

# California Operation Restore Trust Steering Committee

## MEDICARE HOME HEALTH: Eliminating Fraud, Abuse, and Waste



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# INTRODUCTION

## PURPOSE

This report summarizes the findings and recommendations of a California Operation Restore Trust meeting in which focus group participants discussed fraud, abuse, and waste in the Medicare home health benefit.

## BACKGROUND

Operation Restore Trust (ORT) is a two-year initiative designed to address Medicare fraud, waste, and abuse in nursing homes, durable medical equipment, and home health in the five states with the largest Medicare populations (California, Texas, New York, Florida, and Illinois). The ORT is unique in that officials from all agencies involved in eliminating fraud, waste, and abuse have been given the necessary tools and the mandate to work together as a unified team. Officials from the Health Care Financing Administration (HCFA), the Office of Inspector General (OIG), the Administration on Aging, and the Department of Justice are the principal participants in the ORT initiative.

To help identify problems and develop possible solutions concerning the Medicare home health benefit, the California ORT Steering Committee convened a meeting of representatives from HCFA, the OIG, fiscal intermediaries, and the regional attorney's office. Most of the participants have been working with California home health agencies (HHAs) since the beginning of ORT. A few home health experts from other states were included to provide different perspectives and to determine if the problems identified in California are also problems in other ORT states.

During the meeting, attendees participated in each of three different focus groups: licensing and certification; coverage and payment policy; and medical review and quality of care. The focus group format was used because it allows participants from different disciplines and backgrounds to share, discuss, and deliberate their varied experiences and arrive at some agreement concerning problems and potential solutions. The goal of the sessions was to maximize interaction among participants. Moderators were present to stimulate conversation, control the general flow and content of the discussion, transcribe, and summarize.

This report is a summary of the issues and possible solutions discussed in the nine different focus groups. The California ORT Steering Committee recognizes that a considerable amount of work has been done by HCFA and others to identify and correct deficiencies in the home health benefit and that some of the things mentioned in this report may be redundant. Nevertheless, we believe the concerns are still valid and need to be addressed as quickly as possible through changes in law, regulation, or policy. We would also like to caution the reader that, because participants were asked to be creative and not restricted by their

paradigms, some of the suggested solutions may seem iconoclastic or unrealistic. Nevertheless, they are worth considering and evaluating, since they represent the combined thinking of a group of people who are deeply concerned about the integrity and financial viability of the Medicare program and, specifically, its home health benefit.

The report consists of several general findings, each of which includes numerous problems/vulnerabilities. The findings are intended to give some organization to the report, although they are inter-related and some of the problems/vulnerabilities overlap. Immediately following the list of vulnerabilities is a list of suggested solutions. Next to each suggested solution is a symbol indicating if the solution requires a legislative change or if it can be accomplished by HCFA through a regulatory or policy change.



The "HCFA" symbol means that a change in HCFA policies and/or regulations is necessary.



The "Bill" symbol means legislation is necessary.

## **THE CERTIFICATION PROCESS DOES NOT PREVENT PROBLEM PROVIDERS FROM ENTERING AND RE-ENTERING THE MEDICARE PROGRAM**

One of the best ways to reduce fraud, waste, and abuse in the Medicare program is by assuring that only home health agencies with experience in the provision of health care, who are fiscally sound and responsible, can obtain Medicare certification. If more resources and more stringent requirements were part of the certification and recertification process, HCFA could prevent dishonest and incompetent providers and their owners from entering the Medicare program. Focus group participants rated the provider screening and certification process as one of the most important oversight functions for the Medicare program.

Currently, the licensing and certification process for HHAs is inadequate and ineffective. It is too easy to enter the Medicare program. Anyone, regardless of business or health care experience, can become a home health provider. Even individuals who have been part of HHAs that have defrauded the government, been decertified, or declared bankruptcy (and still owe the program millions of dollars in overpayments) can figure out a way to bill and be paid by Medicare. Because HCFA lacks the authority, resources, and tools to properly certify home health agencies, nothing discourages, inhibits, or prevents the same unscrupulous entrepreneurs from continuing to take advantage of the Medicare program and its beneficiaries.

