediaries to reevaluate previously settled cost reports filed by Unihealth agencies. Only one cost report had been reopened and settled by this approach as of May 1978. The reevaluation resulted in a downward adjustment of about $16,000.

On October 6, 1977, Unihealth sued HEW over its decision to analyze Unihealth costs as if it were a franchise operation. A decision on the matter was not reached, however, because on February 14, 1979, the court ruled that it did not have jurisdiction over the matter. This decision has been appealed by Unihealth.

Capital

As of May 1978 the Medicare Bureau had not addressed the nature of the relationship between Capital and the agencies it serves. Further, no action has been taken to determine the need for Capital's services or the reasonableness of its fees.

The fiscal year 1976 cost report filed by Home Health had not been reviewed and settled by the fiscal intermediary at the time of our review. In reviewing Home Health's 1975 cost report, the intermediary auditors concluded that Capital's services had been obtained from a related organization and that reimbursement should be limited to Capital's cost for providing the services, as required by Medicare regulations. However, they could not determine Capital's costs because its owner denied them access to Capital records. The auditors disallowed practically all costs claimed for payments to Capital as a result. Although the auditors did not apply the related organization principles when determining the reasonableness of the 1975 legal and accounting costs, they reduced the amounts claimed from $30,889 to $14,400, based on the auditor's opinion that the costs as claimed were unreasonable. However, all fiscal year 1975 costs questioned by the intermediary have been appealed by Home Health.

Capital's other home health agencies were relatively new at the time of our review and, as such, had not been audited by the intermediary.

CONCLUSIONS

The circumstances under which for-profit organizations have established nonprofit home health agencies have resulted in program abuse. Without competition, these organizations arrange to provide agencies various management and related services; the need for some of these services appears questionable.

Entering into costly service contracts for 35 or 29 years is hardly indicative of prudent management. To prevent such future occurrences, home health agencies should be required to obtain prior intermediary approval for contracts whose costs exceed a specified amount and/or whose term exceeds a specified period of time. We believe $25,000 in the aggregate and 3 years are reasonable limits in this regard.

RECOMMENDATION

We recommend that the Secretary of HEW direct the Administrator of HCFA to require prior intermediary approval of home health agency contracts whose costs exceed a specified amount and/or whose term exceeds a specified period of time.

HEW COMMENTS
AND OUR EVALUATION

Commenting on the above recommendation, HEW pointed out that the duration of contracts was addressed in an intermediary letter issued in September 1978:

> "Where a provider has executed a management services or management consultative services contract of more than 5 years' duration, the costs incurred for services furnished after the 5th year of the contract should not be recognized as a necessary and proper cost by the Medicare program, unless the provider establishes to the satisfaction of the intermediary that these services, at the time they are delivered, are necessary and proper and their costs reasonable as determined by the intermediary in accordance with the applicable sections of program law, regulations and general instructions in effect at the time these services are received. Services furnished during each of the first five years of these contracts as well as the yearly services furnished under contracts of less than 5 years'

duration must always be evaluated by the intermediary to determine the necessity of the services actually made available or received and the reasonableness of the costs of these services."

The above action does not satisfy the intent of our recommendation. The letter is essentially a restatement of existing program requirements that intermediaries reimburse only necessary and proper costs.

The intent to enter into long-term contracts should be considered prima facie evidence that a provider is not acting prudently; accordingly, the intent to proceed in such a manner should be required to be brought to the intermediary's attention. Further, the Bureau's action does not address the various ramifications created by the retroactive denial of a long-term contract. For example, should an intermediary deny payment for all or a major part of such services, providers--and particularly those with 100-percent Medicare clientele--could find themselves legally liable for paying for the services provided, but without the funds to satisfy their obligations.

