S. HRG. 105–210

JACKPOT: GAMING THE HOME HEALTH CARE SYSTEM

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

WASHINGTON, DC

JULY 28, 1997

Serial No. 105–8

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

42–833cc WASHINGTON : 1997

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-055733-X

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JACKPOT: GAMING THE HOME HEALTH CARE SYSTEM

MONDAY, JULY 28, 1997

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 1 p.m., in room SD–562, Dirksen Senate Office Building, Hon. Charles Grassley (Chairman of the committee) presiding.

Present: Senators Grassley, Hagel, Collins, Enzi, Breaux, Glenn, and Wyden.

Also present: Senator Landrieu.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. Thank you all very much for coming. I say good afternoon to you and to everybody. This hearing is entitled, "Jackpot: Gaming the Home Health Care System". I would like to begin by extending thanks to my colleagues, and there will be more coming, to our witnesses, and to members of the public for their interest in this critically important issue of fraud, waste, and abuse in the home health care system.

To begin, I would like to tell you how this hearing came about. Over the past several months, the Committee on Aging asked the FBI, the Department of Health and Human Services, the General Accounting Office, among others, and we asked each independently a question like, if you had something to do with the Committee on Aging and you only had one hearing that you could hold, what would that hearing be that the Committee on Aging should conduct? The unanimous response was home health care fraud. Why? Because it is the system's fastest-growing component and that is a very good reason.

The numbers associated with home care are truly astronomical. Imagine in 1989 the taxpayers were spending only $2.6 billion on home health care. Today, we are spending $18 billion. What is even more amazing is that in just a few years, we will be spending $21 billion. That is a lot of money and that is a meteoric growth.

But the story does not end there. There are legitimate reasons for growth in home health care. For instance, there are more elderly people in need of home care. In addition, home health allows people to stay at home instead of going to a nursing home. Do you know anyone who ever really wanted to go to a nursing home? Neither do I.

But there is a darker side to this story. Some folks are taking a bite out of every taxpayer's pocket and that bite is fraudulent. Sometimes it involves waste and abuse. All of these are rampant. Home care fraud, waste, and abuse is what this hearing that we are having today is all about. It is what we are going to discuss. It is what we are going to see and that is thanks to the FBI. What is even more important, we are going to put a face on home health care fraud.

Deterring, identifying, and prosecuting health care fraud as a general matter is tough. It is resource intensive, it is labor intensive, and it is dependent upon documents. So I thought that it would be important today to illustrate as vividly as I could the importance of documentary evidence, as lawyers like to call it. So as part of the hearing today, you are about to witness a videotape of a physician caught by the FBI in the act of changing legitimate billing records prepared by his medical staff. The physician is engaged in plain old health care fraud. These changes cause bills to be sent to insurance carriers for services either not given or inflated to a higher reimbursement rate. When someone engages in that activity, it is typically called upcoding.

This video was made through the use of a court order. The Department of Justice approved closed-circuit television, allowing the FBI to install the device in the business area of the physician's office. The camera was not in the patient examining area for privacy reasons. The FBI also took precautions to ensure the privacy of the patients by not recording patient identification information. Finally, the FBI has ensured that the defendant, who is now a convicted felon, cannot be identified through the use of this videotape and this hearing. This physician has pleaded guilty to submitting false claims to the health benefit plan and is serving a prison sentence right now.

I also want to say that this extraordinary investigative technique was employed as the only method to identify the individual or individuals responsible for changing the billing records. The correct billing records were changed for the purpose of increasing the reimbursement amounts paid to the doctor.

An often encountered defense used by those committing health care fraud is that the false billing was the result of some inadvertent billing error committed by the billing clerk. However, with the invaluable help of the videotape that you are about to see and after careful review and analysis of the initial and the altered bills versus the medical charts, the individual responsible, which was the doctor, is identified for submitting 100 fraudulent claims.