### **Problems/Vulnerabilities:**

- ☛ **The Standard Survey, which covers only about half of the conditions of participation, does not properly screen providers.** There are three types of surveys for HHAs: a standard survey, a partial extended survey, and a full extended survey. The standard survey, performed at initial application and repeated for annual recertifications, covers only 5 of the 12 conditions of participation and 1 standard. The other surveys are performed only if the state identifies problems in the standard survey.
- ☛ **HCFA makes certification and recertification decisions too quickly.** The HCFA does not take enough time to consider all the aspects of each application and does not require that each item on the application be fully and accurately completed. This has resulted in providers entering the Medicare program who should never have been certified.
- ☛ **HHAs put up facades to pass the initial certification requirements.** Often, HHAs hire temporary consultants who act as principals in the business until certification is granted. After certification, the consultants leave. The organizational structure changes, and the HHA operates without the basic business structure required in HCFA's conditions of participation.
- ☛ **It is too easy to reenter the Medicare program following decertification and/or bankruptcy.** HHA owners have found ways to enter the program using new corporations, owners, and/or by setting up nurse registries that contract with certified

HHAs to bill the program on their behalf.

- ☞ **Tracking and identifying owners and their interests in other HHAs is problematic.** The current tracking system is manual, although an automated system is planned. Individuals with 5 percent ownership or more must be disclosed. An individual could own just under 5 percent in multiple HHAs and never be identified on disclosure forms.
- ☞ **Instead of waiting for recertification, providers dissolve their business and open as a new entity.** The HCFA requires a reasonable assurance period, which is at the discretion of the HCFA regional office, before a decertified provider can re-enter the program. However, a new entity does not have to follow these rules.
- ☞ **Sanctioned providers reopen with relatives and/or friends as new owners.** This is allowed because the sanction applies only to individuals.
- ☞ **Bankruptcy protects individuals from Government sanctions.** Following bankruptcy, individuals are free to start new corporate entities, since the bankruptcy applies only to the defunct corporation.
- ☞ **Contracting for services allows a decertified provider to reopen as a registry without Medicare certification.** A registry can potentially bill through a certified HHA and receive Medicare payments through one or more HHAs.

### Suggested Solutions:



Limit new providers to a conditional or provisional certification for 6 months or 1 year. Certification should not be granted until the HHA has demonstrated its ability to meet all of the Medicare conditions of participation through an on-site medical review, an on-site audit, and a complete review of the HHA's organizational structure.



Require a prior track record. For example, require that an HHA is licensed and functioning for 6 months or longer before it can apply for Medicare certification. Requiring prior experience is good business. It's okay to set arbitrary requirements to protect Medicare and its beneficiaries.



Limit the number of Medicare beneficiaries that the HHA can serve during the provisional certification period and never allow its Medicare patient load to exceed 50 percent of its total business.



Require applicants to post bonds. Bonding would eliminate providers with inadequate financial resources as well as prior criminal records. Bonding builds in legitimacy and would eliminate some of the disreputable HHAs. Fly-by-night

agencies wouldn't be able to get a bond and couldn't become Medicare providers. The bond should be at least \$1 million or equal to the anticipated Medicare receivables during the first year of operation. If the HHA receivables exceed the amount of the bond, the bond must be increased accordingly. If there are overpayments, HCFA should be able to recoup money from the bond or require that the amount of the bond be increased in order for an extended repayment plan to be approved. The bond should not be considered a reimbursable cost for cost report purposes. Note: The Medicare law allows bonding, but the provision has never been implemented.



Use the extended survey for all initial HHA certifications. Consider eliminating "deemed status" for any HHA.



Require immediate notification of changes in structure, ownership, or principal officers. (Current regulations require notification but are vague on timing and exactly what needs to be reported.)



If an HHA owner owes Medicare money, do not grant new certification until the debt is fully repaid.



Require owners (board members and principals as well) to provide their Social Security numbers (SSNs). Expand the SSN requirement to immediate family members. (Medicare regulations already require some of this under program integrity disclosure requirements, but it's not enforced.)



Impose penalties for failure to provide timely notification of changes in organizational structure, ownership, or principals.



If an HHA does not disclose ownership information, decertify it.



Redo Form 1513 (disclosure form), and use it to set up a database. The HCFA central office should maintain the database, with regional office access. Data elements for all owners should include: name, SSN, percent of ownership, prior convictions, names of other companies owned, overpayments written off, business failures, and prior decertifications. The HCFA should collect similar information on family members and other principals in the business. The forms should be retained for 7 years (HCFA now purges much earlier).



When HHAs are sold, require the new owners to assume outstanding debts and liabilities.





