Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HOME HEALTH: PROBLEM PROVIDERS AND THEIR IMPACT ON MEDICARE

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EXECUTIVE SUMMARY

PURPOSE

This report identifies and describes the common characteristics of problem home health agencies and how these agencies contribute to Medicare fraud, abuse, and waste.

BACKGROUND

Medicare covers home health care to homebound beneficiaries who need intermittent skilled nursing care and/or physical or speech therapy. Medicare does not limit the number of visits or the length of home health coverage. Services are covered for as long as reasonable and necessary to treat the patient's illness or injury. There are no beneficiary copayments or deductibles for home care visits.

While the majority of Medicare providers are complying with the home health benefit requirements, recent work by the Office of Inspector General and the General Accounting Office has shown that this benefit is very susceptible to abuse. Furthermore, it is sometimes extremely difficult, and often impossible, for the program to recover overpayments. To gain greater insight about these problems, we examined a stratified random sample of 60 home health agencies from a universe of 698 providers that were identified by the fiscal intermediary, the Health Care Financing Administration (HCFA), or the Office of Inspector General as having met our definition of a "problem" home health agency. We define a problem home health agency as one that has abused or defrauded Medicare or misappropriated Medicare funds through the cost report or claims process. The providers were chosen from five States--New York, Florida, Illinois, Texas, and California--that were the focus for the special Medicare anti-fraud initiative known as Operation Restore Trust.

FINDINGS

One quarter of home health agencies in the five Operation Restore Trust States are "problem" providers, and they receive almost 45 percent of all Medicare expenditures for home health services in these States

Of the $5.7 billion paid to home health agencies in the five Operation Restore Trust States in 1995, problem agencies received $2.5 billion. Nationally, 8949 Medicare-certified home health agencies received $15.4 billion.

Problem home health agencies share ownership and operational characteristics that can thwart overpayment recovery and undermine sanctions

Most problem home health agencies are closely-held corporations. Their owners are frequently involved in related organizations and complex businesses relationships. Some of them have used their corporations to misappropriate Medicare funds and incur substantial Medicare overpayments that cannot be recovered. The owners of problem agencies

frequently rely on family members and consultants to help them run their agencies. Relying almost exclusively on Medicare for income and assets, entrepreneurs are able to open and operate home health agencies without fixed assets or startup costs. The owners and principals can continue to receive Medicare money, because HCFA has few preventive measures.

Expansion of the benefit and the lack of any restrictions on certification have led to ever-increasing administrative problems with little prospect of mitigation

The number of home health agencies has almost doubled, and Medicare home health costs have more than quadrupled since 1989. Thorough review of cost reports and claims can uncover a wide variety of unallowable costs and non-covered services, but submission requirements and limited resources hamper fiscal intermediaries' oversight efforts.

RECOMMENDATIONS

To protect the Medicare home health benefit, HCFA needs to develop and implement additional program safeguards that would (1) strengthen it's ability to identify problem providers, (2) prevent problem HHAs from entering the program, and (3) prevent the Medicare trust fund from incurring further losses due to the activities of problem HHAs.

In order to accomplish this, HCFA should take administrative action or, if necessary, seek legislative authority to:

- require surety bonds of new and existing home health agencies;
- require user fees to cover the cost of certifications, comprehensive reviews, and recertifications;
- require that agency principals have prior health care experience;
- develop a data bank of owners, principals, and related organizations;
- require that agency principals and owners provide their Social Security and Employer Identification numbers prior to certification;
- require that home health agencies are fiscally sound prior to certification;
- deny certification to owners and principals of current or defunct agencies who are not financially responsible and trustworthy;
- preclude the discharge of Medicare debts through bankruptcy.

We also reiterate our previous recommendation that HCFA should:

- tighten controls over the periodic interim payment method of reimbursement and seek legislation that would eliminate it entirely.

PROPOSED LEGISLATION

The President has announced legislative proposals to fight fraud and abuse in health care. Many of the provisions in the President's "Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997" would strengthen HCFA's ability to address our findings regarding problem HHAs. Several of these provisions are also contained in Medicare anti-fraud legislation that has been proposed by Congress. The President's proposals include:

- denying participation in Medicare for any person convicted of a felony,
- requiring providers to furnish Social Security and Employer Identification numbers of all owners and managing employees prior to certification,
- collecting user fees to perform certifications and recertifications,
- excluding entities controlled by family members of sanctioned individuals,
- penalizing anyone who relies on sanctioned individuals to authorize or provide services,
- prohibiting providers from using bankruptcy to stay the recovery of overpayments or discharge Medicare debts,
- clarifying the definitions of homebound and part-time or intermittent services, and
- eliminating PIP through the implementation of prospective payment in the year 2000.

AGENCY COMMENTS

We received comments on the draft report from the Assistant Secretary for Planning and Evaluation and the Assistant Secretary for Management and Budget. Based on their comments we modified the report to more fully describe recent anti-fraud legislative proposals which have been sent to the Congress by the President and to clarify that not all of the increase in home health services in recent years is the result of illegitimate billings by problematic providers.

We also received comments from the HCFA Administrator. The HCFA concurs with the majority of our recommendations, although only partially with two of them that concern the financial stability of HHAs. Furthermore, HCFA does not support our recommendation for a moratorium on certifying new home health agencies until new program controls are put into effect.

We continue to believe that the financial management integrity should be an important criterion in certifying them as suitable for participation in the Medicare program.

With respect to a moratorium, HCFA states that it has the responsibility to establish and implement adequate program requirements and safeguards and that if a home health agency is able to comply with these requirements, it should be allowed to enter the program. We

agree that HCFA does have such a responsibility. We are also aware that numerous legislative proposals similar to those we recommend in this report are now pending before the Congress. If enacted, these proposals would greatly strengthen HCFA's ability to curb abuses. For these reasons, we have withdrawn our recommendation for a moratorium at this time.

However, we remain very concerned about this program. Current program requirements are woefully inadequate to prevent financially irresponsible or fraudulent home health agencies from becoming Medicare providers. On the same day that we are issuing this report, we are issuing another one that shows that, in four of the five States reviewed in this report, 40 percent of Medicare payments for home health should not have been made, resulting in losses of approximately $2.6 billion over a 15-month period. We believe that Medicare cannot continue to sustain losses of this magnitude. If, even after enactment of new legislation and stronger administrative action, there is no major reduction of improper payments, then more dramatic action will need to be taken by HCFA and the Congress. This should include the establishment of strict criteria relating to the trustworthiness of applicants, adequate resources to allow for a thorough review of applicants, and a concurrent decertification of problem providers already certified in the program who are responsible for a disproportionate share of Medicare losses. Under these circumstances, a brief moratorium could be appropriate while HCFA tools up its review mechanisms and reexamines the suitability of previously certified problem providers.

The full text of each agency's comments appears in Appendix D.

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INTRODUCTION

PURPOSE

This report identifies and describes the common characteristics of problem home health agencies (HHAs) and how these agencies contribute to Medicare fraud, abuse, and waste.

BACKGROUND

The Medicare Home Health Benefit

Medicare covers home health care to homebound beneficiaries who need intermittent skilled nursing care and/or physical or speech therapy. Medicare home health benefits include (1) part-time or intermittent nursing care provided directly by or under the supervision of a registered nurse; (2) physical, occupational, and speech therapy; (3) medical social services if related to the patient's health problems; and (4) part-time or intermittent home health aide services when provided as an adjunct to skilled nursing or therapy care. To be covered by Medicare, home health services must be furnished under a plan of care that is signed and reviewed by a physician every 62 days.

Medicare does not limit the number of visits or the length of home health coverage. Services are covered for as long as reasonable and necessary to treat the patient's illness or injury. As a Part A benefit, there are no beneficiary copayments or deductibles for home care.

To be eligible for Medicare reimbursement, HHAs must be certified Medicare providers. The Health Care Financing Administration (HCFA) administers the Medicare program. HCFA contracts with State licensing and certification agencies who are responsible for determining if providers meet and continue to meet the Medicare conditions of participation.

Once certified, providers may furnish home health services using their own staff or others under a contract arrangement. Reimbursement is based on the costs (subject to geographically-based cost limits) incurred in providing covered visits to eligible beneficiaries. Medicare-certified HHAs are either proprietary (private, for-profit), voluntary (private, nonprofit), or Government owned and operated.

The HCFA contracts with eight regional home health intermediaries, referred to throughout this report as fiscal intermediaries, to process home health claims, set reimbursement rates, make payments, educate providers, audit cost reports, and maintain payment safeguards.

Rapid Growth in Home Health

The home health care industry is the fastest growing segment of health care in the United States. This growth began in 1989, when, as a result of a lawsuit, changes in Medicare regulations expanded eligibility and eliminated the cap on the number of visits. Since that time, the number of Medicare-certified HHAs has risen from 5730 in 1990 to 8949 in 1995.

While the number of beneficiaries receiving HHA services has grown, costs to the Medicare program have increased disproportionately. Total annual Medicare expenditures for home health grew from $3.7 billion in 1990 to $15.4 billion in 1995. As detailed in the following chart, home health visits more than tripled and payments more than quadrupled in 6 years.

NATIONAL MEDICARE HOME HEALTH UTILIZATION STATISTICS

	1990	**1995**	**Percent Change***
Total Medicare Beneficiaries	34.2 million	37.6 million	**+10%**
Beneficiaries Who Received HHA Services	1.98 million	3.48 million	**+76%**
Total HHA Reimbursement	$3.7 billion	$15.4 billion	**+316%**
HHA Percentage of Total Medicare Program Dollars	3.7%	8.7%	**+135%**
Average HHA Reimbursement per Patient	$1,892	$4,438	**+135%**
Total HHA Visits	70 million	250 million	**+255%**
Average HHA Visits per Patient	36	72	**+100%**

*Percentages may not be exact due to rounding

Many of these increases can be traced to the influx of for-profit HHAs. According to a 1996 General Accounting Office (GAO) report, proprietary agencies are not only the highest utilizers of HHA services, they have undergone the most rapid growth. In 1993, proprietary agencies provided an average of 78 visits annually per beneficiary, while the number of visits provided by voluntary and government agencies averaged 46. Furthermore, in 1989, 35 percent of all HHAs were proprietary, but, by 1995, approximately 50 percent were. In a 1995 study of variation in Medicare payments for home health services, the Office of Inspector General (OIG) found that proprietary for-profit HHAs receive higher reimbursement per visit and provide significantly more visits per patient than either voluntary non-profit or government owned and operated HHAs.

Inadequacy of Current Safeguards

While the majority of Medicare providers are complying with the home health benefit requirements, recent work by both the OIG and the GAO has shown that the home health benefit is very susceptible to fraud and abuse. For example, the OIG recently completed audits of eight HHAs in Florida, Pennsylvania, and California. These audits revealed that between 19 and 64 percent of the home health visits that had been billed by the HHAs did not meet Medicare coverage guidelines. Patients were not homebound and visits that had been billed to Medicare were not medically reasonable or necessary, not documented or provided, and not authorized by physicians. Preliminary data from Statewide audits in New York, Texas, Illinois, and California show similar problems.

The OIG has investigated numerous cases of home health fraud during the last several years. Appendix C contains a synopsis of some fraud cases that were not included in the sample we selected for this inspection.

