HOME HEALTH AIDE SERVICES FOR MEDICARE PATIENTS

OFFICE OF INSPECTOR GENERAL

OFFICE OF ANALYSIS AND INSPECTIONS

September 1987

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SEPTEMBER 1987

Control # OAI-02-86-00010

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EXECUTIVE SUMMARY

PURPOSE: This inspection was initiated to assess the strengths and weaknesses of existing Medicare standards for home health aide services.

BACKGROUND: Covered health and personal care services provided to eligible patients at home are reimbursed under Medicare. These services include skilled nursing, physical, speech and occupational therapy, medical social services and services provided by home health aides, including personal care. They must be ordered by a physician and provided through a Medicare-certified home health agency. Coverage by Medicare is also dependent upon a homebound patient's need for the part-time or intermittent services of nurses and other skilled professionals. The coverage of home health aide services is contingent upon the need for skilled professional services.

Medicare reimbursement to nearly 6,000 certified home health agencies (HHA's) for all services in 1985 was about $2 billion. By 1990, as many as 2.2 million patients will be receiving home health visits, and as many as 30 percent of those visits will be made by home health aides at a cost of about $750,000,000. Aides will continue to spend triple the amount of time in a patient's home as skilled professionals.

In order for an HHA to participate in the Medicare program, it must meet the Conditions of Participation. These standards, set forth in 42 CFR 405.1201ff, cover such areas as organization, administrative accountability, financial planning and budgeting, recordkeeping, the provision of health services and quality assurance procedures.

Section 42 CFR 405.1227 outlines the single Medicare Condition of Participation and two standards that home care agencies must meet concerning home health aide services.

Section 1861(m)(4) of the Social Security Act requires home health aide services provided to Medicare patients to be "part-time or intermittent" and also requires home health aides to have "successfully completed a training program approved by the Secretary."

The certification of HHA's is carried out by the Health Care Financing Administration (HCFA) through the efforts of State survey agencies. Home care agencies must be licensed in States which require such licensure.

METHODOLOGY: Site visits were made to seven States throughout the country. In each State, discussions were held with home health agency and vendor administrative personnel,

State surveyors and licensure personnel, supervisory visiting nurses, home health aides, Medicare patients, physicians, and representatives of labor unions, educational institutions and home care industry agencies. A total of 62 Medicare patients and 44 home health aides were visited in the patients' homes. A sample of medical records from each home health agency was obtained and reviewed by skilled medical professionals on the inspection team. Additional data were collected. (see Appendix II for details).

MAJOR FINDINGS:

I. MEDICARE PATIENTS' NEEDS FOR KEY HOME HEALTH AIDE SERVICES ARE NOT BEING MET

- A review of patient records revealed that where the plans of care called for specialized services in support of the duties of skilled nurses or physical therapists, the aides failed to document, and perform, half of these tasks. The non-performance of these tasks deprives the Medicare patient of the full benefit of the home care program, and could result in a patient not realizing full rehabilitation potential, or in a patient's condition worsening to the point where re-hospitalization is required.

- Since the Medicare program is already paying for visits of sufficient length to accommodate more specialized services of aides, the Medicare program is paying for aide services not rendered.

- We found that poor supervision of aides is the main reason for the failure to provide ordered care. Substantial weaknesses were noted in the orientation of aides to the needs of patients by supervisory nurses and in the supervision given to the aides in the patients' homes.

- The review of patient records also revealed that home health aides always delivered prescribed personal care services, such as helping patients with baths, care of mouth, skin and hair, assisting them to the bathroom or in use of bed pans and preparing meals for them.

- The aide is viewed as a personal care giver. This perception contributes to the failure of aides to provide specialized services.

- o Serious problems were noted with agencies' use of home health aides under contract. These include: Medicare patient vulnerability to substandard practices and services which are unnecessarily time consuming, frequent and costly.

II. **STANDARDS NOT PROVIDED**

- o The Medicare Condition of Participation for home health aides lacks standards for recruitment, hiring and training. The standards for assignment of aides and supervision do not provide sufficiently objective criteria. As a result, State agencies responsible for surveying home health agencies for compliance with the Condition of Participation find the survey process difficult to perform effectively. Many States provide standards with specific criteria for the training of home health aides, although these standards vary with regard to training curriculum length and content.

- o Improvements in Medicare standards are needed to upgrade the quality of care provided by aides, and to assure the cost-effectiveness of the estimated $650 million Medicare will pay for aides' services in 1988.

- o Low priority is placed by States on home health surveys. This limits the size of survey staffs as well as the number of surveys performed.

III. **PROBLEMS NOTED WITH AGENCY PRACTICES IN EMPLOYING AIDES**

- o Recruitment, hiring and retention of home health aides are major problems for many agencies which offer low pay and limited benefits. These agencies do not attract the most reliable employees and experience a very high turnover rate.

- o Other agencies, however, assure effective selection and retention of aides by offering many incentives, including good pay, benefits and paraprofessional status.

MAJOR RECOMMENDATIONS AND AGENCY COMMENTS:

I. The Health Care Financing Administration (HCFA) should direct State survey agencies, through training programs And written instructions, to review selected

plans of care and the corresponding patient medical records to assure that all prescribed tasks are performed and documented by home health aides. Training and instruction of State surveyors is essential to assure that the Condition of Participation for aides is satisfied.

The HCFA agrees with this recommendation and will take steps to accomplish this.

II. The HCFA should assure that required home visits are made by State surveyors. The criteria for conducting the home visit program should be reevaluated to assure that the program can be effectively carried out within existing budget limitations.

The HCFA indicates that all States have been provided with additional and adequate resources to conduct required HHA home visits.

III. The HCFA should encourage States without specific State regulations on the training of home health aides to develop a curriculum for training home health aides, or adopt an existing curriculum. Completion of an established training program should be a prerequisite of a home health aide position.

The HCFA agrees with this proposal and is developing a revision to the Medicare Conditions of Participation which will strengthen requirements for home health aide training and supervision.

IV. The HCFA should revise those sections in the Health Insurance Manual for home health agencies and fiscal intermediaries (FI's) which deal with services provided by home health aides. The revisions should distinguish between personal care services and those services representing extensions of skilled care, indicating that all tasks in the plans of care, are expected to be performed by aides during each visit.

The HCFA will consider including in the Home Health Agency Manual and the State Operations Manual a section which indicates that HCFA considers it to be a significant health and safety breach if the HHA is not insuring that the home health aide provides the services ordered on the plan of treatment.