LIST OF HOME HEALTH AGENCIES WE REVIEWED

Agency name	Agency type
Florida:	
Home Health Services of Dade County, Inc. (Dade County)--North Bay Village	Private nonprofit
Home Health Services of the United States, Inc. (Home Health)--Hallandale	Private nonprofit
Hollywood Home Health Agency, Inc. (Hollywood)--Hallandale	Private nonprofit
Bay Area Home Health Services, Inc. (Bay Area)--Pinellas Park	Private nonproft
Visiting Nurse Association of Broward County (Broward County VNA)--Fort Lauderdale	VNA
Home Health Care of Pinellas County, Inc. (Pinellas County)--St. Petersburg	Private nonprofit
Medi-Health, Inc. (Medi-Health)--Fort Lauderdale	Private nonprofit
Visiting Nurse Association of Hillsborough County, Inc. (Hillsborough VNA)--Tampa	VNA
Louisiana:	
Home Health Services of Louisiana, Inc. (HHS/Louisiana)--New Orleans	Proprietary
Capitol Home Health Services, Inc. (Capitol)--Baton Rouge	Proprietary
Golden Age Home Care, Inc. (Golden Age)--Metairie	Proprietary

ADDITIONAL EXAMPLES OF ORGANIZATIONS THAT ASSIST WITH ESTABLISHING HOME HEALTH AGENCIES

Medipatient Home Health Care Consultants, Inc.

Medipatient, a Chicago for-profit firm, helped establish home health agencies and provided them ongoing data processing and management services. At least seven home health agencies had been organized by Medipatient, and each agency had signed contracts for Medipatient's data processing and management services.

Medipatient's standard charge for helping establish an agency was $15,000. Charges for data processing services were based on the number of home visits made by an agency--$1.50 for each visit made, a one-time setup charge of $900, and a monthly fixed charge of $95. Medipatient's charge for ongoing management services was $12,000 for the first year, $15,000 for the second year, and $12,000 for each year thereafter. These charges were, however, subject to annual increases based on the cost-of-living index.

One agency established by Medipatient is the In-Home Health Care Service of Suburban Chicago North, Inc. This agency paid Medipatient about $29,900 for data processing and management services in 1976. The agency's executive director previously worked full time for Medipatient's owner; he was subsequently employed by Medipatient as a home health agency financial consultant. In 1976 Medipatient paid him about $10,800 for his services. Blue Cross records show that the executive directors of two other home health agencies having contracts with Medipatient were also Medipatient health consultants.

A Blue Cross of Chicago official stated that Medipatient did not have computer hardware and software; it obtained its computer services from Diversified Computer Applications for approximately $0.50 to $0.60 a visit. Blue Cross said that Medipatient agencies mailed their input data directly to Diversified Computer Applications and received data processing output directly from them. Furthermore, Blue Cross has concluded that the additional charge between that levied by Diversified Computer Applications ($0.50 to $0.60) and that charged by Medipatient ($1.50) is unnecessary, and cost adjustments have been made in cost reports filed by those agencies affiliated with Medipatient.

By letter dated December 7, 1978, attorneys for Medipatient told us that the company ceased operations on June 30, 1978. Cost disallowances by the intermediary caused Medipatient's client agencies to cancel their contracts and prompted Medipatient's decision to cease operations.

Thomas J. Merlo and Company

This company is a public accounting firm located in Miami, Florida, that organizes and provides accounting services to home health agencies. Attorneys for the firm advised us that:

> "At one time or another Merlo and Company may have represented and performed some type of service for twenty (20) different agencies. The services could have been rendered to people who were considering going into the home health agency field, already existing agencies, or newly proposed agencies."

Unlike other for-profit organizations, the firm did not enter into long-term contracts, and the firm's accounting fees are generally based on the number of hours worked.

Five of the agencies were each charged $20,000 for organization and startup costs. 1/ These agencies also appear to be controlled or related to the firm. The firm's owner

--provided free office space to the agencies' bookkeeper, who works in the firm's office;

--financed the agencies through personal loans of $168,000; and

--provided the agencies accounting services.

Mr. Merlo stated that the use of one bookkeeper precluded the need for each agency to employ such an individual. He also stated that he loaned the agencies money because no one else would.

1/For one of the home health agencies, the firm received only $10,000; the remaining $10,000 was paid to two officials of the Hollywood home health agency.