Definition of Problem Home Health Agency

For purposes of this inspection, we tentatively defined a "problem" HHA as one that has been identified by HCFA, a fiscal intermediary, the State certification and/or licensing agency, or the OIG as meeting one or more of the following conditions:

- has incurred significant uncollected overpayments;
- routinely submits cost reports with significant inappropriate and unallowable costs;
- files a cost report that is determined to be unauditable;
- routinely does not file cost reports within a reasonable time;
- has submitted multiple claims for services that are not medically necessary;
- has submitted multiple claims for services that were not rendered;
- continues to submit problem claims despite educational contacts;
- has significant certification deficiencies;
- has been referred to the fiscal intermediary's program integrity unit; or
- has been referred to the OIG by the fiscal intermediary.

As noted in the methodology section which follows, prior to selecting our sample, we further refined our definition to assure that we included only those HHAs with significant and/or multiple problems.

Operation Restore Trust

Operation Restore Trust (ORT) began as a 2-year a new health care anti-fraud demonstration initiative. The ORT is a crackdown on Medicare and Medicaid fraud, waste, and abuse in HHAs, nursing homes, and durable medical equipment suppliers in five States--California, New York, Florida, Texas, and Illinois--that account for 40 percent of the nation's Medicare beneficiaries and program expenditures. As part of ORT, the OIG has undertaken a number of national program inspections aimed at identifying and eliminating systemic weaknesses that allow fraud, waste, and abuse to occur in the Medicare program. We conducted this inspection as part of ORT.

The fiscal intermediaries serving the five ORT States are Blue Cross of California, Blue Cross of Illinois, Aetna (Florida), Palmetto Government Benefits Administrators (Texas), United Government Services (New York), and IASD Health Services Corporation (Iowa, national alternate intermediary).

METHODOLOGY AND SCOPE

In June 1996, the California Operation Restore Trust Steering Committee convened a meeting of representatives from the OIG, HCFA, and the fiscal intermediaries to discuss participants' concerns about fraud, abuse, and waste in the Medicare home health benefit.

Based on that meeting and additional analysis, we developed our initial definition of a "problem" HHA.

From July through September, we visited the five Medicare fiscal intermediaries who serve the ORT States as well as the backup intermediary in Iowa. In addition to conducting interviews with fiscal intermediary audit, medical review, and program integrity staff, we reviewed selected files to determine how and what information is routinely maintained by intermediaries. Based on the visits, we were able to refine our working definition of a problem HHA and develop a list of characteristics to look for during the inspection.

In addition to the fiscal intermediary staff, we conducted visits and telephone interviews with the State licensing and certification agencies and HCFA regional offices to determine what information could be retrieved from their files to help us identify common characteristics. These discussions led us to investigate the use of commercial databases to obtain information about corporations and individuals who either own or manage HHAs. While none of these database systems are comprehensive and all of them have their limitations, we chose CDB Infotek to help validate and complement information we collected.

Although each organization maintains much information, we learned that there is little consistency and considerable variation in the nature and type of information as well as the way the information is maintained and retained. As might be expected, we found considerable duplication of information and data among the various organizations.

Universe and Sample Selection: The universe for this inspection consists of all Medicare-certified HHAs in the ORT States which meet one or more of the conditions listed in our definition of a problem HHA. The list of 698 providers was compiled from lists of problem providers identified by fiscal intermediaries serving the ORT States during the fourth quarter of fiscal year 1996. Our original list had approximately 800 providers, but we refined the list to include only HHAs with significant and/or multiple problems.

PROBLEM MEDICARE HHAs BY ORT STATE

State	Certified HHAs	Problem HHAs
California	653	145
Florida	313	209
Illinois	336	35
New York	213	41
Texas	1214	268
TOTAL	2729	698

We selected 60 providers using a simple random sample, stratified by fiscal intermediary. Our sample consisted of 10 providers for each of the 6 fiscal intermediaries serving the

5 ORT States. For Iowa, we selected 10 HHAs from the ORT States with the proportions based on the total number of agencies per State: 3 from California, 4 from Texas, 1 from Illinois, 1 from New York, and 1 from Florida. For all but one fiscal intermediary, we used spares because file information was missing or an audit was in progress at the time of our visit.

Data Collection: We gathered data from the following sources: (1) the audit, medical review, and program integrity files maintained by the six fiscal intermediaries; (2) public records regarding business ownership, criminal convictions, and related information maintained on-line by CDB Infotek; and (3) files and databases maintained by the OIG, HCFA, and State licensing and certification agencies.

The inspection team conducted on-site visits to the fiscal intermediaries to review their files for the 60 sample HHAs. We combined the information from the on-site reviews with data and information from CDB Infotek as well as HCFA and the OIG. We used a database software program for analysis.

Many of the percentages and statistics mentioned in the report findings are understated for the following reasons:

- We relied on information contained in fiscal intermediary files, and these files are not consistently and uniformly maintained;
- State and national databases are dissimilar and not always thorough;
- Many of these home health agencies are under current investigation and therefore the fiscal intermediary files lack valuable information;
- Many of the HHAs are so new that fiscal intermediary files do not include detailed audit information; and
- Some of the HHAs had not billed Medicare in 1995 because they had filed bankruptcy in a previous year.

FINDINGS

One quarter of home health agencies in the five Operation Restore Trust States are "problem" providers, and they receive almost 45 percent of all Medicare expenditures for home health services in these States

More than 25 percent of the home health agencies in ORT States are problem providers

Of the 2729 HHAs in the 5 ORT States, our list of problem providers totalled 698, or approximately one-fourth of the total number of HHAs. Nationally, there were 8949 Medicare-certified HHAs in 1995.

Of the 676 problem HHAs for which we have ownership information, 80 percent are for-profit with an additional 10 percent designated as non-profit but private. Nationwide, slightly less than 50 percent of all Medicare-certified HHAs are for-profit.

Problem home health agencies received nearly 45 percent of Medicare home health payments in the ORT States

Although the problem providers represented approximately 25 percent of the total number of HHAs in the ORT States, they received $2.5 billion of the $5.7 billion paid to HHAs in these States in 1995.[1] Nationally, Medicare paid $15.4 billion for home health services.

For-profit problem HHAs received $1.74 billion or almost 70 percent of the total Medicare payments that were made to problem providers in the five ORT States. While this represents a smaller percentage of total reimbursement than their numbers might indicate, their average reimbursement per patient is approximately $6000 which is almost 50 percent more than nonprofit problem HHAs.

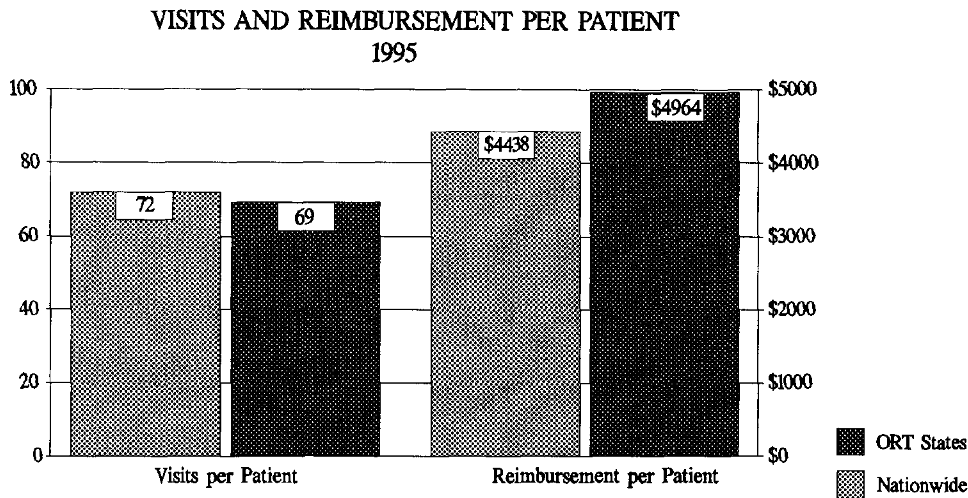
Our sample providers received more than $440 million in 1995. This is almost 8 percent of the total reimbursement in the ORT States for home health services, even though the number of providers represents only 2 percent of the total number of HHAs in these States.

HHAs in ORT States mirror the nation

Thirty percent of all Medicare-certified HHAs are located in ORT States, and they receive almost 40 percent of all Medicare payments for home health services. Despite the fact that

[1] These totals do not include total dollar amounts for some of the chain providers, but rather the individual agencies. Furthermore, these represent total expenditures and is not intended to imply that all of the payments were inappropriate.

they represent a disproportionate share of the national figures, their per patient statistics mirror those for all HHAs.



Although the ORT States are some of the largest in the nation, they represent a variety of characteristics. For example, Texas is the State with the largest number of HHAs, highest Medicare expenditures, and greatest number of total visits. While Texas also ranks near the top in reimbursement and number of visits per patient, several non-ORT States exceed it. In comparison, Florida is slightly above the national average in these categories. California is close to the national average in reimbursement per patient and below the average in visits per patient. New York and Illinois are considerably below average in both of these categories. See appendix A for more detailed State rankings.

Problem home health agencies share ownership and operational characteristics that can thwart overpayment recovery and undermine sanctions

Most problem home health agencies are closely-held corporations whose owners are involved in related organizations and complex business relationships

Problem HHAs are typically for-profit corporations owned by one, two, or, at the most, five individuals. Almost 40 percent of the HHAs in our sample are family-owned, usually by husband and wife teams. Many others are owned by siblings, a sole individual, or two unrelated persons. While many of these closely-held corporations are simple "mom and pop" operations, their annual Medicare revenue ranges from $50,000 to as much as $33 million.

For the most part, the owners of these HHAs are neither health care professionals nor do they have any prior health care business experience. In fact, of the 31 sampled providers for whom ownership background information is readily available, only 14 have an owner who is a health care professional. This is usually a nurse. Those owners who have previous health

care business experience usually gained it at another problem HHA. More commonly the owners came to home health from such unrelated businesses as investment banking, trucking, real estate, accounting, the beauty industry, and even jai alai.

More than half of the problem HHAs have ownership interests in related companies which do business with the home health agency. The related companies frequently own the office space and lease it to the HHA. Some exist merely to provide the HHA with office equipment or lease automobiles for the owners' use. Separate but related companies also provide billing, consultant, and/or administrative services to the HHA.

It is not unusual for owners of problem agencies to have links with other HHAs and questionable relationships with physicians. Nearly one quarter of the owners in our sample own other HHAs, while another quarter have informal links with other HHAs. Fiscal intermediaries have identified numerous situations where a problem HHA has sold patients, shared employees, and used the same referral physicians. They have also discovered potential kickback situations where referring physicians routinely "rubber stamp" plans of care for one or more problem HHAs.

During the course of our inspection, we identified several situations where the owners of problem HHAs are involved in other businesses which they did not disclose as related organizations for Medicare reimbursement purposes. These businesses included durable medical equipment, health consulting, board and care facilities, hospices, retirement homes, and nurse registries which may be providing services directly to the HHA or acting as referral and recruitment sources for the HHA.