V. The HCFA should revise the Home Health Agency Coverage Compliance Review instructions to FI's. Revised instructions should expand the points to be addressed by the FI's during onsite reviews to include comparison of aide tasks specified in plans of care with aide tasks performed, to assure that plans of care tasks for aides are fully implemented.

The HCFA will consider including an instruction in the Coverage Compliance Review Program (Part A Intermediary Manual) which will address this concern.

Full HCFA comments are included in Appendix IV.

INTRODUCTION

Covered health and personal care services provided to eligible patients at home are reimbursed under Medicare. These services include skilled nursing, physical, speech and occupational therapy, medical social services and services provided by home health aides, including personal care. They must be ordered by a physician and provided through a Medicare-certified home health agency. Coverage by Medicare is also dependent upon a homebound patient's need for the part-time or intermittent services of nurses and other skilled professionals. The coverage of home health aide services is contingent upon the need for skilled professional services.

Medicare reimbursement to nearly 6,000 certified home health agencies (HHA's) for all services in 1985 was about $2 billion. By 1990, as many as 2.2 million patients will be receiving home health visits, and as many as 30 percent of those visits will be made by home health aides at a cost of about $750,000,000. Aides will continue to spend triple the amount of time in a patient's home as skilled professionals.

In order for an HHA to participate in the Medicare Program, it must meet the Conditions of Participation. These standards, set forth in 42 CFR 405.1201ff, cover such areas as organization, administrative accountability, financial planning and budgeting, record keeping, the provision of health services and quality assurance procedures.

Section 42 CFR 405.1227 outlines the single Medicare Condition of Participation and two standards that home care agencies must meet concerning home health aide services. Outlined in summary form below, they include the following requirements:

Hiring - aides are able to read, write, and carry out directions, and are mature and capable enough to deal with sick patients.

Training - aides are carefully trained in assisting patients to achieve maximum self-reliance.

Assignment of Duties - aides are assigned specific duties by a registered nurse.

Supervision - aides are closely supervised by a registered nurse or other professional staff every two weeks.

The regulation also identifies tasks which home health aides are trained to perform and duties which they may be assigned by a registered nurse. The regulation does not always define tasks and duties, such as "personal care", but they may be grouped into three categories and include the following:

1. Personal Care Services: Helping patient with bath, care of mouth, skin and hair. Helping patient to bathroom or in using bed pan. Changing patient's bed linen. Assisting with meal preparation and household services essential to health care at home to maintain a clean, healthful and pleasant environment. Completing appropriate records.

2. Extension of Skilled Nursing Services: Assistance with medications that are ordinarily self-administered, simple exercises, specific treatments, clinical observations and nutrition. Reporting changes in the patient's condition to the supervising nurse. Completing appropriate records.

3. Extension of Rehabilitation Services: Assistance with ambulation and exercises as an extension of skilled therapy services. Reporting changes in the patient's condition to the supervising nurse or therapist. Completing appropriate records.

Section 1861(m)(4) of the Social Security Act requires home health aide services provided to Medicare patients to be "part-time or intermittent" and also requires home health aides to have "successfully completed a training program approved by the Secretary."

The certification of HHA's is carried out by the Health Care Financing Administration (HCFA) through the efforts of State survey agencies. Home care agencies must be licensed in States which require such licensure.

FINDINGS

MEDICARE PATIENTS' NEEDS FOR SOME KEY HOME HEALTH AIDE SERVICES ARE NOT BEING MET

1. Plans of Care Not Being Followed

All 62 patient records reviewed contained plans of care which called for aides to perform tasks representing personal care services; 85 percent of the plans also called for aides to perform tasks which represented an extension of nursing or rehabilitation services. Examples of the tasks found in plans of care in support of nursing services included the following: assisting with dialysis; diabetic monitoring (urine testing); catheter care; foot soaks; special skin care; observation and notation of changes in respiratory condition; encouraging intake of fluids; recording intake and output of fluids; taking of temperature, pulse and respiration with readings noted. For rehabilitation, it was noted that aides were often asked to help with exercises, transfers to and from bed and ambulation training as taught by the physical therapist, and recording progress in activities of daily living.

A comparison of the 62 aide plans of care with corresponding aide activity sheets revealed that prescribed personal care tasks were always documented as having been performed. However, in 48, or 91 percent, of the 53 cases where extensions of skilled services were prescribed, one or more tasks were not documented by the aides as having been performed. In half of these cases, one or more of those tasks were never documented; in the other half, one or more of those tasks were only occasionally documented. Overall, nearly half of the prescribed extension tasks expected to have been performed during more than 1,600 aide visits were not documented.

Responses from both patients and aides support the conclusion that all personal care tasks were actually performed. Responses also support the conclusion that a lack of documentation indicates that the extension tasks were not performed by the aides.

Since the services provided by home health aides as an extension of nursing or rehabilitation services are intended to be a continuum of skilled care, failure to provide the services deprives the patient of the full benefit of the home care program. A patient who has a therapy treatment twice a week without any aide-assisted

"practice" between skilled visits may not achieve her/his full rehabilitation potential as quickly, if at all. When key observations are not made by an aide or are not noted for the nurse, the patient's condition may worsen, and skilled treatment essential to the patient's recovery might not be started.

Special treatments assigned to aides, such as foot soaks or special skin care, if not performed, could lead to serious skin deterioration. In cases of this kind, patients may require re-hospitalization.

To gain an insight as to why so many aide tasks were not documented and apparently not performed, the inspection team made follow-up contacts with supervising nurses and administrative personnel of a number of HHA's which had been previously visited. The consensus of these respondents was that the primary and continuing cause of the problem was the lack of orientation of aides by supervising nurses to patient cases and tasks as well as the lack of ongoing onsite supervision of aides by professionals. One respondent said:

> "The start-up visit is essential in every single case to introduce the aide, give the case plan and demonstration of tasks. The supervision every two weeks must be onsite with the aide."

Another respondent indicated that extension tasks were not performed by aides because they are usually alone with patients and lack confidence without the proper support of skilled professionals. She said:

> "The aide may be fearful of doing a procedure if they are not shown it specifically. They are aware they might hurt a patient and get into trouble if they do it wrong ... The therapist or nurse must meet with the aide in the home and show them what should be done."