I now would ask Special Assistant Agent in Charge John Lewis to come to the witness table to explain what we are about to see in this video. Just so that everyone knows, Special Agent Lewis during the investigative phase of this case was the supervisor of the Health Care Fraud Squad in the FBI field office where this investigation was conducted. Special Agent Lewis, thank you.

Senator BREAUX. Mr. Chairman, I was just wondering whether other members would get a chance to make some opening comments before we get to the witnesses.

The CHAIRMAN. He is not a witness. He is part of my opening comment.

Senator BREAUX. All right.

The CHAIRMAN. So yes, we are going to let everybody give opening statements. Everybody is going to be able to give opening comments, but I am not done with mine yet.

Mr. LEWIS. Thank you and good afternoon, Senators. On July 29, 1992, a former employee of the physician you are now viewing contacted the FBI and provided information that led to the opening of a criminal health care fraud investigation. During the initial stages of this investigation, we learned that several private insurance carriers, Medicare, and CHAMPUS were aware of similar complaints and, in fact, had initiated internal auditing procedures based upon the complaints.

Our investigation began with the development of several key sources of information, including current and former employees of this doctor. These sources, together with other information, revealed the longstanding scheme to defraud health care insurers. The scheme was perpetrated by this doctor's systemic alteration of medical claim forms for patients seen at either of his two clinics. Claim forms by the hundreds were altered by this doctor to add fictitious charges, fictitious diagnoses, and to upcode medical services performed.

Our investigation determined that following a patient's visit to one of his two clinics, this doctor reviewed nearly every patient chart and related medical claim form. Alterations were thereafter made to his own patients' medical claim forms as well as to patients of other doctors. This investigation determined that alterations were made by this doctor as much as 6 months after a patient's initial visit and then submitted to insurers for payment.

The recurring alterations and unusually high billings caused the doctor to increasingly fall into disfavor with the health care insurers with whom he dealt. As his fraudulent activities progressed, he was terminated by a company and then others and was no longer able to submit claims under his own name. He continued to see patients and maneuvered around this problem by preparing subsequent medical and billing records using another doctor's name.

Our investigation learned that this doctor effected these changes by utilizing his computer both at home via modem and in his office to alter patient medical and billing information contained in his office's medical software system. We knew from several live sources that he was doing this, we were seeing the end results of his fraud from cooperating insurers, but our investigation to date did not have the smoking gun. We needed to independently corroborate this information if ultimate prosecution was to yield the highest potential for success.

On December 10, 1993, the FBI obtained appropriate court authority to enter this subject's clinic and install a closed-circuit video camera within his private office. From a monitoring site located elsewhere, agents assigned to this case captured the video images you are now seeing and more. Through the use of this investigative technique, we were able to monitor and record this doctor in the act of altering patient records in order to inflate charges.

With the help of his own medical office software, we were able to collect clear evidence of each patient's original medical informational entries, all changes made to the original entries, the date

and time of the changes, and the computer station from which the changes were made. This video surveillance helped conclude this investigation by providing a clear image of the person responsible for making these changes.

During the segment shown here today, this doctor is altering patient billing information, some of which was later incorporated into his indictment. In one of the two segments, he is shown wearing gloves for what you might think is his attempt at avoiding the possibility of leaving latent fingerprint evidence behind. On this day where we now know he added a total of $2,700 to billing statements, the gloves are being used to protect his hands from the January cold, that is, the heat was not turned on in his office.

By contrast, this particular day was not one of his best. He went on to inflate his billings a total of approximately $10,000 in this particular month. His best day, we would later learn, was $16,000 in added charges.

On March 8, 1994, a series of Federal search warrants were executed at his home and his two clinics. In addition to seizing numerous patient files, a variety of weapons were seized, including a fully automatic H&K MT–5, one Colt AR–15, an AK–47, and a silencer fitted for a .22 caliber handgun. We seized approximately $135,000 in cash and uncovered a number of unusual items, such as a telephone voice changer, the Encyclopedia of Revenge, tracer ammunition, night-vision goggles, and a How to Disappear Completely manual.