Either don't allow contracting for services or allow contracting only with other Medicare certified agencies. Significantly limit the percentage of the business that can be contracted. For example, only allow one type of therapy to be contracted-out and require that all others services be provided by HHA employees.

### **THE OPEN-ENDED BENEFIT, BROADLY DEFINED BENEFICIARY ELIGIBILITY CRITERIA, AND COST-BASED REIMBURSEMENT SYSTEM CONTRIBUTE TO OVERUTILIZATION, ABUSE, AND FRAUD**

Participants in the focus groups have found that the problems among home health agencies are far more systemic and widespread than just the actions of a few rogue providers intent on defrauding Medicare. In many instances, unclear, imprecise, or deficient regulations coupled with confusing and complex guidelines predispose the program to fraud, abuse, and waste. Participants commented that the program has been so open-ended since the liberalization of benefits in 1989 that any unscrupulous entrepreneur can figure out how to become wealthy without much effort.

Precious resources are wasted because the home health industry views the Medicare benefit as long-term care, since there are no limits on the number or length of services. Participants commented that the home health program definitely funds long-term care at home, and "we're trying to fix a bad system." One participant further noted that private insurers pay for skilled services, not personal care and that we need to separate skilled services from personal care rendered by home health aides and limit benefits accordingly.

The current payment mechanism for home health, which is based on interim payments and cost report settlements, does not discourage fraud, waste, and abuse. Participants complained about the cost-based payment system and suggested that it is obsolete and should be abandoned in favor of a more prudent reimbursement system.

#### **Problems/Vulnerabilities:**


- ☛ **Exceptions to the definition of "homebound" are confusing and difficult to monitor.** The definition of homebound allows for such activities as attending church, running errands, etc. The exceptions have been used by unscrupulous providers to challenge clear-cut determinations that services are not medically necessary.
- ☛ **Unlike the SNF benefit, a prior stay is not required.** Anyone can receive home health services without any prior hospital or outpatient stay. This allows HHAs to provide services to larger populations with less monitoring. Patients who might otherwise not need services are added to the rolls.
- ☛ **The interpreted definition of part-time or intermittent care leads to overutilization by allowing an infinite number of visits.** A 1989 court case led to a change in the


interpretation of “part-time and intermittent care” to “part-time or intermittent care.” This allowed HHAs to drastically increase the number of visits per patient.


☞ **The long-term nature of the benefit, i.e., coverage of chronic care, creates difficulties in determining which services are medically necessary and which are incidental.** The HCFA needs to decide if the home health benefit is going to focus on post-acute episodes or chronic care. Providing long-term care can blur the line between medically necessary services and more incidental services such as housekeeping. It is extremely difficult to prove services were not medically necessary unless multiple services are deemed inappropriate.


☞ **Cost-based reimbursement systems do not provide incentives for providers to properly manage costs.** Providers bill as often as they want and have no incentive to limit visits or costs. Other payment caps, such as the part B limit on physical therapy, drive providers into the home health business.


### Suggested Solutions:

 Define a home health visit. How much of the visit can involve incidental services?


 Define criteria for discharging patients from home care.


 Require that HHAs bill based on increments of hours or portions of hours rather than per visit. Develop and implement a fee schedule for visits. Pay an hourly rate.

 Offer bonuses for meeting rehabilitation goals compared to open-ended therapies.

 Adopt managed care for the home health benefit.

 Impose a cap on reimbursement and/or the number of visits.

 Develop and implement a prospective payment system. Although this system would address the cost of home health services, it would not solve the problem of determining eligibility (i.e., is the patient homebound?).

 Consider competitive bidding as a long-range solution. Overutilization is a much bigger issue than fraud. The long-term solution is selective contracting through competitive bidding. Legislative authority already exists, and precedents have been set. Competitive bidding is already being used for durable medical equipment, laboratories, and coronary bypass surgery on a demonstration basis. NOTE: California's Medicaid program shifted from cost reimbursement to competitive bidding for acute hospitals. It was difficult to do, but it revolutionized the program.

## **THE LACK OF PHYSICIAN AND BENEFICIARY INVOLVEMENT AND ACCOUNTABILITY HAS CONTRIBUTED SIGNIFICANTLY TO OVERUTILIZATION AND ABUSE**

Relying on physicians to oversee the medical necessity and delivery of home health services has been entirely ineffective. The home health benefit anticipates that physicians will act as gatekeepers. Physicians are supposed to certify initial plans of care, periodically review treatment plans, and review and recertify the entire plan every 62 days. The expectation is that physicians will help control utilization by monitoring beneficiary eligibility and the medical necessity of services. To encourage this, in January 1995, HCFA began paying physicians for reviewing these plans of care (POC). Unfortunately, this system is not working, and physicians are not acting as gatekeepers but instead are unwittingly or knowingly helping unscrupulous operators defraud and abuse Medicare.