The Board of Directors for four agencies were the same. Two of the three original board members were employees of the firm, while the third board member stated that he was asked by Thomas J. Merlo to serve on the board. Attorneys for the firm stated that other parties, not Mr. Merlo, selected the Board of Directors. For the fifth agency, which was located in Baltimore, Maryland, Mr. Merlo's sister was on the Board of Directors.

The firm was also involved in charging one of the agencies an excessive rental fee. (See p. 21.) As of July 5, 1978, the Medicare Bureau had taken no specific action on the activities between Thomas J. Merlo and Company and the home health agencies that the company has organized.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C 20201

MAR 29 1979

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Home Health--Tighter Fiscal Controls Needed." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

STATEMENT OF DEPARTMENT ACTION

Comments of the Department of Health, Education, and Welfare on the General Accounting Office's Draft Report entitled, "Home Health -- Tighter Fiscal Controls Needed," B-164031 (3), dated November 3, 1978

Overview

In the summer of 1975, the Atlanta, Georgia, Medicare regional office reported that the number of home health agencies in Florida was increasing. Most of these new agencies are operated by family-sponsored private nonprofit corporations for the sole purpose of furnishing medically necessary health care services to homebound Medicare beneficiaries. Once these agencies start to participate in the Medicare program, Medicare becomes their only source of patient care revenue. Despite the nonprofit character of these corporations, they are neither cost conscious nor prudently operated from a Medicare standpoint. Consequently, they incurred operating costs not typical of the long-standing public and voluntary home health agencies that furnish a similar range of health care services to a mix of patients, without regard to the patient's health care insurance status.

In late 1975 and early 1976, the Atlanta regional office reported further findings on these matters. Mainly, they found the costs fell into the category of administrative operating costs, and were either unreasonable in the amount or unnecessary by comparison to the public and voluntary agencies.

The cost and the regional office's concerns about them are similar to the type of costs identified and concerns expressed in the findings and recommendations outlined in the GAO report. These findings and concerns were the basis of the GAO's audit activity which culminated in this report.

As stated in the GAO report, home health agency records audited had not yet been reviewed by the Medicare intermediaries servicing these agencies. Despite this fact, the GAO speculates that only some of the questionable costs discovered would have been noted and properly acted on by intermediaries.

In recognition of the practical operating restraints intermediaries experience, primarily from an audit staff standpoint, it has been necessary to concentrate and direct intermediary provider audit activity towards that segment of the health care industry (hospitals) which receives the bulk (94-96 percent) of the funds disbursed from the Federal Hospital Insurance Trust Funds.

We concur with GAO's overall recommendation that the Medicare program examine more closely the operating costs incurred by home health agencies and claimed for Medicare reimbursement. We have completed and have underway a number of actions which will address home health agency operating costs through the Medicare reimbursement process.

GAO Recommendation

That the Secretary of HEW direct the Administrator of HCFA to:

-- Develop section 223 cost limits by type of home health care visit.

Department Comments

We concur.

A Notice of Proposed Initial Schedule of Limits, by type of home health visit has been published in the Federal Register on March 7, 1979. The Medicare regulation which implements the reimbursement limits authority in the Medicare law requires that reimbursement limits be applied prospectively. Application of these limits will have to take into account the varied methods of cost finding currently available to home health agencies. A single method of cost finding and a uniform method of cost reporting also are being developed.

GAO Recommendation

That the Secretary of HEW direct the Administrator of HCFA to:

-- Develop section 223 cost limits for individual home health care cost elements or groups of elements, such as management and clerical costs, where feasible and appropriate.

Department Comments

We concur with the objective of this recommendation.

Our first priority in this matter of Medicare reimbursement limits on home health costs has been to issue limits by type of home health visit. After these limits have been published in final form, the data collection necessary to establish limits on elements of cost can begin. The need to impose limits on elements of cost will depend on the effect the overall limits have on per-visit costs.

GAO Recommendations

That the Secretary of HEW direct the Administrator of HCFA to:

--emphasize to providers that costs claimed under Medicare must be documented; and

--require intermediaries to routinely test, on a sample basis, provider adherence to the documentation requirements.

Department Comments

We concur.