One respondent said that the assignment of multiple aides to the same patient precluded supervision. Nurses cannot orient and supervise multiple aides effectively, nor assure uniformly effective performance of tasks. She also said that it was a good practice to have aides present at patient conferences with skilled professionals, but that practice was discontinued at her agency.

Other causes cited by respondents included deficiencies in aide training, especially in the area of documenting tasks performed. It was noted that since many aides lack language skills to articulate tasks performed, many agencies frequently have aides use a checklist to identify those tasks.

2. Majority of Undocumented Tasks Were Assigned to Vendor Aides

Medicare requires HHA's to meet all standards for home health aide services, whether or not the services are provided directly or under contract. The HHAs' must assure that vendors they contract with also meet the Medicare standards for aide services.

Among the 44 home health aides providing services to the 62 patients, 15 were employees of vendors contracting with six of the 16 HHA's, and three were under direct contract to a seventh HHA. Over one-half of the aides were employees of 12 HHA's (three also contracted for some aide services and fall into both groups). The chart below summarizes the documentation of extension tasks by both groups of aides for the 48 patients visited.

Aides	Patients	Visits	Assigned Tasks	Undocumented Tasks
18 Contract	18	939	2,022 (tasks per patient X visits)	1,070
26 Staff	30	663	1,760	771
44	48	1,602	3,782	1,841 (49%)

3. Vendor Aide Visits Tend To Be Long, Frequent And Costly

The average length of visit for the first group of 18 aides was 2.6 hours, while the second group of 26 aides spent an average of 1.8 hours on each visit. Three HHA's in one Eastern State, where contracting for aide service is prevalent, allow vendor aides to spend as much as 4 hours on each home visit. Staff aides of the other HHA's spend under 2 hours per visit. Vendor aides also average more visits per week than staff aides. Because of high turnover among aide staff, vendors try to place aides on cases for longer periods of time with minimal travel. In addition, labor union

agreements affecting many vendor aides make it costlier per hour to place those aides in a patient's home for less than three hours. For example, one union agreement with a vendor stipulates that aides will be paid $1 more per hour on visits of under three hours.

4. Lack Of Control Over Vendor Aides Makes HHA Patients Vulnerable To Substandard Practices

In 1985, 6 of the 16 sample HHA's in three Eastern States contracted with 18 vendors for all or part of the nearly 150,000 home health aide visits provided to Medicare patients. Of those total visits, 72 percent were made by vendor aides the six HHA's did not recruit, hire, train or assign to patient cases. These HHA's assured vendor aides complied with standards in various and often effective ways. In addition, it was found that vendors' deficiencies discovered by some HHA's were not reported to Medicare authorities and were not always corrected. One HHA conducted 1984 and 1985 annual audits of one of its vendors.Out of 165 aide personnel files audited, 211 deficiencies were found. Areas of deficiency included physical exams, health tests and immunizations, references, and in-service training.

Out of a small sample of 15 Medicare patients and vendor aides visited by the inspection team in three Eastern States, there was one case where the aide did not arrive at the patient's home when expected; the patient was a wheelchair-bound amputee on dialysis who lived alone. Another problem case involved a vendor aide who did not show up at the patient's home as scheduled for four days. Neither the vendor nor the HHA was aware of it, until the patient complained. Some State surveyors and supervisory nurses said this occurs frequently.

5. Supervision of Home Health Aides Is Found to be Inconsistent And Ineffective, Especially When Multiple Aides Visit The Same Patient

The previously noted comments on poor supervision were supported by the inspection team's observations during the study. Weaknesses were noted in the areas of aide orientation and on-the-job training for individual patients by supervisory nurses. How supervision is to be carried out is not specified by Medicare regulations, although registered nurses must make supervisory visits every 2 weeks, with or without the aide's presence.

Many supervising nurse and agency respondents believe that aide orientation and on-the-job training for specific patients, when conducted by supervising nurses, is the only effective way to assure that all prescribed tasks are properly performed.

There was evidence that aides were given an orientation by the supervising nurse on the first aide visit in only 22 percent of cases reviewed. This orientation introduces the aide to the patient and family, and allows for discussing the home environment and reviewing the plan of care. Demonstrations of tasks are given by the nurse followed by return demonstrations by the aide. Orientation is considered more important when prescribed aide tasks include extensions of skilled services.

When HHA's and vendors substitute aides on patient cases, the supervising nurse visits do not effectively serve the purpose intended. Orientation to the patient and on-the-job training should be repeated for each aide, but often are not. One nurse supervising vendor aides said:

> "Ideally we will be there at the aides' first visit to orient her to the tasks. If not possible, I could make a telephone call. I always make an effort to be onsite the first time to teach the aide, but the aide changes and I can't always go in every time. It is a frustration!"

A senior agency official of one of the HHA's advised that "rotation of aides" was based on assigning the more experienced aides to new problem cases. However, a vendor official with more direct involvement in assignment of aide staff to the HHA's patients advised that part-time vendor aides paid an hourly rate are usually taken off cases to give work to vendor full-time aides who are salaried. A common complaint from ex-patients of this agency is "too many different aides." Documentation in two-thirds of the patient cases indicates supervising nurse visits were not made when the aide was present. Medicare regulations do not specify that the aide must be present. One nurse emphasized the importance of coordinating supervisory visits with aides when she said:

> "At least once a month there should be onsite supervision while the aide is in the home. Personally, I wouldn't want to be responsible for an aide if I didn't see her performance."

Although some nurses expressed difficulty coordinating their visits with the aide in the home, many felt it was essential to good care.

6. Aides Are Perceived As Primarily Personal Care Workers

We learned from our discussions with patients, aides and supervising nurses, that home health aides are generally perceived as "caring companions" whose most important functions are to keep patients clean, lend emotional support to patients and family and provide some housekeeping services. Expectations for aides seldom encompass duties to assist patients in achieving maximum self-reliance.

Eighty percent of all patient, aide and nurse respondents identified personal care, especially bathing, as the most important service aides provide. Emotional support of patients and families ranked as the second most important service provided by aides. Where family members lived with patients, aide visits were seen as providing a needed respite from looking after the patient. While the third-ranking service according to patients and aides was housekeeping, the third-ranking service in the view of nurses was the extension of either nursing or rehabilitation services.