The complex web of interrelated businesses enables the owners of some problem HHAs to maximize their Medicare reimbursement while claiming that the HHA itself barely breaks even or operates at a loss. Some owners receive full-time salaries from the HHA despite having ownership interest and concomitant responsibilities in other companies. Others may be paid twice for the same service, as in the case of HHA owners who also own board and care facilities. The HHAs are paid to provide home health aide services to the board and care residents while the board and care facility receives per diem that is intended to include aide services. Still others may own property or equipment that is worth far less than the amount they are charging the HHA and the HHA is reporting on its cost report as a Medicare patient-related expense. (See appendix B for an illustration of these issues.)

The owners of problem home health agencies frequently rely on family members and consultants to help them run the agency

Problem HHAs typically employ or contract with relatives to serve in key positions. More than half of the HHAs in our sample paid spouses, siblings, children, nieces, nephews, and/or in-laws to perform services for the HHA. One-quarter of the agencies have 4 or more relatives who serve as owners and employees and 4 of the agencies employ, or contract with, 10 or more family members.

Family members rarely have any health care experience. Rather, they come from such diverse backgrounds as military service, engineering, and teaching. We also noted that several family members were college students with no prior work experience.

Some relatives are on the HHA's payroll but perform little or no work. One HHA, for example, contracted with the owner's nephew to maintain the agency's computers for $250,000. The nephew was a full-time college student at the time, and his services were not commensurate with the amount of money he was paid. In another situation, the HHA's payroll included three relatives. The checks that were issued to these relatives were not cashed by the relatives but instead were returned to the agency and cashed by the HHA's owners. These relatives were "ghost employees" whose existence allowed the agency to claim costs that were never really incurred.

While many consultants provide valuable services for start-up agencies, a few have earned their reputations as inside experts who can help HHAs "maximize their Medicare reimbursement." They claim to have intimate knowledge of each fiscal intermediary's operations and promise to "work the system" to increase the HHA's reimbursement rate and the owner's compensation allowance as well as to insulate the owner from personal liability.

Three-fourths of the HHAs in our sample use management or reimbursement consultants who specialize in home health. We identified 13 consultants who each work for 2 or more of the problem HHAs in our sample. We were able to ascertain that nearly half of these consultants were former fiscal intermediary, State agency, or HCFA employees.

Following the advice of these consultants, problem HHAs realize even higher reimbursement than their counterparts. For the sampled HHAs, reimbursement per beneficiary was more than 20 percent higher when 1 of the 13 consultants was involved ($7042 vs. $5787). These HHAs also consistently make exorbitant claims for administrative overhead, such as owner's salary. For example, one HHA claimed $200,000 salaries each for the husband and wife owners, plus an additional $100,000 for their daughter owner. Another claimed a total of $350,000 for husband and wife owner salaries.

Use of these consultants is not always a "guarantee" of success. Each of the five HHAs in our sample that was involuntarily terminated based on an expanded certification survey had contracted with one of these consultants.

Relying almost exclusively on Medicare for income and assets, entrepreneurs are able to open and operate home health agencies without fixed assets or startup costs

Problem HHAs rarely treat non-Medicare patients. For more than three-quarters of the sampled providers, greater than 90 percent of their income is derived from Medicare. In Texas, where there has been a marked increase in the number of HHAs in the last few years, the sample HHAs average an astonishing 98 percent of income from Medicare. Few, if any, of them have contracts with health maintenance organizations or Medicaid, both of whom frequently restrict the number of home health services, limit payment, or more closely monitor services than does Medicare.

If it were not for Medicare accounts receivable, problem agencies would have almost nothing to report as assets. Agencies tend to lease their office space, equipment, and vehicles. They are not required by Medicare to own anything, and they are almost always undercapitalized. On average, cash on hand and fixed assets amount to only one-fourth of total assets for the HHAs, while Medicare accounts receivable frequently equal 100 percent of total assets. These agencies are almost totally dependent on Medicare to pay their salaries and other operating expenses.

For a home health agency, there are virtually no startup costs or capitalization requirements. In many instances, the problem agencies lease everything without collateral. They do not pay user fees to Medicare, they do not reimburse Medicare for the cost of the State agency survey, and they do not even have enough cash on hand to meet their first payroll.

More than half of the agencies in our sample claimed that they lost money. The average net income was less than $7500. So why and how do they stay in business and why do they keep expanding? Because they are able to manipulate the Medicare cost reimbursement system and provide the owners and other principals with personal income that far exceeds the concept of "reasonable cost."

The owners and principals of problem home health agencies can continue to receive Medicare money, because HCFA has few preventive measures

Problem HHAs can accumulate substantial and uncollectible Medicare overpayments. When overpayments are determined by the fiscal intermediary, or even before it has a chance to do so, many HHAs file bankruptcy or merely cease business to avoid the debt. After these HHAs declare bankruptcy or disappear, Medicare has little chance of recovery because the debts apply only to the defunct corporation, not to individual owners or their other businesses.

Approximately one-third of the agencies in our sample receive periodic interim payments (PIP) from Medicare. For those HHAs, payments are made on a regular basis without regard for the services they provide or the claims they submit. The PIP payments are reconciled against actual expenses when the cost report is submitted, which may be as long as 5 months after the end of the HHA's fiscal year. The other agencies in our sample receive interim payments based on the claims they submit during the course of the year. These are also reconciled when the cost report is submitted. Under either payment method, overpayments can accrue. The PIP method, however, leaves the program more vulnerable because there may not even be claims to substantiate the payments that have been made.

One-third of the sample HHAs incur significant overpayments every year. These overpayments range from $100,000 to several million annually. For the providers in our sample on PIP, the overpayments are greatest. In fact, seven of the PIP providers account for $56 million in outstanding overpayments. In a 1995 report, the OIG noted that PIP providers accumulate a disproportionate share of Medicare overpayments and recommended that HCFA more closely monitor the PIP program and seek legislation that would eliminate it entirely.

The 60 HHAs in our sample have a combined outstanding Medicare debt exceeding $321 million. Of that amount, at least $63 million will never be recovered, because the HHAs are no longer in business, have no assets, or have filed bankruptcy. Almost all of these HHAs are repeat offenders, who maintain consistently high overpayment balances and regularly request, and sometimes are granted, extended repayment plans.

The HCFA can terminate a problem provider, but like closing the barn door after the horse runs off, the action comes too late to recover Medicare's losses. Nine HHAs in our sample have been terminated involuntarily, and two others had branches that were terminated. Three providers, who were involuntarily terminated, left the program owing a total of $47 million.

Owners of problem HHAs find ingenious ways to make money even when their businesses are terminated. For example, one HHA profited by selling its patients to another HHA for $1,000 each. Another sold its branches to its employees who then proceeded to obtain Medicare certification.

Problem providers don't let termination or bankruptcy interfere with taking advantage of Medicare. Many reorganize and open a new HHA, often joining forces with key individuals from other problem providers. Owners and key staff, especially nurses and administrators, move from one problem provider to another, often bringing their patients and unscrupulous practices with them.

Even when Medicare terminates an HHA, other HHAs owned by the same individual through different corporations continue to operate. For example, the principals of one family-owned HHA operate several related HHAs, each established as a separate corporation; one HHA filed for bankruptcy without affecting the others. When Medicare terminated another HHA, its owners simply discharged the patients and then readmitted them to another HHA they owned in a city nearby.

Some problem HHAs simply cease doing business after receiving hundreds of thousands or even millions in reimbursement, often without bothering to inform HCFA or the fiscal intermediary. Still others undergo a change of ownership where the new owner does not assume the prior owner's assets or liabilities.

The HCFA does not require fiscal solvency through secured assets or surety bonding. This leaves Medicare holding the bag when a problem provider goes out of business. Under the Medicare conditions of participation, HCFA may require HHAs to meet "such additional requirements (including conditions relating to bonding or escrow accounts, as the Secretary finds necessary for the financial security of the program)...." However, HCFA has not enforced this provision.

Expansion of the benefit and the lack of restrictions on certification have led to ever-increasing administrative problems with little prospect of mitigation

The number of agencies and Medicare costs have grown dramatically since 1989

In 1989, based on a lawsuit (Duggan v. Bowen), HCFA implemented regulatory changes that expanded eligibility for home health services and eliminated the cap on the number of visits. Since that time, the number of HHAs nationally has almost doubled. During the same period, the percentage of beneficiaries receiving home health services has increased but not nearly as significantly as the number of visits and reimbursement per patient, each of which has more than doubled.

Certain States have expanded more than others. In Texas and California, the number of Medicare-certified agencies has increased by more than 50 percent in just 2 years. In terms of reimbursement, Texas has gone from approximately $750 million to $1.8 billion total home health reimbursement and from $4300 in average per patient reimbursement to $7100 per patient in the same time period. While California has had a similar growth pattern, Texas has surpassed the other ORT States in each of these categories while still serving fewer beneficiaries than either California or Florida.

Some States limit the number of HHAs, but Medicare costs still rise

In contrast to the uncontrolled growth in Texas and California, in New York and Florida the number of agencies has grown by less than 10 percent. Since HCFA does not limit the number of certified HHAs, controls are at the State's discretion. Both Florida and New York require new HHAs to go through a Certificate of Need process before they can be licensed. Unfortunately, the mere existence of a Certificate of Need requirement does not guarantee that all new HHAs are actually needed. In response to questions about the value of the Certificate of Need, some of our contacts believe that it is "just another way for the State to make money" without really addressing or controlling the need for new HHAs.

In Florida, because of the way the Certificate of Need is administered, the number of HHAs continues to rise, albeit at a slower rate than in States without this requirement. New York, on the other hand, decided to stop processing new HHA applications early in 1994, effectively imposing an informal "moratorium" on new agencies.

One effect of limiting the number of new HHAs is that existing HHAs grow larger. For New York and Florida, the two sample States with a Certificate of Need requirement, the 1995 average reimbursement per HHA was $3.3 million and $4.6 million respectively. The next highest State averaged $1.9 million per agency.

Another effect in States which limit new HHAs is that the existing agencies have larger beneficiary patient loads. In Florida and New York, for example, the average number of beneficiaries per agency is over 900; HHAs in Texas average only 200 beneficiaries each.

In States like New York and Florida, having fewer HHAs to monitor has made the fiscal intermediary's, HCFA's, and the State agency's oversight responsibilities much more manageable. Despite their increased size, each HHA's modus operandi remains the same so the government and its contractors need not deal with all of the problems inherent in new agencies, particularly ones that are just entering the business to "get rich quick."

In States where the number of new HHAs has increased dramatically during the last few years, fiscal intermediaries estimate that as many as 50 percent of the new agencies are problem providers.

Problem agencies frequently exceed national and State averages in several areas

Compared to their respective States and the rest of the nation, problem agencies typically:

(1) have a higher average number of visits per patient,
(2) receive higher average reimbursement per patient,
(3) see more chronic patients,
(4) are relatively newer, and
(5) are located in dense population areas where few, if any, new agencies are needed.