Most beneficiaries, with a minimum amount of education, adequate information, and some incentive, can effectively monitor their own health care. However, for the home health benefit, beneficiaries receive no information regarding the number, type, and cost of services that have been billed for their care. Furthermore, they have no financial liability or responsibility. Essentially, beneficiaries are out of the loop. This lack of involvement by the two groups closest to the actual delivery of services, beneficiaries and physicians, creates a situation without sufficient checks and balances to deter and prevent fraud, waste, and abuse.

### **Problems/Vulnerabilities:**

- ☛ **Physicians are not playing the role of gatekeeper as intended, or they are performing it perfunctorily, at best.** Physicians are not aware of the requirements or simply do not care. They want the HHA to take charge. The "attending" physician turns out to be any physician. Some agencies even shop around for physicians to perform certifications and recertifications.
- ☛ **The regulations do not require that physicians see patients before signing POCs.** Consequently, they may not see patients or even their medical charts.
- ☛ **Physicians are not consulted when a patient's condition changes (either positively or negatively) as required by HCFA.** Physicians are not even contacted by HHAs; sometimes nurses will change the orders.
- ☛ **Some HHAs utilize "boilerplate" POCs.** Some respondents had no problem with an agency preparing the POC, but suggested that there should be an independent party authorizing services, such as an intermediary or independent regional organization.
- ☛ **Beneficiaries do not have any financial liability, and they do not receive any information regarding the number and cost of services rendered.** Unlike other

services, beneficiaries have no concept of what is being billed to the Medicare program and have no financial incentive to limit the services they receive.

☞ **The HHAs do not promote independence by teaching beneficiaries self-care.** Many beneficiaries are able to provide some of their own basic health care, but HHAs discourage them from doing so. For example, diabetics, who have been injecting themselves with insulin for years, are encouraged by HHAs to let the home health agency perform the "procedure" when the beneficiary becomes Medicare-eligible.

### Suggested Solutions:

**HCFA**  
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Strictly define who can be considered the "attending physician" for home health. The HCFA should require that the attending physician, who signs the POC and recertification, is the physician who decided that the beneficiary needs home care. The HCFA could also require that the physician has an established relationship with the beneficiary as evidenced by Medicare claims preceding the date of the POC.

**HCFA**  
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Set minimum standards that require physicians to see the patient at, or near, the time the POC is developed. In addition, the physician who signs the POC should be required to examine the beneficiary when he recertifies the POC to determine whether home health care is still necessary.

**HCFA**  
MEDICARE • MEDICAID

Establish a definite time limit between the physician examination and the development of the POC.

**HCFA**  
MEDICARE • MEDICAID

Have independent certifiers review POCs.

**HCFA**  
MEDICARE • MEDICAID

Pay the physician for reviewing and signing the POC and require the physician to bill for recertifying. Not all physicians currently bill. If there is no corresponding bill from the physician, Medicare should not pay for the services.

**HCFA**  
MEDICARE • MEDICAID

Allow physicians to approve POCs for a limited number of visits. Once a beneficiary has received a certain level of benefits, require prior approval by an independent peer review entity for additional benefits.

**HCFA**  
MEDICARE • MEDICAID

Track physicians who are approving POCs to determine if their patterns warrant review. This would require including the physician UPIN on each claim.

**HCFA**  
MEDICARE • MEDICAID

Offer bonuses or incentives to beneficiaries who are good managers of their own health care needs.

**HCFA**  
MEDICARE • MEDICAID

Have beneficiaries sign completed claim forms, nurses notes, or visit logs to acknowledge receipt of services.



Send Explanation of Medicare Benefits (EOMBs) for home health care to the beneficiaries so that they can check for improper billing. Include the number of visits, dates, services rendered, and the dollar amount billed and paid.



Unless an agency can prove a patient cannot learn self-care, limit the number of visits for certain diagnoses.



Create an incentive for patients and their families to reduce overutilization by requiring co-payments.