Current Medicare regulations and general instructions require home health agencies, as well as all other classes of providers receiving Medicare reimbursement on the basis of reasonable cost, to maintain adequate data, both statistical and financial, on individual elements of costs. These regulations and general instruction further require that this data be capable of verification by qualified auditors. We will publish, in early 1979, additional instructions which emphasize that such documentation must exist.

Increased funds have been made available to intermediaries to audit home health agency fiscal records to assure these agencies comply with Medicare's regulatory cost reimbursement principles and general program instructions.

GAO Recommendation

That the Secretary of HEW direct the Administrator of HCFA to:

--clarify and strengthen program instructions with regard to the specific types of promotional activities that are allowable and require providers to document the scope and nature of the duties of agency employees often designated as discharge planners or hospital coordinators.

Department Comments

We concur.

Instructions which explain, in considerable detail, the Medicare principles, instructions and policies on the allowability of costs generated by home health agency advertising activities and the activities home health agencies engage in to assist hospital discharge planners were issued in April 1978 and again emphasized in instructions issued in September 1978. Additional instructions will be issued in early 1979 to further emphasize and explain these requirements. The instructions issued to date clearly define

allowable and unallowable advertising costs and clearly explain that costs home health agencies incur to assist hospitals to perform hospital patient discharge planning are not an allowable cost of the home health agency for Medicare reimbursement purposes.

GAO Recommendations

That the Secretary of HEW direct the Administrator of HCFA to:

--emphasize to home health providers that prior approval is required for those fringe benefits not otherwise specifically authorized; and

--require that home health agencies provide specific reporting on the salaries and fringe benefits furnished individual employees.

Department Comments

We concur.

Current instructions require that fringe benefits not specifically identified in these instructions receive prior approval of the provider's Medicare intermediary before the costs of the fringe benefit can be included in the provider's allowable costs. We will publish additional instructions in early 1979 which emphasize this requirement. Increased funds have been made available to intermediaries to audit home health agency fiscal records to assure compliance with Medicare's regulatory cost reimbursement principles and general program instructions.

The uniform method of cost reporting being developed for home health agencies will require the specific reporting of employee salaries and fringe benefits by functional cost center.

GAO Recommendation

That the Secretary of HEW direct the Administrator of HCFA to:

--require prior intermediary approval for home health agency (management services) contracts whose costs exceed a specified amount and/or whose term exceeds a specified period of time.

Department Comments

We concur with the intent in this recommendation that purchased management services be necessary and their cost be reasonable.

Instructions were issued in September 1978, concerning these costs. These instructions require intermediaries to apply Medicare reimbursement principles and policies to costs of purchased management services.

In addition, instructions are being issued to HCFA regional offices requiring these offices to determine, where such contracts exist, whether the HHA is in compliance with the regulatory requirement that the administrative and supervisory function of an HHA not be delegated to another agency or organization.

In addition to our comments on the above recommendations, the following actions also relate to our efforts to contain home health agency operating costs:

1. National data on Home Health Agency Visit Costs were provided to all intermediaries to assist them in developing guidelines for use in evaluating the reasonableness of agency costs.

2. The Medicare Bureau's Division of Direct Reimbursement (DDR), which services 391 home health agencies, has developed reasonable cost-per-visit guidelines as described in the GAO report. These guidelines are currently being applied to all agencies services by DDR for cost reporting periods beginning on or after July 1, 1978.

3. Instructions are being prepared for release by April 1979 directing intensified intermediary review of Medicare home health care billing forms submitted by proprietary and private nonprofit home health agencies.

As mentioned in our overview comments, the GAO audit findings in this draft report were discovered at 11 home health agencies whose fiscal and accounting records (for the years audited by the GAO) had not yet been audited by the Medicare intermediaries for these agencies. The Medicare cost report settlement process requires that claimed costs be reviewed by the intermediary audit staff to assure that Medicare reimburses only costs which are both reasonable in amount and necessary to the overall production of the medically necessary health care services the provider-furnished Medicare beneficiaries. This settlement process results in the disallowance, i.e., the nonrecognition by Medicare, of costs not related to patient care and the unreasonable amount of otherwise allowable costs.

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