- *Problem HHAs perform significantly more visits per patient.* Sample agencies ranged from as low as 20 visits per patient for the newest providers to as high as 285 visits per patient for older agencies. Forty percent of the problem HHAs exceeded an average 100 visits per patient. As shown in the following chart, problem HHAs routinely exceed the statewide average number of visits per patient:

COMPARISON OF AVERAGE NUMBER OF VISITS PER PATIENT

	Problem HHAs	Statewide HHAs
CA	89	53
FL	87	78
IL	73	54
NY	61	49
TX	143	116

According to HCFA data, problem HHAs significantly exceed other HHAs in average number of visits per patient even when case mix, based on age, race, primary diagnosis, and gender, is taken into consideration. Furthermore, three-quarters of our sample providers rank in the top third of the nation for total number of visits per agency. Almost half of the sample providers also rank in the top third for average number of visits per patient.

- *Problem HHAs have a higher average reimbursement per patient.* Nearly two-thirds of our sample providers have an average reimbursement per patient that is higher than the national average which is $4438. One-third have patients whose average reimbursement exceeds $7000, and six of them have average reimbursements that exceed $12,000 per patient. For six of the HHAs in our sample, their average reimbursement per patient grew between 150 and 340 percent in 1 year.

- *Problem HHAs serve more chronic patients.* The majority of the HHAs in our sample specialize in patients who are rarely discharged. Although these patients may need fewer skilled nursing visits, they may need routine visits by both nurses and home health aides for the rest of their lives. Diabetes and hypertension are two of the most common diagnoses for these types of patients.

- *Problem HHAs are newer.* One-third of the sample HHAs have been certified for less than 4 years.

- *Problem HHAs tend to be located in saturated markets.* Nearly one quarter of our sample have solicited patients, swapped patients (ping ponging), sold patients or provided medically unnecessary services. Because they operate in markets where there are enough HHAs to serve the Medicare population, they use these strategies to enlist and retain patients. The fiscal intermediaries serving these HHAs have even received allegations that a patient does not need skilled nursing care, so the HHA is supplying someone to mow the lawn, shop, chauffeur, or keep the beneficiary company.

The lack of requirements for background checks, credit checks, and prior health care experience allows anyone, even those with questionable pasts, to receive Medicare certification

The current certification process does not take into account HHA owners' credit and financial history, criminal records, or past work experience. This allows certification to be granted to just about anyone. Bankruptcies, unpaid Federal debts (including Medicare overpayments), even criminal convictions (that are not specifically related to Medicare and Medicaid), do not preclude individuals from obtaining Medicare certification for their HHAs.

By utilizing a readily available commercial database, we were able to determine that more than one-third of the HHAs we researched had questionable backgrounds. We found instances where the HHAs and their owners had filed bankruptcy, defaulted on loans, failed to pay Federal or State taxes, and had been found guilty of criminal wrongdoing. Many of these existed before the HHA became certified. For example:

- The owner of one of the HHAs in our sample, who was listed as a co-debtor on two Federal tax liens against a nursing service, opened another Medicare-certified HHA a few years later. The latter HHA went out of business in mid-1996 and did not inform HCFA, its fiscal intermediary, or the State agency. As a result, the HHA continued

to receive Medicare checks, never submitted a cost report, and, a few months later, filed bankruptcy.

- The owner of another HHA went bankrupt twice and had a felony conviction prior to opening the HHA.

Some fiscal intermediaries have begun using online services to verify information supplied by HHAs. However, since HCFA does not preclude certification in these situations, any negative information that is discovered is of limited value. At present, the most common use of the online service is to identify undisclosed related organizations for cost report audit purposes.

Thorough review of cost reports and claims can uncover a wide variety of unallowable costs and noncovered services, but submission requirements and limited resources hamper fiscal intermediaries' oversight efforts

Fiscal intermediary resources for oversight have not kept pace with the rapid increase in the number of HHAs. In California, 80 new HHAs opened in a recent 4-month period, but the fiscal intermediary's oversight resources were not increased proportionately. In fact, their resources for fiscal year 1997 were decreased. Furthermore, fiscal intermediaries are funded to perform only a few on-site audits. For example, one fiscal intermediary is funded to perform less than 12 percent of its home health agency audits on-site, while another is funded to perform approximately 20 percent. The on-site audit is usually very limited in scope, and less than 5 percent of all audits are comprehensive reviews of all the costs claimed by an individual HHA.

- *HHAs can receive Medicare payments for 18 months or more before any improperly claimed costs are identified and disallowed by a fiscal intermediary.* HHAs are required to submit cost reports within 5 months after the close of their fiscal year. This means that an HHA can operate for up to a year and a half before the fiscal intermediary has an opportunity to review costs and make adjustments. Some problem HHAs have billed and received large Medicare payments for 12 to 16 months and then gone out of business without filing cost reports. When this happens, Medicare has no way to identify unallowable costs, let alone collect any overpayments. Three HHAs in our sample went out of business without filing cost reports. One of these had incurred $6 million in overpayments that are now uncollectible.

  When problem HHAs do submit cost reports, fiscal intermediaries frequently find significant unallowable costs during on-site audits. However, because the number of on-site audits is limited, we cannot measure the full extent of the problems. The following examples, which represent audit adjustments from our sampled providers, illustrate the types of adjustments that could be made only through on-site audits:

  Unreasonable Owner's Compensation: The allowable amount for owner's compensation is based on the time and type of work that the owner does for

the HHA. One HHA owner, who also runs a major home health consulting business, claimed a full-time salary from the HHA. The owner of another HHA is a full-time school teacher who claimed a full-time salary from the HHA. Yet another owns a private duty nursing service, a retirement home, a health care facilities construction company, a durable medical equipment company, and an automobile rental agency and still claimed a $182,000 salary from the HHA.

<u>Undisclosed Related Organizations</u>: These entities typically (1) lease office space, equipment, or automobiles to the HHA, (2) provide financial, management consulting, or maintenance services, or (3) contract with the HHA to provide direct patient services or supplies. HHA owners profit through their interest in the related organizations which they do not mention on the cost report.

For example, one HHA had six or more related agencies that provided everything from nursing services and medical supplies, to maintenance, construction, and property leasing. None of the companies were disclosed on the cost report even though they were owned by the HHA owner or his family. In this agency's case, the four principals claimed salaries of $152,000 each on the HHA's cost report. Another agency claimed costs for a medical supply company whose address was actually a Seven-Eleven convenience store. This medical supply company did not exist, and the convenience store was, in fact, owned and operated by one of the HHA owner's relatives.

<u>Ghost Employees</u>: To inflate the cost of providing patient care services, the HHA maintains records that indicate salaries were paid to employees who do not exist. In one case, the fiscal intermediary discovered that salary or compensation checks were written to nonexistent employees, the checks were cashed, and the money was returned to the owners.

<u>Nonpatient-related Expenses</u>: Because Medicare reimburses HHAs only for the costs associated with patient care, some agencies lump nonpatient-related expenses with patient-related ones in an attempt to bury the nonreimbursable costs. For the HHAs in our sample, auditors have become aware of such "buried" items as trips to resorts, the purchase of liquor for a national HHA association meeting, promotional items such as T-shirts, home remodeling, purchase of real and personal property, health club dues, and even maintenance of a horse.

<u>Discrepancies in Visit Counts</u>: This situation has been discovered during on-site audits, when there were no records to substantiate patient visits that had been billed to Medicare. When this is discovered, the fiscal intermediary puts the HHA on prepayment review. In response, one problem provider simply increased claims volume to compensate for the increased denial rate.

Unreasonable Contractor or Related Organization Costs: Both of these practices are ways for owners of problem providers to maximize reimbursement. High payments to contractors can be an indication of kickbacks, while high payments to related organizations end up back in the owner's pocket.

- *By conducting on-site medical reviews, fiscal intermediaries can discover a variety of fraudulent and abusive practices that can't be identified during routine claims processing.* Fiscal intermediaries often uncover illegal or questionable patient-related practices during on-site medical reviews of problem providers. Many of these practices are discovered only during on-site reviews, because problem HHAs often know how to document claims to make them look legitimate. Some of the most common fraudulent and abusive practices include:

  - billing for services not rendered; for example, padding visits,

  - billing for noncovered services; for example, where the patient does not qualify because he is not homebound,

  - providing services that are not medically necessary; for example, therapy services or durable medical equipment,

  - favoring one or two chronic diagnoses from which the patients will never recover; for example, hypertension and diabetes,

  - ping ponging; for example, sharing beneficiaries with other agencies, and

  - using rogue doctors or nurses; for example, doctors who sign plans of care without seeing the patient or nurses who contract with several agencies and cannot possibly make all of the visits for which they bill, e.g., the full-time owner of 1 HHA who billed 32 visits in a single day through another agency.

  While on-site medical reviews can be invaluable oversight tools, problem providers know that limited fiscal intermediary resources mean there is little chance they will be selected for review. Also, since fiscal intermediaries notify providers well in advance of planned visits, problem HHAs have plenty of time to make sure that their "documentation" is complete. They know that fiscal intermediaries rarely contact beneficiaries for verification.

Under Operation Restore Trust, the fiscal intermediaries servicing at least two of the ORT States have participated in HCFA regional office initiatives to conduct multidisciplinary on-site HHA reviews. These reviews, which include medical, accounting, and certification areas, have resulted in numerous investigations and terminations of HHAs that should not have been certified in the first place. In California, 47 expanded surveys were conducted and, as a result, 23 HHAs have been terminated or voluntarily withdrew from the Medicare program.

RECOMMENDATIONS

To protect the Medicare home health benefit, HCFA needs to develop and implement additional program safeguards that would (1) strengthen it's ability to identify problem providers, (2) prevent problem HHAs from entering the program, and (3) prevent the Medicare trust fund from incurring further losses due to the activities of problem HHAs.

In order to accomplish this, HCFA should take administrative action or, if necessary, seek legislative authority to:

- require that each HHA obtain a surety bond equal to the amount of anticipated Medicare billings during its fiscal year. Should the HHA's claims exceed the amount of the bond before a cost report has been filed and audited, the HHA should be required to increase the amount of the surety bond accordingly. The cost of the bond should not be considered reimbursable for Medicare cost reporting purposes.

- require "user fees," so that new and existing HHAs are required to pay for their initial certifications, comprehensive on-site reviews, and recertifications. If this is not possible, we believe that the allocation of additional resources to the certification and monitoring effort by the fiscal intermediaries, State agencies, and HCFA regional offices will pay for itself, because it will substantially reduce or even eliminate the continued accrual of uncollectible overpayments as well as payments for noncovered and medically unnecessary services.

- require that the majority of the HHA's principals have prior health care experience directly related to the provision of home health services in order to receive Medicare certification.

- develop a data bank of owners, principals, and other HHA officials and related organizations so that their activity can be monitored, tracked, and cross-referenced.

- require that all HHA owners and principals provide their individual Social Security numbers and Employer Identification numbers when they submit an application to become Medicare providers.

- prior to certification, assure that new HHAs are financially sound and have adequate fiscal recordkeeping capabilities and that their owners and principals are qualified and trustworthy. This should be accomplished through a comprehensive on-site review by an interdisciplinary team of auditors, medical reviewers, and State surveyors.

- refuse to enter into a provider agreement with any HHA whose owners or principals:

    - owe money to the Federal government in the form of Medicare overpayments, tax liens, or unpaid loans;

- have filed bankruptcy or have negative credit ratings;

- have prior criminal records; and/or

- have been associated with, or are the relatives of the owner of, a Medicare provider who was found to defraud, abuse, or otherwise misappropriate Medicare dollars.