**FEDERAL OVERSIGHT ACTIVITIES CANNOT INSURE THAT HOME HEALTH SERVICES ARE MEDICALLY NECESSARY, OF AN ACCEPTABLE QUALITY OF CARE, OR BILLED PROPERLY**

After certification, Medicare imposes few controls on HHAs to assure that they retain qualified staff, provide quality care, and bill appropriately. Medical review, cost report audits, and recertifications have not proven to be effective means of controlling costs or utilization or assuring the integrity of the benefit. Because these activities have not been adequately funded, neither state agencies nor fiscal intermediaries have been able to devote sufficient resources to monitoring HHAs. Furthermore, most of the effort has been concentrated on postpayment review which does not prevent the fraud, abuse, or waste from occurring.

**Problems/Vulnerabilities:**

- ☞ **Staff may not be properly licensed.** The initial survey requires surveyors to verify that nurses are licensed. State surveyors can access a toll-free telephone number to find out if a nurse is licensed; however, the verification does not occur each time a new nurse is hired. Furthermore, HHAs do not properly monitor contracted services, such as nursing registries. Certified HHAs are required to keep copies of contracted nurses' and aides' licenses, but this is not always done. Home health aides are a particular concern, since investigators have found that some of the aides are non-licensed undocumented aliens.
- ☞ **Beneficiaries may be at risk, because nurses and home health aides have access to their homes.** Medicare does not require background checks on HHA employees. This may endanger an already vulnerable population.
- ☞ **Larger providers are difficult to monitor since branch offices can bill different fiscal intermediaries.** The original intent was for nationwide companies with multiple locations to use Blue Cross of Iowa. But the use of multiple intermediaries by one company with several branches is not specifically prohibited.
- ☞ **In a cost-based reimbursement system, audits are the primary method of monitoring providers; however, funding for on-site visits is limited and audits are**

**post-payment in nature.** Without on-site audits, HHAs can commit fraud and still appear legal and clean on the surface. Desk audits without detailed backup documentation frequently do not uncover inappropriately claimed costs, duplicate claims, claims for services not rendered, services that duplicate those provided by facilities, or falsified records. Funding for on-site visits has been very limited, and this situation is further complicated by the large distances between HHAs and their fiscal intermediaries. Often, inappropriate costs take 2 to 3 years to disallow and, by that time, the company may have gone out of business.

- ☞ **There is no systematic way to track nurses, aides, and physicians for billing purposes.** Claims do not require license numbers and UPINs. Without this information, prepayment edits are not possible.
- ☞ **Duplicate services and billings are common for home health services provided to residents of board and care facilities.** HHAs provide services for residents of board and care facilities and subsequently bill Medicare. In many states, part of the Medicaid per diem is supposed to cover these services. The Medicare fiscal intermediaries frequently do not know if a beneficiary is in a board and care facility.
- ☞ **Licensing and certification staff, medical review personnel, and cost report staff do not share information regarding problem individuals and agencies.** Many HHAs with administrative and management problems also have cost report problems. Medical reviews are not as focused as they could be if there was coordination with licensing and certification staff.
- ☞ **Kickbacks and self-referrals are commonplace in the home health industry.** Doctors, board and care facility administrators, and others receive kickbacks for referrals to HHAs and DME companies. In addition, HHAs bill Medicare for services provided to relatives and friends which may not even be rendered.

### **Suggested Solutions:**



Routinely review HHA records to ensure staff is properly licensed.



Complete criminal background checks on HHA employees who have access to patients' homes.



Develop a system to assure that registered nurses supervise home health aides biweekly, as the regulations require.



Licensing and certification staff should coordinate findings with fiscal intermediary staff. There should also be cross-training.



When possible, recertification surveys should be performed at the same time as on-site cost report audits to facilitate information sharing and coordinate findings.



Require same or related companies to deal with the same fiscal intermediary.



Until the structure of the program changes, there need to be more on-site reviews. Adequate funding should be provided. Responsible fiscal intermediaries should be geographically closer to HHAs.



Require unique identifiers (UPIN, license, code) on claims for all providers, physicians, therapists, nurses, and suppliers for whom services are being billed. Develop a database that would track the services provided by them.



Based on a statistical sample, fiscal intermediaries should interview physicians and beneficiaries to validate services.



Auditors should be taught how to identify services that are potentially medically unnecessary.



Fiscal intermediaries should be funded to conduct pre-payment medical review on new and problem HHAs.



Intermediaries should validate information in medical records.