One agency utilized aides primarily for providing limited personal care services, regardless of the need of its patients for other services aides are normally expected to provide. All four patients from this agency had plans of care calling for "personal care and bath" only; two of the four patients had received physical therapy, but the aides' plans of care in those cases did not call for any tasks in support of the rehabilitation services. The Registered Physical Therapist member of the inspection team felt that an extension of rehabilitation services by the aides in these cases was appropriate and would have been beneficial to the patients. Aides indicated that this agency also does not allow them to do housekeeping, meal preparation or shopping. Such services may be covered by Medicare and appropriate for specific patients. Where aides did not carry out the tasks considered extensions of skilled services, the length of visits did not appear to be a major factor. In those cases, aide visits were as brief as 45 minutes and as long as 4 hours, averaging about 2 hours per visit, usually a sufficient time to complete assigned tasks. Medicare fiscal intermediaries routinely reimburse agencies for aide visits assuming all tasks were performed as prescribed in plans of care.

STANDARDS NOT PROVIDED

1. Medicare Regulations For Home Health Aides Are Not Adequate

Surveyors in 11 of the 12 States contacted view Medicare regulations as barely adequate, or even inadequate, in helping them do their job. A typical complaint was that Medicare regulations "have too many gaps and are open to too much interpretation." Others cited the lack of training standards as a major weakness. "There's a real void in the Medicare regulations there!" said a surveyor in a Western State. Another deficiency noted was the lack of a standard for the selection of aides.

A review of the Medicare Condition of Participation for home health aides and its two specific standards indicates very few criteria. There are no specific standards for the selection and training of home health aides. For example, the Condition states that aides should be "carefully trained", but it does not specify curriculum content or length, or required classroom and clinical hours, or the need for continuing (in-service) education or on-the-job training.

In one of the two areas where the Condition does establish a standard, which requires assignment of aides to cases to be made only by a registered nurse, there are no criteria which provide a basis for the assignment such as patient needs and the abilities of specific aides. The other Medicare standard deals with aide supervision. While it requires that a registered nurse or other appropriate professional supervise the aide, it does not specify that the aide must be present during supervision.

2. Application Of Medicare Regulations Is Subjective; Guidelines Offer Limited Help

The decision by State surveyors as to whether agencies meet the overall Condition of Participation is largely left to the surveyor's subjective judgment. Consequently, while elements of the Condition (selection or training of aides) or standards (assignment of duties and supervision of aides) may be out of compliance, surveyors may still determine that the Condition is met. The only enforcement power to assure correction of specific deficiencies by non-compliant agencies is an involved decertification process which is rarely used.

Several surveyors indicated that HCFA's interpretive guidelines for survey agencies offered them little help in applying Medicare regulations during the survey process. Some criteria are provided for the assignment of aides to patients and there is a reference to "continuing staff education" being provided to aides. But HCFA guidelines say nothing about how many failures to comply with elements or standards are permitted before the Condition of Participation is judged "Not met." One surveyor indicated that failure to meet either or both standards would always be cited as deficiencies but would rarely be enough to find the Condition not met.

3. Most States Contacted Have Their Own Regulations; They Contain More Specific Criteria For Training Aides Than Medicare Regulations

Of the 16 States queried, 11 said they had their own regulations. Most said that their regulations give surveyors some specific and objective criteria, primarily in the area of training, to determine an agency's compliance with Medicare regulations. (see Appendix III for listing). The following elements are significant:

Course Curricula

Training course length is specified in nearly all the States which have their own regulations, with the length ranging from 42 to 230 total hours. Five of the States with regulations require supervised clinical training of from 15 to 30 hours as a prerequisite to successful completion. Prior approval of home health aide training curricula is required by seven States. One State requires training through a uniform curriculum offered statewide by vocational-technical schools and regional community colleges. Another State requires training programs to be equivalent in content and depth to the National Homecaring Council's "Model Curriculum."

Continuing Education

Of the 11 States with their own regulations, the general need for continuing education is cited in five States while three other States specify that aides receive at least 12 hours of in-service training a year.

Certification of Successful Completion

A certificate attesting to successful completion of aide training is required in 6 of the 11 States with regulations, with 3 States' certificates reflecting State seals and approval of the training. In one State, certificates are issued by the licensing agency directly to the aide with a certificate number kept on permanent registry. The application for the certificate must come from the trainer and attest to the aide's successful completion of a course approved by the State.

Supervision

With regard to supervision, most of the State regulations are the same as Medicare's. Only one State requires that a registered nurse provide direct supervision, i.e., while the aide is present, to the home health aide in the patient's home at least every 2 weeks.

Since Federal regulations offer few specific criteria, surveyors in the five States which do not have any State regulations experience difficulty when agencies contest findings of non-compliance. These States have developed internal procedures to compensate, e.g., recommending a particular training curriculum as one which meets the Medicare regulations. However, such recommendations do not carry the force of regulations and agencies are not compelled to comply with them. These surveyors indicated they must also spend more time and resources to assure compliance without the benefit of objective criteria. It is much harder to assure that an aide is "carefully trained" where States have no specific criteria mandating a curriculum, or where State regulations do not require prior approval of curricula. One surveyor in the East stated "It would make our job easier if we could simply verify that an agency uses aides that have been certified as passing a training program that is approved."

4. Respondents Want More Specific Medicare Standards

Virtually all the respondents queried, including all surveyors, agreed that having a nationally mandated training standard for home health aides would be useful. Several recommended wider use of the National Homecaring Council's "Model Curriculum" developed in 1978 and used extensively around the country as the basis for many

home health aide training programs. One survey nursing consultant said "It would make my job easier. It would improve the quality of work produced, and assure more uniform practices from state to state."

The Chief of another State's Home Health Survey Section recommended "Revisions to include specific criteria for training, i.e., number of hours, curriculum content, composition of faculty and credential requirements."

She also suggested modifying the current Medicare standards for assignment and supervision of aides by the:

> "... addition of the requirement for orientation of all Home Health Aides to the patient, family and the written instructions of duties. Verification of Home Health Aides' competency to carry out instructions should be clearly documented in the patient's clinical record ..."

This individual further recommended that patient and family orientation "be added to the responsibilities of the registered nurse (RN) in the Conditions of Participation."

A State surveyor from a State without regulations indicated that former Medicare regulations are still used in that State as a guideline for compliance. These former regulations established four Conditions of Participation, including one each for home health aide services, selection of home health aides, assignment of duties and supervision. All the Conditions contained some specific criteria to be met for compliance.