- preclude the discharge of Medicare debts through bankruptcy.

We also reiterate our previous recommendation that HCFA should:

- tighten controls over the PIP program, more closely monitor HHAs that are on PIP, and seek legislation to eliminate this method of reimbursement.

Proposed Legislation

The President has announced legislative proposals to fight fraud and abuse in health care. Many of the provisions in the President's "Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997" would strengthen HCFA's ability to address our findings regarding problem HHAs. Several of these provisions are also contained in Medicare anti-fraud legislation that has been proposed by Congress. The President's proposals include:

- denying participation in Medicare for any person convicted of a felony,
- requiring providers to furnish Social Security and Employer Identification numbers of all owners and managing employees prior to certification,
- collecting user fees to perform certifications and recertifications,
- excluding entities controlled by family members of sanctioned individuals,
- penalizing anyone who relies on sanctioned individuals to authorize or provide services,
- prohibiting providers from using bankruptcy to stay the recovery of overpayments or discharge Medicare debts,
- clarifying the definitions of homebound and part-time or intermittent services, and
- eliminating PIP through the implementation of prospective payment in the year 2000.

Agency Comments

We received comments on the draft report from the Assistant Secretary for Planning and Evaluation and the Assistant Secretary for Management and Budget. Based on their comments we modified the report to more fully describe recent anti-fraud legislative proposals which have been sent to the Congress by the President and to clarify that not all of the increase in home health services in recent years is the result of illegitimate billings by problematic providers.

We also received comments from the HCFA Administrator. The HCFA concurs with the majority of our recommendations, although only partially with two of them that concern the

financial stability of HHAs. Furthermore, HCFA does not support our recommendation for a moratorium on certifying new home health agencies until new program controls are put into effect.

We continue to believe that the financial management integrity should be an important criterion in certifying them as suitable for participation in the Medicare program.

With respect to a moratorium, HCFA states that it has the responsibility to establish and implement adequate program requirements and safeguards and that if a home health agency is able to comply with these requirements, it should be allowed to enter the program. We agree that HCFA does have such a responsibility. We are also aware that numerous legislative proposals similar to those we recommend in this report are now pending before the Congress. If enacted, these proposals would greatly strengthen HCFA's ability to curb abuses. For these reasons, we have withdrawn our recommendation for a moratorium at this time.

However, we remain very concerned about this program. Current program requirements are woefully inadequate to prevent financially irresponsible or fraudulent home health agencies from becoming Medicare providers. On the same day that we are issuing this report, we are issuing another one that shows that, in four of the five States reviewed in this report, 40 percent of Medicare payments for home health should not have been made, resulting in losses of approximately $2.6 billion over a 15-month period. We believe that Medicare cannot continue to sustain losses of this magnitude. If, even after enactment of new legislation and stronger administrative action, there is no major reduction of improper payments, then more dramatic action will need to be taken by HCFA and the Congress. This should include the establishment of strict criteria relating to the trustworthiness of applicants, adequate resources to allow for a thorough review of applicants, and a concurrent decertification of problem providers already certified in the program who are responsible for a disproportionate share of Medicare losses. Under these circumstances, a brief moratorium could be appropriate while HCFA tools up its review mechanisms and reexamines the suitability of previously certified problem providers.

The full text of each agency's comments appears in Appendix D.

APPENDIX A

The following 5 tables represent summary data of all home health agencies in all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. We obtained the information from the HCFA Customer Information System. The five charts contain the same information, sorted by five important variables. The ORT States are at or near the top when looking at aggregate numbers of claims, total reimbursement, total patients, and total visits. The ORT States tend to drop to average or below average, however, when looking at per patient statistics.

NOTE: The five ORT States are shaded for emphasis.

HHA SUMMARY DATA -- STATES SORTED BY TOTAL REIMBURSEMENT FOR 1995

State	Total Claims	Total Reimbursement	Total Patients	Total Visits	Average Reimbursement per Patient	Average Visits per Patient
TX	2,017,336	$1,762,784,352	245,223	28,492,559	$7,188	116
FL	1,177,823	$1,437,381,433	289,392	22,673,540	$4,967	78
CA	1,087,558	$1,232,292,688	262,411	13,858,769	$4,696	53
TN	741,475	$747,043,282	110,771	13,157,404	$6,744	119
NY	662,393	$710,025,600	196,361	9,588,465	$3,616	49
PA	921,427	$697,116,831	223,913	10,108,911	$3,113	45
LA	897,294	$656,604,845	84,095	12,064,526	$7,808	143
MA	743,379	$565,869,870	120,494	11,237,546	$4,696	93
IL	735,237	$551,026,844	153,542	8,227,909	$3,589	54
GA	588,527	$525,999,053	95,980	10,209,736	$5,480	106
MI	478,751	$467,980,050	126,675	6,268,031	$3,694	49
OH	642,806	$466,023,099	145,721	7,770,724	$3,198	53
AL	549,376	$453,834,415	81,565	9,766,686	$5,564	120
OK	495,363	$450,743,746	60,483	7,796,641	$7,452	129
MS	422,495	$355,159,176	59,503	7,374,113	$5,969	124
NC	468,223	$330,028,822	99,146	5,534,482	$3,329	56
MO	438,561	$318,538,153	94,108	4,946,663	$3,385	53
IN	372,097	$312,954,991	71,141	5,592,118	$4,399	79
NJ	369,893	$293,786,448	98,482	4,188,451	$2,983	43
CT	267,680	$271,695,871	57,721	4,562,117	$4,707	79
VA	318,982	$245,974,060	72,829	3,758,603	$3,377	52
KY	334,927	$211,726,968	59,623	3,977,675	$3,551	67
SC	216,685	$182,528,625	47,404	3,180,825	$3,850	67
AR	273,556	$170,554,835	45,393	3,579,627	$3,757	79
CO	160,774	$159,199,686	34,883	2,293,206	$4,564	66
MD	163,397	$147,122,944	49,829	1,854,381	$2,953	37
AZ	124,257	$141,433,666	33,697	1,914,602	$4,197	57
WA	167,805	$137,248,931	45,926	1,744,537	$2,988	38
WI	183,638	$127,119,783	46,720	1,981,404	$2,721	42
UT	106,580	$118,925,525	19,147	1,998,036	$6,211	104
KS	138,376	$111,786,864	29,900	1,821,852	$3,739	61
OR	112,281	$90,461,850	29,338	1,109,631	$3,083	38
MN	113,175	$86,935,663	31,721	1,342,319	$2,741	42
IA	144,491	$86,559,442	35,640	1,739,504	$2,429	49
WV	155,911	$84,849,043	28,151	1,542,992	$3,014	55
ME	112,663	$78,920,340	21,637	1,504,263	$3,647	70
RI	92,245	$77,826,643	19,195	1,211,596	$4,055	63
NM	88,288	$63,197,547	15,760	1,044,356	$4,010	66
PR	184,272	$60,675,397	38,332	1,410,561	$1,583	37
NV	43,171	$56,590,722	11,960	787,453	$4,732	66
NH	95,963	$56,346,863	17,558	1,162,998	$3,209	66
ID	68,267	$56,047,308	13,443	877,159	$4,169	65
NE	69,127	$47,397,869	17,524	748,666	$2,705	43
VT	76,165	$37,284,278	12,626	827,436	$2,953	66
MT	46,152	$32,342,351	10,351	540,432	$3,125	52
DE	38,376	$28,865,907	9,843	478,895	$2,933	49
WY	23,882	$23,883,264	5,261	415,050	$4,540	79
DC	21,029	$21,439,998	6,717	258,496	$3,192	38
ND	34,782	$20,619,203	8,485	382,079	$2,430	45
HI	18,207	$20,154,084	4,702	244,968	$4,286	52
SD	32,855	$19,557,153	7,768	326,003	$2,518	42
AK	7,638	$9,475,697	1,974	90,338	$4,800	46
VI	656	$780,953	170	10,207	$4,594	60

HHA SUMMARY DATA -- STATES SORTED BY TOTAL PATIENTS FOR 1995

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MS	422,495	$355,159,176	59,503	7,374,113	$5,969	124
CT	267,680	$271,695,871	57,721	4,562,117	$4,707	79
MD	163,397	$147,122,944	49,829	1,854,381	$2,953	37
SC	216,685	$182,528,625	47,404	3,180,825	$3,850	67
WI	183,638	$127,119,783	46,720	1,981,404	$2,721	42
WA	167,805	$137,248,931	45,926	1,744,537	$2,988	38
AR	273,556	$170,554,835	45,393	3,579,627	$3,757	79
PR	184,272	$60,675,397	38,332	1,410,561	$1,583	37
IA	144,491	$86,559,442	35,640	1,739,504	$2,429	49
CO	160,774	$159,199,686	34,883	2,293,206	$4,564	66
AZ	124,257	$141,433,666	33,697	1,914,602	$4,197	57
MN	113,175	$86,935,663	31,721	1,342,319	$2,741	42
KS	138,376	$111,786,864	29,900	1,821,852	$3,739	61
OR	112,281	$90,461,850	29,338	1,109,631	$3,083	38
WV	155,911	$84,849,043	28,151	1,542,992	$3,014	55
ME	112,663	$78,920,340	21,637	1,504,263	$3,647	70
RI	92,245	$77,826,643	19,195	1,211,596	$4,055	63
UT	106,580	$118,925,525	19,147	1,998,036	$6,211	104
NH	95,963	$56,346,863	17,558	1,162,998	$3,209	66
NE	69,127	$47,397,869	17,524	748,666	$2,705	43
NM	88,288	$63,197,547	15,760	1,044,356	$4,010	66
ID	68,267	$56,047,308	13,443	877,159	$4,169	65
VT	76,165	$37,284,278	12,626	827,436	$2,953	66
NV	43,171	$56,590,722	11,960	787,453	$4,732	66
MT	46,152	$32,342,351	10,351	540,432	$3,125	52
DE	38,376	$28,865,907	9,843	478,895	$2,933	49
ND	34,782	$20,619,203	8,485	382,079	$2,430	45
SD	32,855	$19,557,153	7,768	326,003	$2,518	42
DC	21,029	$21,439,998	6,717	258,496	$3,192	38
WY	23,882	$23,883,264	5,261	415,050	$4,540	79
HI	18,207	$20,154,084	4,702	244,968	$4,286	52
AK	7,638	$9,475,697	1,974	90,338	$4,800	46
VI	656	$780,953	170	10,207	$4,594	60