Fiscal intermediary staff should be expected to search for kickbacks when they review claims and cost reports.



Require nurses and aides to complete a trip or visit log and submit the log with the claims. The beneficiary should be required to sign the log.



Track beneficiaries who account for a large volume of HHA claims.



Develop and implement a prepayment claims edit that would limit the number of visits per day for nurses, aides, and therapists. Limit the number of consecutive days a nurse can work.



Identify subcontracted services on the claim form via a modifier.



Prohibit HHAs from billing for services rendered to relatives of either direct employees or contract staff (perhaps by expanding the Stark self-referral ban).



Eliminate cost reports. Adopt a fee-for-service (based on a fee schedule) payment policy.



Require the preparer of the cost report to assume financial liability for its accuracy.



Require the owner of the HHA to sign the cost report.



Eliminate payments of home health benefits that duplicate services that are supposed to be provided by board and care facilities.

### **HHAs FACE FEW PENALTIES FOR NONCOMPLIANCE, FRAUD, OR ABUSE**

Once an HHA has been certified, there is little that HCFA can do to penalize the agency and its owners. Decertification is not easy since providers believe they have a “right” to do business with Medicare and frequently use political influence to prevent HCFA from taking any adverse action.

The HCFA has few administrative remedies at its disposal. Coordination with other agencies, such as the OIG and the United States Attorney’s Office, for criminal or civil investigation and prosecution is very time-consuming and unproductive, unless the case is particularly egregious. Therefore, the best way to address fraud and abuse in the home health area is to prevent it from happening in the first place. However, in cases where this is not possible, HCFA needs stronger administrative penalties that it can impose timely and effectively.

#### **Problems/Vulnerabilities:**

- ☛ **Providers file late cost reports, often with significant overpayments.** The current requirement that HHAs submit cost reports within 5 months of the end of the fiscal year is too lenient. Some providers do not even meet that deadline. Others never file their cost reports. Significant overpayments are rarely repaid when HHAs voluntarily terminate or go out of business.
- ☛ **Fiscal intermediaries do not routinely stop payments to HHAs that have cost report problems.** Even after costs have been disallowed, payments continue.
- ☛ **Bankruptcy protects providers from HCFA suspensions and sanctions.** The courts protect individuals and corporations that file bankruptcy. Unless fraudulent activity is proven, HCFA rarely recoups overpayments.
- ☛ **Very few HHAs are prosecuted.** The likelihood of prosecution is small. Investigators face many obstacles because of the extremely complex nature of home health cases.
- ☛ **Judges are reluctant to impose penalties against corporations and their owners.**
- ☛ **Even when records are altered or falsified, Administrative Law Judges (ALJs) frequently rule in favor of HHAs.**



- ☞ **Providers sell patient lists without fear of kickback penalties.** Kickback cases are difficult to prove and rarely result in criminal prosecution.
- ☞ **Providers use contracting to avoid liability.** HHAs attempt to shield themselves from prosecution and penalties by claiming that they are not responsible for contracted employees (such as nurses and therapists) who submit false charge slips.

**Suggested Solutions:**



Toughen penalties/sanctions for non-compliance. Penalties should be similar to those established in the Clinical Laboratory Improvement Amendments (CLIA). Under CLIA, an owner who is sanctioned (decertified for quality of care reasons) is prohibited from providing any health service to Medicare beneficiaries for 2 years.



Require timely filing of cost report. Shorten current requirement from 5 to 3 months. If a cost report is late, HCFA should begin decertification proceedings and withhold future Medicare payments.



Fiscal intermediaries should discontinue payments to HHAs when overpayments are discovered through cost report audits or sample claims reviews. As mentioned earlier, a bond should be required if an HHA is granted an extended repayment plan.



Permit administrative sanctions against individuals. This would avoid having to go through the conviction process.



Add a threshold amount (for example, \$5,000 in disallowed claims), before a provider can request a hearing before an ALJ.



Make selling or trading patient lists illegal.



HHAs should be automatically excluded from Medicare when they bill for unlicensed branches. Exclusions should be for 10 years and should affect individuals as well as corporations.



Penalties should be modeled after those of the Internal Revenue Service (IRS). The IRS imposes 100 percent penalties in certain situations.



Eliminate periodic interim payments and require that HHAs bill no less than monthly.



Contracting should be eliminated or limited. HHAs should not be allowed to abrogate their responsibility to assure that services are rendered.