5. Effective Application Of Medicare And State Regulations Are Limited By Other Problems:

A. Low priority for home health surveys limits survey staff and number of surveys performed

We found that certified home health agencies are not usually resurveyed annually. Among the 16 home health agencies visited by the inspection team in 1986, 1 was last resurveyed in early 1986, 5 in 1985, 7 in 1984, 1 in 1983 and 2 in 1981. In fact, in most sample States, resurveys are backlogged 1 to 4 years. The reasons for the lack of resurveys are:

- Federal/State budget restrictions limit survey resources allocated for home health agencies. Most agencies are surveyed by one or two registered nurses, without other disciplines represented. One State survey agency had only three nurses available in 1985 to cover a growing number of certified agencies, now nearly 300. One State agency official indicated:

  The principal problem is adaptation of the Federal budgetary process to State Agency practices. In recent years, budget cuts and time lag in approval of Federal funding for the program has all but eliminated any national planning for maintaining necessary staff and resources to carry out certification activities.

- Home health agency recertifications are given the lowest survey priority by State agencies. The survey staff does give priority to agencies seeking Medicare reimbursement prior to certification. The dramatic increase in agencies seeking certification since 1981 has heavily taxed State survey resources.

B. Surveys performed are limited by logistical factors

Certified agencies' branch offices are not usually visited on resurveys, although a sample of some branch office patients may be reviewed as part of a survey. This circumstance is due primarily to two factors:

- The large size of some agencies. Some have as many as 20 branch offices. These branch offices sometimes fall within the survey jurisdiction of more than one of the State's regional survey offices.

- Branch offices are sometimes located hundreds of miles from the parent office, making it impractical and costly for a surveyor to visit them. These branch offices might be sub-units and, as such, subject to independent certification, if criteria for designating an office as a sub-unit were stringently applied.

C. Training for State surveyors has not emphasized home health care

The HCFA training for new and experienced State surveyors has traditionally been built around institutional activity, i.e., hospitals, skilled nursing facilities. Since the fall of 1985, HCFA training has been geared more specifically to home health care. Several survey agencies complained about training and suggested remedial action. One survey agency representative said:

> "Basic Training sessions for surveyors do not address the Home Health agency survey process. Training sessions for newly hired surveyors, to accommodate changes in State Agency personnel, are not readily available. Advanced training for home health agency surveyors is limited or non-existent."

Another surveyor said:

> "I recommend specific training in home health by HCFA centrally and through regional offices. There has not been enough emphasis on home care in past training. There are currently 200 certified home health agencies in this state and the number is growing. We need more staff and training."

D. Mandated home visits during surveys are not being made

Home visits during State surveys, required by a recent HCFA directive (November 1985), are not routinely made to Medicare patients in 11 of the 12 States contacted. Some limited experimentation has been tried in several States, but generally implementation is lagging because:

- The HCFA has not provided any additional funding for this activity.
- The HCFA criteria for implementation are extensive and scheduling visits could add more than a day to the survey process. For example, patient consent for the visit is required, and surveyor sample patients served by branch offices may be located far from the parent office of the agency.
- Many States are skeptical about the efficacy of home visits.

PROBLEMS AND BEST PRACTICES IN PROVIDING HOME HEALTH AIDE SERVICES

1. Recruitment of Aides Is Costly To Many Agencies; Competition for Desirable Workers Is Keen And Employee Turnover Is High

Forty percent of the home health agencies and aide vendor agencies contacted during the inspection have had major problems recruiting, hiring and retaining aides. The 10 agencies serve primarily urban and suburban areas in three Eastern States and one Southern State. Six of the 10 agencies train the aides they recruit and hire, while 4 agencies recruit aides already trained or utilize aides provided by vendors under contract.

All 10 agencies recruit aides through the use of daily and/or weekly newspaper advertising, flyers distributed in local communities, church and merchant bulletin boards and word-of-mouth. Several agencies offer cash bonuses to aide staff for referring candidates. The cost of advertising is high and the number of respondents screened is much higher than those actually interviewed, trained or hired. One agency administrator's statement is typical: "We have suspended recruiting because it was too expensive. Too many people didn't show up for employment interviews. One in twenty came. It was too costly to do screening." Nonetheless, this agency has since returned to recruiting aides for its staff because of great dissatisfaction with the performance of the aides provided by vendors.

One vendor, which recruits and trains aides in a suburban area, screened nearly 1,000 applicants over the last 3 years. After an extensive and costly interviewing process, only 411 people were selected for training; of that number, 324 aides were graduated and hired. The major concern expressed by respondents about aides trained under these circumstances was the pressure agencies are often under to assign aides to patients when the aide's ability and reliability are questionable.

An agency administrator summarized the predominant view of respondents about the hiring and training of aides: "If the future will continue to see paraprofessionals doing more and more for patients, there must be higher standards for training and pay."

- One phenomenon affecting many of the agencies is the movement of a segment of the workforce, made up of mature women, to local employers such as fast food chains. Many of these women are filling jobs previously held by teenagers. Many of the people responding to agency recruitment efforts tend to be looking for transient employment. One vendor indicated that half the aides they train and hire are single parents, some on public assistance, whose reliability is affected by day care and school schedules. Aide turnover rates of from 20 percent to 50 percent annually have perpetuated the recruitment problems of the 10 agencies, making recruitment a constant and costly process.

2. Agencies With Staffing Problems Offer Few Incentives to Assure Effective Selection And Retention Of Aides

Eleven agencies reported problems retaining aides, including the 10 agencies with recruiting problems. One major characteristic of these agencies is that they offer prospective aides the lowest wages and benefits among all the 25 agencies contacted. Agency administrators agreed this was the major reason for hiring and turnover problems. A typical response was: "Its hard to keep good aides because of poor pay and lack of benefits." In suburban and rural areas, the aides must provide their own transportation, usually a car, because public transportation is poor or nonexistent. In these cases, a valid license and fully-insured car is also required. One vendor does not reimburse its aides for transportation costs, while others provide reimbursement for mileage between patients' homes only.

Other disincentives, include:

- generally no pay during classroom training which may last up to 4 weeks.
- up to 6 months work for the agency or vendor before a certificate attesting to the aide's successful completion of the required training is awarded.
- no upward mobility opportunities and extremely limited hourly wage increases.

- o work assignments in some urban areas which are considered dangerous with no additional compensation made for these assignments.

- o little or no allowance for uniforms.