In the search of his home, we also found a burn box, an old rectangular wooden box situated next to the home fireplace and full of a fire starter of sorts. In the box were about 1,000 patient billing claim forms that were no longer needed because he had created new forms comprised of his fraudulent changes. The subsequent indictment of this doctor would include fraud counts associated with the medical claim forms found in this box.

On August 24, 1995, the Federal grand jury indicted this doctor on 137 criminal counts and superceded with a second indictment on April 24, 1996, charging him with a total of 185 criminal counts.

During this investigation, we uncovered unnecessary medical tests, such as a laryngoscopy, a procedure normally accomplished by an ear, nose, and throat specialist where a tube is run down through a patient's nose and throat. If you would have seen this family practitioner during our investigative period complaining of a sore throat, you would have very likely experienced this procedure. Even more troubling were the sexually transmitted disease tests run on some of his elderly patients. This doctor also used a credit service to aggressively pursue patients who either refused or could not pay their portion of his altered charges.

Perhaps most disturbing in all this was the disregard this doctor had for his patients' long-term medical welfare. They became a tool by which he could scam insurers. In perpetrating this scheme, fictitious medical histories were created for numerous patients who today are not sure what past diagnoses and treatments were legitimate. Along the same line, insurance companies today maintain an inventory of medical histories for many of his patients which is inaccurate. For his patients, how this will affect their future health

care diagnosis, treatment, and dealing with insurance carriers is unknown.

On the day before trial was to start, on October 29, 1996, this doctor entered a plea of guilty to three criminal counts in exchange for facing trial on all 185. He was later sentenced to 15 months in the Federal penitentiary, where he is today, a 3-year term of supervised release, and was ordered to pay restitution. Last, his license has been suspended indefinitely by the State licensing authority.

The CHAIRMAN. Thank you. I appreciate that very much, Special Agent Lewis.

Mr. LEWIS. You are welcome.

The CHAIRMAN. I want to take a minute to comment not on what you said but to go on about the oversight of our hearing. Today's hearing is going to concentrate on waste, fraud, and abuse. Now, of course, this is not to say that everyone in the home health care industry is crooked. That is simply untrue. Indeed, most, and I want to emphasize, most of the home health care providers are honest, caring individuals giving the American taxpayers their money's worth.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES GRASSLEY

Good afternoon and welcome to this hearing entitled JACKPOT: Gaming the Home Health Care System. I would like to begin by extending thanks to my colleagues, to the witnesses and to members of the public for their interest in this critically important issue—fraud, waste and abuse in the home health care system.

I would like to tell you how this hearing came about. Over the past few months the Committee on Aging asked the Department of Health and Human Services, the Federal Bureau of Investigation, and the General Accounting Office, among others—each independently—the following question: If there was only one hearing that could be conducted by the Committee on Aging what would it be? The unanimous response was "home health care fraud." Why? Because it is the fastest growing component in the health care system.

The numbers associated with home care are truly astronomical. Imagine in 1989 taxpayers spent $2.6 billion on home health care. Today we are spending about $18 billion. What's even more amazing is that the figure is likely to grow to more than $21 billion in the next few years. That's a lot of money. I call that "meteoric" growth.

But the story does not end there. There are legitimate reasons for growth in home health care. For instance there are more elderly people in need of home care. In addition, home health allows people to stay at home instead of going to a nursing home.

But there is a darker side to the story. Some folks are "taking a bite" out of every taxpayer's pocket. Fraud, waste and abuse are rampant. Home care fraud, waste and abuse is what this hearing is about. It is what we are going to see, thanks to the FBI. Even more important, we are going to put a face on home health care fraud.

Deterring, identifying and prosecuting health care fraud is tough. It is resource intensive, labor intensive and dependent on documents. So, I thought that it would be important today to illustrate, as vividly as I could, the importance of "documentary evidence."