HHA SUMMARY DATA -- STATES SORTED BY TOTAL VISITS FOR 1995

State	Total Claims	Total Reimbursement	Total Patients	Total Visits	Average Reimbursement per Patient	Average Visits per Patient
TX	2,017,336	$1,762,784,352	245,223	28,492,559	$7,188	116
FL	1,177,823	$1,437,381,433	289,392	22,673,540	$4,967	78
CA	1,087,558	$1,232,292,688	262,411	13,858,769	$4,696	53
TN	741,475	$747,043,282	110,771	13,157,404	$6,744	119
LA	897,294	$656,604,845	84,095	12,064,526	$7,808	143
MA	743,379	$565,869,870	120,494	11,237,546	$4,696	93
GA	588,527	$525,999,053	95,980	10,209,736	$5,480	106
PA	921,427	$697,116,831	223,913	10,108,911	$3,113	45
AL	549,376	$453,834,415	81,565	9,766,686	$5,564	120
NY	662,393	$710,025,600	196,361	9,588,465	$3,616	49
IL	735,237	$551,026,844	153,542	8,227,909	$3,589	54
OK	495,363	$450,743,746	60,483	7,796,641	$7,452	129
OH	642,806	$466,023,099	145,721	7,770,724	$3,198	53
MS	422,495	$355,159,176	59,503	7,374,113	$5,969	124
MI	478,751	$467,980,050	126,675	6,268,031	$3,694	49
IN	372,097	$312,954,991	71,141	5,592,118	$4,399	79
NC	468,223	$330,028,822	99,146	5,534,482	$3,329	56
MO	438,561	$318,538,153	94,108	4,946,663	$3,385	53
CT	267,680	$271,695,871	57,721	4,562,117	$4,707	79
NJ	369,893	$293,786,448	98,482	4,188,451	$2,983	43
KY	334,927	$211,726,968	59,623	3,977,675	$3,551	67
VA	318,982	$245,974,060	72,829	3,758,603	$3,377	52
AR	273,556	$170,554,835	45,393	3,579,627	$3,757	79
SC	216,685	$182,528,625	47,404	3,180,825	$3,850	67
CO	160,774	$159,199,686	34,883	2,293,206	$4,564	66
UT	106,580	$118,925,525	19,147	1,998,036	$6,211	104
WI	183,638	$127,119,783	46,720	1,981,404	$2,721	42
AZ	124,257	$141,433,666	33,697	1,914,602	$4,197	57
MD	163,397	$147,122,944	49,829	1,854,381	$2,953	37
KS	138,376	$111,786,864	29,900	1,821,852	$3,739	61
WA	167,805	$137,248,931	45,926	1,744,537	$2,988	38
IA	144,491	$86,559,442	35,640	1,739,504	$2,429	49
WV	155,911	$84,849,043	28,151	1,542,992	$3,014	55
ME	112,663	$78,920,340	21,637	1,504,263	$3,647	70
PR	184,272	$60,675,397	38,332	1,410,561	$1,583	37
MN	113,175	$86,935,663	31,721	1,342,319	$2,741	42
RI	92,245	$77,826,643	19,195	1,211,596	$4,055	63
NH	95,963	$56,346,863	17,558	1,162,998	$3,209	66
OR	112,281	$90,461,850	29,338	1,109,631	$3,083	38
NM	88,288	$63,197,547	15,760	1,044,356	$4,010	66
ID	68,267	$56,047,308	13,443	877,159	$4,169	65
VT	76,165	$37,284,278	12,626	827,436	$2,953	66
NV	43,171	$56,590,722	11,960	787,453	$4,732	66
NE	69,127	$47,397,869	17,524	748,666	$2,705	43
MT	46,152	$32,342,351	10,351	540,432	$3,125	52
DE	38,376	$28,865,907	9,843	478,895	$2,933	49
WY	23,882	$23,883,264	5,261	415,050	$4,540	79
ND	34,782	$20,619,203	8,485	382,079	$2,430	45
SD	32,855	$19,557,153	7,768	326,003	$2,518	42
DC	21,029	$21,439,998	6,717	258,496	$3,192	38
HI	18,207	$20,154,084	4,702	244,968	$4,286	52
AK	7,638	$9,475,697	1,974	90,338	$4,800	46
VI	656	$780,953	170	10,207	$4,594	60

HHA SUMMARY DATA -- STATES SORTED BY AVERAGE REIMBURSEMENT PER PATIENT FOR 1995

State	Total Claims	Total Reimbursement	Total Patients	Total Visits	Average Reimbursement per Patient	Average Visits per Patient
LA	897,294	$656,604,845	84,095	12,064,526	$7,808	143
OK	495,363	$450,743,746	60,483	7,796,641	$7,452	129
TX	2,017,336	$1,762,784,352	245,223	28,492,559	$7,188	116
TN	741,475	$747,043,282	110,771	13,157,404	$6,744	119
UT	106,580	$118,925,525	19,147	1,998,036	$6,211	104
MS	422,495	$355,159,176	59,503	7,374,113	$5,969	124
AL	549,376	$453,834,415	81,565	9,766,686	$5,564	120
GA	588,527	$525,999,053	95,980	10,209,736	$5,480	106
FL	1,177,823	$1,437,381,433	289,392	22,673,540	$4,967	78
AK	7,638	$9,475,697	1,974	90,338	$4,800	46
NV	43,171	$56,590,722	11,960	787,453	$4,732	66
CT	267,680	$271,695,871	57,721	4,562,117	$4,707	79
MA	743,379	$565,869,870	120,494	11,237,546	$4,696	93
CA	1,087,558	$1,232,292,688	262,411	13,858,769	$4,696	53
VI	656	$780,953	170	10,207	$4,594	60
CO	160,774	$159,199,686	34,883	2,293,206	$4,564	66
WY	23,882	$23,883,264	5,261	415,050	$4,540	79
IN	372,097	$312,954,991	71,141	5,592,118	$4,399	79
HI	18,207	$20,154,084	4,702	244,968	$4,286	52
AZ	124,257	$141,433,666	33,697	1,914,602	$4,197	57
ID	68,267	$56,047,308	13,443	877,159	$4,169	65
RI	92,245	$77,826,643	19,195	1,211,596	$4,055	63
NM	88,288	$63,197,547	15,760	1,044,356	$4,010	66
SC	216,685	$182,528,625	47,404	3,180,825	$3,850	67
AR	273,556	$170,554,835	45,393	3,579,627	$3,757	79
KS	138,376	$111,786,864	29,900	1,821,852	$3,739	61
MI	478,751	$467,980,050	126,675	6,268,031	$3,694	49
ME	112,663	$78,920,340	21,637	1,504,263	$3,647	70
NY	662,393	$710,025,600	196,361	9,588,465	$3,616	49
IL	735,237	$551,026,844	153,542	8,227,909	$3,589	54
KY	334,927	$211,726,968	59,623	3,977,675	$3,551	67
MO	438,561	$318,538,153	94,108	4,946,663	$3,385	53
VA	318,982	$245,974,060	72,829	3,758,603	$3,377	52
NC	468,223	$330,028,822	99,146	5,534,482	$3,329	56
NH	95,963	$56,346,863	17,558	1,162,998	$3,209	66
OH	642,806	$466,023,099	145,721	7,770,724	$3,198	53
DC	21,029	$21,439,998	6,717	258,496	$3,192	38
MT	46,152	$32,342,351	10,351	540,432	$3,125	52
PA	921,427	$697,116,831	223,913	10,108,911	$3,113	45
OR	112,281	$90,461,850	29,338	1,109,631	$3,083	38
WV	155,911	$84,849,043	28,151	1,542,992	$3,014	55
WA	167,805	$137,248,931	45,926	1,744,537	$2,988	38
NJ	369,893	$293,786,448	98,482	4,188,451	$2,983	43
MD	163,397	$147,122,944	49,829	1,854,381	$2,953	37
VT	76,165	$37,284,278	12,626	827,436	$2,953	66
DE	38,376	$28,865,907	9,843	478,895	$2,933	49
MN	113,175	$86,935,663	31,721	1,342,319	$2,741	42
WI	183,638	$127,119,783	46,720	1,981,404	$2,721	42
NE	69,127	$47,397,869	17,524	748,666	$2,705	43
SD	32,855	$19,557,153	7,768	326,003	$2,518	42
ND	34,782	$20,619,203	8,485	382,079	$2,430	45
IA	144,491	$86,559,442	35,640	1,739,504	$2,429	49
PR	184,272	$60,675,397	38,332	1,410,561	$1,583	37