- o agency treatment of aides as "second-class" employees rather than paraprofessional members of a home care team.

3. Other Agencies Assure Effective Selection And Retention Of Aides Through Best Practices

The practices of most of the remaining 14 agencies in the sample group have resulted in effective hiring and retention of aides. Incentives offered to prospective employees have assured stable individuals and low or no turnover. Consequently, recruitment has rarely been a problem. Several agencies have waiting lists of prospective employees. Most of the agencies can afford to be selective in filling occasional vacancies.

The practices of these agencies include:

- o hiring aides, already trained, who have up to 2 years of patient care experience.

- o offering wages or salaries which provide annual earnings of from $12,000 to $18,000.

- o providing extensive health insurance and sick and vacation leave benefits.

- o reimbursing travel expenses at rates of $0.18 to $0.28 per mile, or the full cost of public transportation used.

- o providing advancement opportunity through significant incremental wage increases for both length of service and effective performance.

- o providing opportunities for positions of greater responsibility within the agency, and offering other incentives, such as tuition assistance programs to encourage continuing education in related health careers.

- o acknowledging aides as important members of the interdisciplinary home health care team.

4. Agency Practices Limit Efficient Use Of Aide Staff

Agency and vendor administrators agreed that many factors influence the assignment of aides to patients. Although a patient's condition was frequently cited as a main consideration, in practice most assignments appear to have been made based on the availability of the aide, the patient's location and the aide's access to transportation. This was particularly true where vendors provided aides under contract.

Most of the 25 agencies and vendors indicate they try to assign the same aide to a patient for the duration of the plan of care. However, a review of medical records showed 42 percent of the patients had three or more aides assigned to them over a period from 1 to 6 months. Vendors frequently substitute aides on cases because of turnover and unreliability of their aide staff.

5. Agency Policies and Practices Influence Length Of Aide Visits

Aides in six agencies indicated that the amount of time spent with each patient was influenced by the agencies' policies. A proprietary agency in one Western State requires all home health aide visits to Medicare patients to be 2 hours, regardless of whether the needs of individual patients require more or less time. One aide from this agency said: "Two hours is not enough for certain patients."

A proprietary agency in another Western State contracts directly with individual aides and pays them on a per visit basis. The aides stated that they spend about 30 to 45 minutes with each patient and see six to eight patients per day. Although they provided personal care services to their patients, including bathing, the taking of temperature, pulse and respiration readings and transferring the patient from bed, one aide said that an hour was needed just to properly bathe patients.

6. Medicare Fiscal Intermediary Policies Affect Agency Practices

Although HCFA policy directives are used by all fiscal intermediaries (FI), respondents in seven States indicated that FI application of policies varied both within States and from State-to-State. These policies, which have become more restrictive in recent years, have influenced the length and frequency of aide visits provided by most of the 16 agencies. Respondents

indicated that services which will be reimbursed will always be provided. Aide services that are frequently denied, based on experience with FI decisions, will be limited or not provided at all.

RECOMMENDATIONS

I. The Health Care Financing Administration (HCFA) should direct State survey agencies, through training programs and written instructions, to review selected plans of care and corresponding patient medical records to assure that all prescribed tasks are performed and documented by home health aides. Training and instruction of State surveyors is essential to assure that the Condition of Participation for aides is satisfied.

II. The HCFA should provide State survey agencies with administrative guidelines for assisting home health agencies in the selection, training, assignment and supervision of aides. This will prepare surveyors to help home health agencies correct deficiencies found during the survey process.

III. The HCFA should assure that required home visits are made by State surveyors. The criteria for conducting the home visit program should be reevaluated to assure that the program can be effectively carried out within existing budget limitations.

IV. The HCFA should encourage:

- States without specific State regulations on the training of home health aides to develop a curriculum for training home health aides, or adopt an existing curriculum. Completion of an established training program should be a prerequisite for a home health aide position.

- Organizations such as the National Homecaring Council, National Association For Home Care and the Joint Commission on the Accreditation of Hospitals to work with their members to improve home health aide services through more effective training and supervision.

V. The HCFA should revise those sections in the Health Insurance Manual for home health agencies and fiscal intermediaries (FI's) which deal with services provided by home health aides. The revisions should distinguish between personal care services and those services representing extensions of skilled care, indicating that all tasks in the plans of care are expected to be performed by aides during each visit.

VI. The HCFA should revise the Home Health Agency Coverage Compliance Review instructions to FI's. Revised instructions should expand the points to be addressed by FI's during onsite reviews to include comparison of aide tasks specified in plans of care with aide tasks performed, to assure that plans of care tasks for aides are fully implemented.

VII. The HCFA should review home health aide services provided under a contract to determine whether a limitation on such services would be appropriate, in view of the findings that aides under contract:

- did not perform the majority of extensions of skilled care tasks assigned to them;
- subjected Medicare patients to substandard practices; and
- made visits which were unnecessarily time consuming, frequent and costly.

APPENDIX I

HIGHLIGHTED HISTORY OF INTEREST IN HOME HEALTH ISSUES

In 1981, studies of home health services under Medicare by The General Accounting Office (GAO) and HCFA included findings and recommendations related to home health aide services. The GAO found that the use of aide services to assist beneficiaries with personal care could be reduced because either the beneficiary or family and friends often could and would have provided the care required. The HCFA identified overutilization of home health aide services resulting from Medicare fiscal intermediary misinterpretation of utilization policy.

Legislative changes in Section 1861(m)(4) of the Social Security Act in 1980 required home health aides to have "successfully completed a training program approved by the Secretary." The HCFA drafted a regulation which established a training curriculum to meet the intent of law. That regulation was never finalized and no training standard was established.

On October 19, 1981, the Senate Permanent Subcommittee of Investigations, chaired by Senator William Roth, followed an investigation into home health services with a report. Responding to concerns about home health agencies' practices in providing many services under contractual arrangements the Subcommittee recommended that nursing services and one other service be provided only by employees of the agencies. This recommendation was made to alleviate questionable circumstances under which many agencies, characterized as "brokerage houses" by the Subcommittee, had been providing services.

In 1982, HCFA advised the Subcommittee that its recommendation would be reviewed. At the request of then HCFA Administrator Davis, regulations were drafted addressing the Subcommittee's concerns as well as others HCFA had about the Conditions of Participation for home health agencies. Those regulations were never finalized, and home health agencies are still permitted to provide many skilled and home health aide services under contract.

At recent hearings on "Home Care Quality" held by the House Select Committee on Aging, testimony was presented which highlighted a number of issues addressed in this report. The Committee also released a report prepared by the American Bar Association, entitled "The Black Box of Home Care Quality", which addresses quality standards and systems for monitoring

the quality of care provided under Federal and State Programs. The Chairman of the House Select Committee on Aging, Representative Edward R. Roybal, sponsored a bill to address home care quality problems the Committee has identified. Among the reforms in the bill are "administrative and judicial sanctions" for quality assurance violations; the establishment by HHS of "training requirements for all individuals delivering home care services"; and the development of "certification requirements for homemakers, home health aides and personal care attendants."

In April 1987, the Senate Special Committee on Aging, Senator John Melcher, Chairman, held a hearing on "Home Care: The Agony of Indifference, the Role of the Older Americans Act in Assuring Access to Quality Home Care." Senator Melcher noted in his opening remarks at the hearing his intention to find a way to "insure quality home care to the millions of Americans who need it."

APPENDIX II

PROFILE OF REVIEW AND METHODOLOGY

The inspection included onsite visits in seven States (California, Connecticut, Illinois, New York, Pennsylvania, Tennessee and Texas) to 16 selected Medicare certified home health agencies (HHA's). Visits were also made in three of those States to nine aide vendor agencies with whom six of the 16 HHA's contract for aide services. Discussions were held with 194 respondents in these States and in five other States (Colorado, Iowa, Michigan, Minnesota and Ohio). Information on State standards was also provided by Florida, Iowa, Louisiana, Oregon and Virginia.

The 16 HHA's consisted of 12 voluntary agencies, including three hospital-based, and 4 proprietary organizations. Three agencies primarily serve urban areas, while two serve suburban areas; seven serve urban/suburban areas; three serve urban/suburban/ rural areas; and 1 a rural area. The nine vendors are primarily located in urban/suburban areas of three eastern States and one southern State.

Respondents included HHA and vendor administrative personnel, State surveyors and licensure personnel, supervisory visiting nurses, home health aides, Medicare patients, physicians, and representatives of labor unions, educational institutions and home care industry agencies. A total of 62 Medicare patients and 44 home health aides were visited in the patients' homes.

Medical records from each HHA were obtained and reviewed by skilled medical professionals on the inspection team. The records corresponded to active and discharged Medicare cases selected onsite. Three active patients per agency were selected for a home visit at a time when their home health aide was present. A discharged patient from each agency was also visited at home, where possible.

The remaining data included agency policies and procedures concerning home health aides; personnel records of aides interviewed; contracts with vendors providing aide services; labor union agreements; State laws and regulations and other standards concerning aides; and training curricula from State agencies and public and private educational institutions.

APPENDIX III

EFFECTIVE STATE STANDARDS

The following State standards are drawn from the 11 States in the inspection sample which have regulations for home health aide services. These standards are recognized by the inspection team as being effective in helping to assure that home health aides are capable of providing the highest quality services to Medicare patients.

Recruitment and Hiring

Trainees receive pay

The State of Connecticut requires agencies to hire prospective home health aides before classroom training begins. The agencies must provide aides with 10 hours of orientation to the agency. During the orientation and 60 hours of classroom training, agencies must pay the prospective aides minimum wage.

Training

Prior approval of training programs

Seven States require prior approval of training programs for home health aides: California, Connecticut, Illinois, Iowa, New York, Oregon and Texas.

Clinical experience required in training programs

Five States' training standards require a minimum of from 15 to 30 hours clinical experience before training is considered complete: California, Iowa, New York, Texas and Virginia. In New York, a graduate of classroom training is not deemed qualified to practice as a home health aide until clinical experience is completed. In California, home health aides do not qualify for State certification (attesting to successful completion of training) until all training requirements, including clinical experience, have been met.

Uniform statewide system for training

The State of Connecticut requires that all approved training programs for home health aides are conducted by the State Department of Education, Bureau of Vocational Technical Schools or the Regional Community College program coordinated by the Matatuck Community College.

Recognition of successful completion of training

Three States provide official State certificates attesting to the successful completion of training by the home health aide: California, Connecticut and Illinois. In the two latter states, certificates are issued by trainers/employers but a record of certification is not maintained on any permanent State registry.

In California, the Licensing and Certification Division of the Department of Health Services issues certificates directly to the home health aides. Each aide receives a certification number permanently assigned to the aide, and a record of certification is maintained on a registry by the licensing agency.

Continuing (in-service) education

Three States require employing agencies to provide a minimum amount of annual in-service training for home health aides: Connecticut, New York and Oregon.

Supervision

Periodic and direct supervision of aides

The State of California, alone, requires that a registered nurse provide direct supervision of the home health aide, i.e., while the aide is present, at least once every 2 weeks.

Ratio of supervisory nurses to home health aides

Three States mandate that a specific ratio exist between supervising nurse and home health aide staff: California, Connecticut and Florida.

APPENDIX IV

HCFA COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

File Copy

Memorandum

OFFICE OF THE INSPECTOR GENERAL

1987 JUL 24 PM 2:56

Date: JUL 23 1987

From: William L. Roper, M.D.
Administrator

Subject: OIG Draft Report "Home Health Aide Services for Medicare Patients" (OAI-02-86-00010)

To: The Inspector General
Office of the Secretary

We have reviewed the draft report on the quality of home health aide services provided to Medicare patients. We appreciate the analysis in the OIG report and are pleased to report that HCFA is in the process of responding to two of the major concerns contained in the OIG report: the need for better training of home health aides; and improved and more frequent home visits by State surveyors.

Our comments on the specific recommendations are attached for your consideration. Thank you for the opportunity to comment on this report.

Attachment

IG	✓
DIG	✓
~~AIG-A~~	
AIG-AI	✓
~~AIG-I~~	
ADM	
OGC/IG	
EX SEC	✓
DATE SENT	7/24

Comments of the Health Care Financing Administration
on the OIG Draft Report, "Home Health Aide Services
for Medicare Patients" (OAI-02-86-00010)

OIG Recommendation

HCFA should direct State survey agencies, through training programs and written instructions, to review selected plans of care and the corresponding patient medical records to assure that all prescribed tasks are performed and documented by home health aides. Training and instruction of State surveyors are essential to assure that the condition of participation for aides is satisfied.