HHA SUMMARY DATA -- STATES SORTED BY AVERAGE VISITS PER PATIENT FOR 1995

State	Total Claims	Total Reimbursement	Total Patients	Total Visits	Average Reimbursement per Patient	Average Visits per Patient
LA	897,294	$656,604,845	84,095	12,064,526	$7,808	143
OK	495,363	$450,743,746	60,483	7,796,641	$7,452	129
MS	422,495	$355,159,176	59,503	7,374,113	$5,969	124
AL	549,376	$453,834,415	81,565	9,766,686	$5,564	120
TN	741,475	$747,043,282	110,771	13,157,404	$6,744	119
TX	2,017,336	$1,762,784,352	245,223	28,492,559	$7,188	116
GA	588,527	$525,999,053	95,980	10,209,736	$5,480	106
UT	106,580	$118,925,525	19,147	1,998,036	$6,211	104
MA	743,379	$565,869,870	120,494	11,237,546	$4,696	93
WY	23,882	$23,883,264	5,261	415,050	$4,540	79
AR	273,556	$170,554,835	45,393	3,579,627	$3,757	79
IN	372,097	$312,954,991	71,141	5,592,118	$4,399	79
CT	267,680	$271,695,871	57,721	4,562,117	$4,707	79
FL	1,177,823	$1,437,381,433	289,392	22,673,540	$4,967	78
ME	112,663	$78,920,340	21,637	1,504,263	$3,647	70
KY	334,927	$211,726,968	59,623	3,977,675	$3,551	67
SC	216,685	$182,528,625	47,404	3,180,825	$3,850	67
VT	76,165	$37,284,278	12,626	827,436	$2,953	66
NM	88,288	$63,197,547	15,760	1,044,356	$4,010	66
NV	43,171	$56,590,722	11,960	787,453	$4,732	66
NH	95,963	$56,346,863	17,558	1,162,998	$3,209	66
CO	160,774	$159,199,686	34,883	2,293,206	$4,564	66
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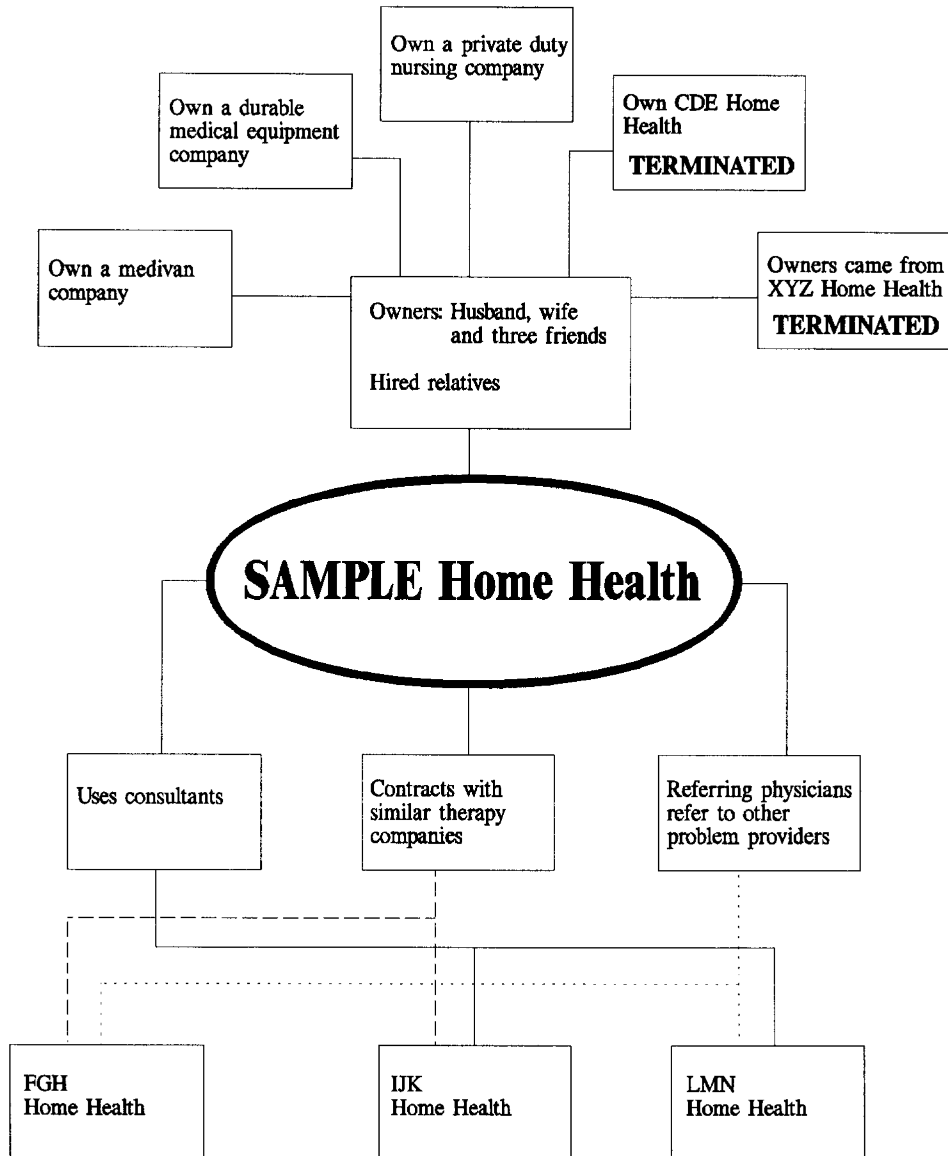
RI	92,245	$77,826,643	19,195	1,211,596	$4,055	63
KS	138,376	$111,786,864	29,900	1,821,852	$3,739	61
VI	656	$780,953	170	10,207	$4,594	60
AZ	124,257	$141,433,666	33,697	1,914,602	$4,197	57
NC	468,223	$330,028,822	99,146	5,534,482	$3,329	56
WV	155,911	$84,849,043	28,151	1,542,992	$3,014	55
IL	735,237	$551,026,844	153,542	8,227,909	$3,589	54
MO	438,561	$318,538,153	94,108	4,946,663	$3,385	53
CA	1,087,558	$1,232,292,688	262,411	13,858,769	$4,696	53
OH	642,806	$466,023,099	145,721	7,770,724	$3,198	53
HI	18,207	$20,154,084	4,702	244,968	$4,286	52
VA	318,982	$245,974,060	72,829	3,758,603	$3,377	52
MT	46,152	$32,342,351	10,351	540,432	$3,125	52
MI	478,751	$467,980,050	126,675	6,268,031	$3,694	49
DE	38,376	$28,865,907	9,843	478,895	$2,933	49
NY	662,393	$710,025,600	196,361	9,588,465	$3,616	49
IA	144,491	$86,559,442	35,640	1,739,504	$2,429	49
AK	7,638	$9,475,697	1,974	90,338	$4,800	46
PA	921,427	$697,116,831	223,913	10,108,911	$3,113	45
ND	34,782	$20,619,203	8,485	382,079	$2,430	45
NE	69,127	$47,397,869	17,524	748,666	$2,705	43
NJ	369,893	$293,786,448	98,482	4,188,451	$2,983	43
SD	32,855	$19,557,153	7,768	326,003	$2,518	42
MN	113,175	$86,935,663	31,721	1,342,319	$2,741	42
WI	183,638	$127,119,783	46,720	1,981,404	$2,721	42
OR	112,281	$90,461,850	29,338	1,109,631	$3,083	38
DC	21,029	$21,439,998	6,717	258,496	$3,192	38
WA	167,805	$137,248,931	45,926	1,744,537	$2,988	38
MD	163,397	$147,122,944	49,829	1,854,381	$2,953	37
PR	184,272	$60,675,397	38,332	1,410,561	$1,583	37

APPENDIX B

A COMPLEX CORPORATE WEB



APPENDIX C

The OIG, in conjunction with other Federal, State, and local law enforcement agencies, has conducted numerous successful fraud investigations and audits regarding the home health benefit before and during Operation Restore Trust. A synopsis of some of the cases that were completed during the past 2 years follows. The summaries are in no particular order. They represent cases that were not included in our sample of 60 problem home health agencies.

- An employee of an HHA in Missouri was sentenced to 21 months imprisonment and 2 years of probation and was ordered to pay $6000 in restitution after pleading guilty to making false Medicare claims. Over a 2-year period, the employee misrepresented herself as a licensed social worker. The HHA owner allowed the employee to perform psychiatric services on nursing home patients, but billed Medicare as if the owner had performed the services. Overpayments amounted to $23,000.

- The co-owner of a Washington D.C. HHA was sentenced to 27 months in prison and ordered to pay full restitution of $100,000. The HHA defrauded the Medicare and Medicaid programs by billing for 1450 skilled nursing visits in a 10-month period for which there were neither time slips nor nurses' notes. It also billed for hospitalized patients. Another co-owner was also convicted disappeared after escaping from a detention center assignment.

- The former owner of a Texas HHA was sentenced to 27 months incarceration after pleading guilty to presenting false claims to Medicare. The owner was indicted for billing for visits which the HHA did not make. This combined with the owner's prior State conviction for embezzlement led to the lengthy sentence. The HHA billed for $49,000 in false claims during the first 6 months of business.

- Two owners/operators of a Las Vegas HHA pleaded guilty for attempting to defraud the Medicare program. The owners tried to set up an Arizona HHA by offering a physician an arrangement for compensation. They agreed to hire the physician's husband in exchange for Medicare referrals. The owners also submitted false information during the Medicare certification process.

- The owner and owner's brother/employee of a Texas HHA agreed to pay $20,000 to resolve civil liability for submitting fraudulent Medicare cost reports. They conspired to include false expenses for medical supplies, office supplies, and automobile leases on the cost reports. The brother was president of a medical supply company that sold products to the HHA at a 100 percent markup. The brother also altered invoices for supplies that weren't purchased and fabricated automobile lease contracts from vendors who did not lease automobiles.

- In Utah, HCFA obtained $149,490 from an asset seizure related to an earlier civil judgment against the owner of nine HHAs in seven States. The owner had pleaded

guilty to criminal charges related to false claims, kickbacks, and income tax fraud. The owner set up a billing company for the HHA without revealing the relationship between the two companies, claimed costs for ghost employees, paid kickbacks, and omitted income on tax returns for 1990 through 1994. The Medicare overpayment totaled $3.5 million. Sentencing will be in June 1997.

- The owner of two Texas HHAs pleaded guilty to one count of making false statements in a Medicare cost report. Charges against the spouse and son were dismissed. The owner agreed to pay $794,700 in restitution and to forfeit the building housing one of the HHAs. Sentencing is scheduled for May 1997.

- Both the president and administrator of a California HHA pleaded guilty to fraud and conspiracy in a Medicare scheme. Over a 17-month period, they submitted false claims totaling up to $2.5 million, paid kickbacks for Medicare referrals, created fraudulent medical records documenting home visits, and submitted false cost reports. Altogether the two had billed Medicare more than $9.9 million for more than 88,900 visits to 680 beneficiaries, some of whom were deceased, and were paid $5.6 million by Medicare. The president did not have a health care background, but was instead a former nightclub owner. The president started the agency with a registered nurse friend who left soon after Medicare certification. The administrator was also a former nightclub manager.

- The former owner of a Michigan HHA pleaded guilty to defrauding the Medicare program. The owner failed to disclose related organizations on the cost report and lied during the certification process, saying that the agency had a medical director. Medicare paid the agency a total of $3.4 million.

- The owner/president, the vice president, and the risk manager for a Georgia HHA were sentenced to Medicare, Medicaid, and other fraud. The founder and CEO, who pleaded guilty to charging Medicare and Medicaid for campaign contributions, ghost employees, and personal vacation trips, was sentenced to 33 months incarceration followed by 200 hours community service. He also was fined $25 million and ordered to pay $11.5 million in restitution. The vice president was sentenced to 151 months incarceration and 3 years of probation, fined $75,000, and ordered to repay $710,000. The vice-president was convicted of making false statements about salaries for ghost employees and a related organization, converting worker's compensation premiums to personal funds, using Medicare funds to support a consulting business, embezzling employee health insurance and benefit plan funds, committing bank fraud, and laundering money. The risk manager was sentenced to 97 months incarceration and 3 years of probation after being convicted of mail fraud and conspiracy to defraud the Medicare and Medicaid programs. The risk manager's consulting business was sentenced to 5 years of probation, fined $250,000, and ordered to pay restitution of $710,000.

- The owner of a now-defunct HHA was arrested in Texas after being indicted for charges related to Medicare fraud. The owner had written off more than $3.5 million in fraudulent expenses in cost reports from 1991 through 1994.

- An accountant pleaded guilty to submitting fraudulent cost reports to Medicare. A joint investigation by OI and the FBI led to a negotiated plea by the accountant. He agreed to cooperate with the Government in investigating the HHAs involved. One HHA owner reported being approached by the accountant with a scheme in which employee bonuses would be counted on the cost report and then kicked back to the owner.

- A Michigan HHA owner was sentenced to 5 months house arrest and ordered to pay $18,000 for his part in a Medicare fraud scheme. The owner sold the HHA to another HHA, but all documents relating to the sale and employees were backdated. The backdating allowed the acquiring HHA to bill Medicare for all care provided by the original owner's HHA, thereby covering all acquisition costs. In addition, the original owner received a salary of $5,000 a month, although the owner did not perform services commensurate with the payments. This salary was charged to Medicare.

- A Missouri HHA owner/operator was indicted for mail fraud, forgery, and Medicare fraud. The former owner allegedly submitted false statements to HCFA to obtain a Medicare provider number. Between 1991 and 1994, the owner used the provider number to accrue $1.5 million in Medicare overpayments. The owner has also been charged with submitting inflated expenses on cost reports and forging a physician's signature in order to receive Medicare payments totaling $100,000.

- The owner of two Pennsylvania HHAs was sentenced to 2 years probation, assessed $50, and ordered to perform 100 hours of community services. The owner submitted claims for personal expenses, such as hotel stays, meals, flowers, clothing, and placing her husband and nanny on the company payroll. Because of the owner's financial situation, no civil action will be taken. However, on the basis of a Medicare carrier review, $300,000 was withheld and retained by the program.

- Blue Cross of Illinois disallowed $454,220 in consulting costs claimed by a consulting company. The intermediary also disallowed compensation costs claimed by two HHAs for services rendered by individuals associated with the consulting company. It also is reopening the 1991 cost report looking to disallow $175,000. Blue Cross of California and Iowa have already disallowed costs totally $636,800. Intermediaries in Pennsylvania and Florida are also looking into the situation. The costs have been disallowed because the providers cannot demonstrate that services were rendered to the extent billed, that they were related to patient care, or that the providers actually worked at the site. This is an on-going ORT case.