HCFA Comments

HCFA agrees that training and instruction of State agency surveyors are essential to assure that the Condition of Participation for home health aides is satisfied. HCFA will send a communication to all regional offices requesting that they notify State agencies to review selected home health agency medical records and plans of treatment to assure that all aides' prescribed tasks are performed and documented as ordered by the patients' physicians.

HCFA will also continue to address clinical records review at all of its training sessions for State surveyors and will emphasize scrutinization of adherence to physicians orders with respect to services requested of, and provided by, home health aides.

OIG Recommendation

HCFA should provide State survey agencies with administrative guidelines for assisting home health agencies (HHAs) in the selection, training, assignment and supervision of aides. This will prepare surveyors to help home health agencies correct deficiencies found during the survey process.

HCFA Comments

The role of the surveyor is to assess and enforce Federal regulations rather than serve as a consultant to a provider in correcting its deficiencies. HHAs, as with other Medicare and Medicaid providers, are expected to be aware of the program's health and safety requirements and to comply with them.

The interpretive guidelines used by surveyors to assist them in conducting surveys of HHAs cannot impose more restrictive requirements than the conditions of participation.

It is true that a condition or standard may be met even though there is a deficiency at the standard or element level. However, this applies only if the deficiency:

- o Is not inconsistent with a statutory requirement;
- o does not interfere with adequate patient care;
- o does not represent a hazard to patients' health and safety;
- o is capable of being corrected within a reasonable period of time;
- o is one that the institution is making reasonable plans and efforts to correct; and
- o is not out of general conformity with the specific elements or the condition or standard stated at the beginning of each section of the requirements.

If there is a deficiency, the HHA also must submit an acceptable plan of correction before it can be certified or continue to be certified.

OIG Recommendation
HCFA should assure that required home visits are made by State surveyors. The criteria for conducting the home visit program should be reevaluated to assure that the program can be effectively carried out within existing budget limitations.

HCFA Comments
As evidence of HCFA's belief in the effectiveness of surveys, all States have been provided with additional resources to conduct HHA home visits. The budgeted amounts for FYs 1986, 1987 and 1988 are adequate for the continued required home visits by State surveyors.

Program data, with regard to workload accomplished, indicate that in FY 1986 States were required to inspect 3,161 HHAs (53 percent coverage). States actually surveyed 5,001 HHAs (84 percent coverage), a 58 percent increase over the minimally acceptable target. We have increased the minimally acceptable coverage level from 53 percent to 75 percent as reflected in the FY 1988 budget. Adequate Federal resources are provided each State to conduct required survey coverage levels.

In February 1987, HCFA awarded a contract to Abt Associates of Cambridge, Massachusetts, to develop an outcome oriented approach to survey HHAs. As a part of the contract, the current survey process and forms (including home visit procedures) are to be reevaluated and revised. This contract is expected to be completed in about 12 months.

OIG Recommendation
HCFA should encourage States without specific State regulations on the training of home health aides to develop a curriculum for training home health aides, or adopt an existing curriculum. Completion of an established training program should be a prerequisite of a home health aide position.

HCFA Comments
HCFA is developing a proposed revision to the Medicare Conditions of Participation which will strengthen requirements for home health aide training and supervision in a manner which addresses this recommendation and which will create incentives for States to develop a curriculum for training home health aides or to adopt an established curriculum.

OIG Recommendation
HCFA should encourage organizations such as the National Homcaring Council, National Association for Home Care and the Joint Commission on the Accreditation of Hospitals to work with their members to improve home health aide services through more effective training and supervision.

HCFA Comments
HCFA routinely disseminates information to national organizations for use in training providers of services. HCFA staff have appeared as guest speakers at meetings of the American Health Care Association to share information and data. We will continue to maintain a working relationship with these organizations and will encourage them to work with their members to improve home health aide services.

OIG Recommendation
HCFA should revise those sections in the Health Insurance Manual for HHAs and fiscal intermediaries (FI's) which deal with services provided by home health aides. The revisions should distinguish between personal care services and those services representing extensions of skilled care, indicating that all tasks in the plans of care are expected to be performed by aides during each visit.

Also, HCFA should revise the Home Health Agency Coverage Compliance Review instructions to FI's. Revised instructions should expand the points to be addressed by FI's during onsite reviews to include comparison of aide tasks specified in plans of care with aide tasks performed, to assure that plans of care tasks for aides are fully implemented.

HCFA Comments
It is not clear to us whether OIG is recommending that HCFA revise the Home Health Agency Manual and the Coverage Compliance Review Program to require intermediaries to deny payment for home health aide services when the aide provides ordered personal care, but does not provide the extensions of skilled nursing services which are ordered on the plan of treatment. If so, we cannot support the recommendation because we do not believe there is a statutory basis for denying Medicare payment for a home health aide visit where all coverage criteria are met, even if the aide did not provide some of the services which were ordered on the plan of treatment.

However, we would consider including in the Home Health Agency Manual and the State Operations Manual, a section which indicates that HCFA considers it to be a significant health and safety breach if the HHA is not ensuring that the home health aide provides the services ordered on the plan of treatment.

We also would consider including in the Coverage Compliance Review Program (Part A Intermediary Manual), a statement which indicates that intermediaries who become aware of situations in which the home health aide is not providing all of the services required to be provided by the aide in the plan of treatment, should bring the situation to the attention of the HCFA regional office. The regional office would be responsible for reviewing the information provided by the intermediary, forwarding it to the State agency, and determining the nature of the action to be taken by the State agency.

OIG Recommendation

HCFA should review home health aide services provided under a contract to determine whether a limitation on such services would be appropriate.

HCFA Comments

We believe that the proposed regulations will resolve the findings of the OIG study with respect to supervision of aide services which are provided under contract.

General Comment

One of the problems identified in the report (page 18) is that intermediary application of policy varies both within States and from State to State. It is alleged that these policies have influenced the length and frequency of aide visits provided.

In October 1986, HCFA began assigning/reassigning freestanding home health agencies (HHAs) to 10 designated regional intermediaries. These transfers will be completed by September 1, 1987. A proposed rule has also been published to assign/reassign provider-based HHAs to the designated intermediaries. It is anticipated that the reduction in the number of intermediaries processing HHA bills will lead to greater consistency. Since the designation of the 10 regional intermediaries, HCFA has been working with them to identify areas where inconsistent determinations have been made, to arrive at proper determinations, and to see that in the future the guidelines will be applied uniformly.