- The owner of a Louisiana HHA was sentenced to 5 years probation and ordered to repay $119,000. The owner listed expenses of a costume shop and a magazine that

the individual owned in the HHA's cost report. Expenses included payroll, leases, telephone services, and advertising.

- The owner of a Louisiana HHA, four employees, and one personal friend defrauded Medicare by submitting false cost reports, concealing financial transactions with fictitious corporations, forging physician signatures on certificates of medical necessity, claiming services that were never rendered, and submitting claims for services to non-Medicare qualifying individuals. The owner was sentenced to 37 months in prison and ordered to make restitution of $221,220 to the Department for conspiracy, false statements, and mail fraud. The administrator, quality assurance coordinator, staff coordinator, and licensed practical nurse were also sentenced to prison, with terms ranging from 3 to 18 months and ordered to pay restitution and fines totaling $67,370. A personal friend who allowed the owner to use the friend's name in the fraud scheme was sentenced to 3 months and ordered to make $62,270 in restitution. All were given 3 years supervised release following their prison terms.

- A recently issued audit, conducted by the OIG and Blue Cross of California, reviewed a sample of 100 claims for which a California HHA received Medicare monies. The 100 claims represented 1,895 visits to 92 beneficiaries. Of those, 1,214 visits, or 64.1 percent, were deemed unallowable. Reasons included beneficiaries who were not homebound, services claimed that were not reasonable and necessary, services provided without valid physician orders, and services without supporting documentation. Approximately $2.2 million were estimated to be unallowable.

APPENDIX D

AGENCY COMMENTS

The full text of comments received from the Health Care Financing Administration, the Office of the Assistant Secretary for Planning and Evaluation, and the Office of the Assistant Secretary for Management and Budget.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

DATE: JUL 21 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report entitled: "Home Health Problem Providers and Their Impact on Medicare," (OEI-09-96-00110)

We reviewed the above-referenced report that identifies and describes the common characteristics of problem home health agencies, and how these agencies, contribute to Medicare fraud, abuse, and waste.

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

Attachment

Health Care Financing Administration (HCFA) Comments on the Office of Inspector General (OIG) Draft Report entitled: "Home Health Problem Providers and Their Impact on Medicare," (OEI-09-96-00110)

OIG Recommendation

To protect the Medicare home health benefit, HCFA needs to develop and implement additional program safeguards that would: (1) strengthen its ability to identify problem providers; (2) prevent problem home health agencies (HHAs) from entering the program; and (3) prevent the Medicare trust fund from incurring further losses due to the activities of problem HHAs. HCFA should take administrative action or, if necessary, seek legislative authority to:

Require that each HHA obtain a surety bond equal to the amount of anticipated Medicare billings during its fiscal year. Should the HHA's claims exceed the amount of the bond before a cost report has been filed and audited, the HHA should be required to increase the amount of the surety bond accordingly. The cost of the bond should not be considered a reimbursable expense for Medicare cost reporting purposes.

HCFA Response

We concur. Bonding provides a higher level of scrutiny before HHAs are permitted to participate in the Medicare program.

OIG Recommendation

Require "user fees," so that new and existing HHAs are required to pay for their initial certifications, comprehensive on-site reviews, and recertifications. If this is not possible, we believe the allocation of additional resources to the certification and monitoring effort by the fiscal intermediaries, state agencies, and HCFA regional offices will pay for itself, because it will substantially reduce, or even eliminate, the continued accrual of uncollectible overpayments as well as payments for noncovered and medically-unnecessary services.

HCFA Response

We concur. HCFA agrees and supports such a proposal.

OIG Recommendation

Require the majority of the HHA's principals have prior health care experience directly related to the provision of home health services in order to receive Medicare certification.

HCFA Response

We concur. The current HHA conditions of participation at 42 CFR 484.4 prescribe the personnel qualifications for the administrator. The CFR states: "Administrator, home health agency. A person who: (a) Is a licensed physician; or (b) Is a registered nurse; or (c) Has training and experience in health service administration and at least 1 year of supervisory or administrative experience in home health care or related home health programs." HCFA published in the Federal Register on March 10, 1997, a proposed revision to the conditions of participation at 42 CFR 484.4 to read: "The administrator of a home health agency must: (i) Be a licensed physician; or (ii) Hold an undergraduate degree and (A) Be a registered nurse; or (B) Have education and experience in health services administration, with at least 1 year of supervisory or administrative experience in home health care or a related health care program, and in financial management."

OIG Recommendation

Develop a data bank of owners, principals, and other HHA officials and related organizations so their activity can be monitored, tracked, and cross-referenced.

HCFA Response

We concur. The new provider enrollment process, which includes a new national enrollment application for Part A and Part B providers, will provide HCFA with a comprehensive profile of all Medicare providers. It will allow Medicare to screen applicants before they are authorized to receive payments for services because it requires contractors to verify all data provided on the application; e.g., licensure information, prior sanction or exclusion information, place of business, ownership information, billing contracts, tax identification data, etc. The new application will collect information on owners, principals, and managing and directing employees of HHA organizations. The revised enrollment application will be implemented for initial use by Part A providers in July 1997. In conjunction with the new application, HCFA will develop and implement the Provider Enrollment, Chain, and Ownership System. This database will consolidate ownership data collected on the enrollment application by Medicare contractors and the National Supplier Clearinghouse. Similar to the enrollment application, this database will contain national data on Part A (owners and managing employees) and Part B providers. We expect to implement this system by the end of calendar year 1997.

<u>**OIG Recommendation**</u>

Require all HHA owners and principals to provide their individual Social Security numbers and Employer Identification numbers when they submit an application to become Medicare providers.

<u>**HCFA Response**</u>

We concur. We support this recommendation.

<u>**OIG Recommendation**</u>

Prior to certification, ensure that new HHAs are financially sound and have adequate fiscal recordkeeping capabilities and their owners and principals are qualified and trustworthy. This should be accomplished through a comprehensive on-site review by an interdisciplinary team of auditors, medical reviewers, and state surveyors.

<u>**HCFA Response**</u>

We partially concur. While we agree with the intent of the recommendation, we believe the provisions in the President's Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997, take a more appropriate approach in addressing problem HHAs.

<u>**OIG Recommendation**</u>

Refuse to enter into a provider agreement with any HHA whose owners or principals:

- owe money to the Federal Government in the form of Medicare overpayments, tax liens, or unpaid loans;

- have filed bankruptcy or have negative credit ratings;

- have prior criminal records; and/or

- have been associated with, or, are the relatives of the owner of a Medicare provider who was found to defraud, abuse, or otherwise misappropriate Medicare dollars.

HCFA Response

We partially concur. While we agree we should refuse to enter into provider agreements with HHAs whose owners and principals do not live up to certain financial standards, we believe the provisions in the President's Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997 take a more appropriate approach in addressing problem HHAs.

OIG Recommendation

Preclude the discharge of Medicare debts through bankruptcy.

HCFA Response

We concur. The President announced legislative proposals to fight fraud and abuse in health care, including precluding individuals and entities from discharging Medicare debts through bankruptcy.

OIG Recommendation

Impose a moratorium on any new HHA certifications until adequate program safeguards are implemented, unless the HHA can demonstrate that it will be operating in an underserved area.

HCFA Response

We nonconcur. HCFA has the responsibility to establish and implement adequate program requirements and safeguards. If an HHA is able to comply with these requirements, it should be allowed to enter the Medicare program.

OIG Recommendation

We also reiterate our previous recommendation that HCFA should:

Tighten controls over the periodic interim payment (PIP) program, more closely monitor HHAs that are on PIP, and seek legislation to eliminate this method of reimbursement.

HCFA Response

The President announced, as part of his Balanced Budget Act of 1997, the elimination of PIP for HHAs effective on or after the implementation of HHA Prospective Payment on October 1, 1999. We support the President's Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JUN 10 1997

TO: June Gibbs Brown
Inspector General

FROM: David F. Garrison Jeff Merkowitz for
Principal Deputy Assistant Secretary
for Planning and Evaluation

SUBJECT: OIG Draft Report: "Home Health: Problem Providers and Their Impact on Medicare," OEI09-96-00110 -- CONCUR WITH COMMENTS.

I concur with this report and submit the following comments.

My staff met with your staff in March of 1997 to discuss this report. Though ASPE is quite pleased with the changes that the IG has made, we continue to be concerned that the report can be confusing if the reader is not familiar with the history and evolution of the home health benefit.

Specifically, we are concerned that one might conclude that all post-1989 home health visits by the sampled problem providers in the five ORT states were fraudulent. ASPE recommends that the IG make the following changes:

1. The findings on page ii of the Executive Summary that refers to the home health program benefit expansion and the lack of restrictions on certification could be confusing to the reader. The report implies that all post-1989 utilization is suspect when in fact the *Duggan* settlement liberalized the home health eligibility criteria and the availability of services. The *Duggan* case is relevant to the post-1989 growth in costs, utilization and the number of Medicare-certified HHAs. A sentence should be inserted here that explains how the home health benefit changed substantially as a result of the *Duggan v. Bowen* lawsuit.

2. Similarly, in describing that 45 percent of all Medicare expenditures for home health services went to the problem providers in the five ORT states, the reader might conclude that the provision of these services were somehow fraudulent or unnecessary. The IG should insert a sentence explaining that though it is clear that problem providers may have taken advantage of the liberalization in the benefit since 1989, this does not mean that all visits provided to these patients by these providers were "problem" or unnecessary visits.

3. The first sentence on page 12 of the report -- "In 1989, Congress enacted changes..." is not correct. Please insert the following sentence:

   "On July 1, 1989, regulatory revisions to the home health benefit as a result of the *Duggan v. Bowen* lawsuit became effective. The *Duggan* decision resulted in easing barriers to program participation and expanding the types of services provided to beneficiaries."

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JUN 17 1997

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OFFICE OF INSPECTOR GENERAL

MEMORANDUM TO: The Inspector General
Attention: June Gibbs Brown

FROM : John J. Callahan LaVarne Burton -for-
Assistant Secretary for Management and Budget

SUBJECT : ***Concur with Comment:*** OIG Draft Report: "Home Health: Problem Providers and Their Impact on Medicare"
OEI-09-96-00110

ASMB commends the OIG for its strong recommendations for combating Medicare fraud, waste, and abuse in the home health benefit , as outlined in this draft report. However, since this draft report was written, Congress has offered several proposals as part of Medicare reconciliation legislation that would address some of the OIG's concerns. Furthermore, the current draft does not completely recognize all the President's legislative proposals to address home health fraud. In order to ensure that the OIG final report is as timely as possible, ASMB suggests that OIG rewrite its recommendations section to acknowledge the following:

- Both the President and Congress are recommending elimination of periodic interim payments (PIP) upon implementation of a home health prospective payment system in FY 2000.

- The President has proposed giving the Secretary authority to exclude Medicare certifications to provider applicants convicted of a felony.

- Congress has proposed Medicare legislation that would require surety bonds for home health agencies.

- Congress has proposed Medicare legislation that would exclude health entities from participating in Federal health programs if ownership of the entity is transferred to an immediate family member in anticipation of, or following, a conviction