As part of the hearing today, you are about to witness a videotape of a physician caught by the FBI in the act of changing legitimate billing records prepared by his medical staff. The physician is engaged in health care fraud. These changes caused bills to be sent to insurance carriers for services either not given or inflated to a higher reimbursement rate, what's typically called "upcoding."

This video was made through the use of a court order. The Department of Justice approved closed circuit television (CCTV) allowing the FBI to install the device in the business area of the physician's office. The camera was not in the patient examination area for privacy reasons. The FBI also took precautions to ensure the privacy of the patients by not recording patient identifying information. Finally, the FBI has ensured that the defendant, who is now a convicted felon can not be identi-

fied through the use of this videotape in this hearing. This physician has pleaded guilty to submitting false claims to a health benefit plan and is serving a prison sentence.

I also want to say that this extraordinary investigative technique was employed as the only method to identify the individual or individuals responsible for changing the billing records. The correct billing records were changed for the purpose of increasing the reimbursement amounts paid to the doctor. An often encountered defense used by those committing health care fraud is that the false billing was the result of some inadvertent billing error committed by the billing clerk. However, with the invaluable help of the video tape you are about to see and after a careful review and analysis of the initial and the altered bills versus the medical charts, the individual responsible, a doctor, is identified for submitting hundreds of fraudulent claims. I would ask that Assistant Special Agent-In-Charge John Lewis come to the witness table to explain what we are about to see in this video. Just so everyone knows, Special Agent Lewis, during the investigative phase of this case, was the supervisor of the Health Care Fraud squad in the FBI field office where this investigation was conducted.

Today's oversight hearing is concentrated on waste, fraud and abuse. Now this is not to say that everyone in the home health care industry is a "crook"—that is simply untrue—Indeed most of the home health care providers are honest, caring individuals, giving the American taxpayer—their money's worth.

In discussion of our five witnesses, we have on one panel an individual who knows firsthand about home health care fraud because she is presently serving a 33-month sentence in Federal prison for home health care fraud.

The second panel is made up of two witnesses representing the Office of Inspector General of the Department of Health and Human Services and the General Accounting Office. These witnesses will provide us with findings of several intensive reviews that they completed recently regarding home health care.

The third panel has two witnesses, as well. One panelist represents a fiscal intermediary for the Medicare health care and I am proud to say that that is headquartered in my State of Iowa. The second and final panelist is the Secretary of Health for the State of Louisiana.

Finally, before turning to Senator Breaux and my other colleagues, I want to continue to encourage every American, every American who pays taxes, who has elderly parents, who has aging family members, and who will one day, with a little luck, grow old graciously, to continue helping the law enforcement community. We all know that when it comes to Medicare payments, the old adage that the Government pays for it is really a joke on all of us. The Government does not pay for Medicare. You do, I do, and we all do. Your continued help is critical in helping to keep the safety net of home care available to those who need it today and for those who will need it tomorrow.

Senator Breaux.

OPENING STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Thank you very much, Mr. Chairman. These hearings are, indeed, extremely important. They are long overdue. We should be holding more hearings such as this, and on a regular basis. I am delighted with your observation that this is not intended to be an indictment of home health care in general because there are notable and outstanding examples of where home health care has reduced costs for the Medicare Program and provided very valuable services to the people who receive those services.

But having said that, there is also a problem in this particular area as there are problems in other areas of Medicare with regard to how we spend the taxpayers' dollars. It is interesting, I think, that when we face the task of trying to save the Medicare system for the 38 million Medicare beneficiaries in this country that we have not been very innovative in how we go about doing it. Everybody says to those of us in Congress and in policymaking positions that they want us to do what is necessary in order to save Medicare. If we do nothing, Medicare will become insolvent in the year 2001. That is right around the corner.

But every time suggestions are made as to what should be done, people say, fix it, but not that way. Fix it, but do not increase my premiums. Fix it, but do not cut my benefits. Fix it, but do not increase the eligibility age. But, Senator, fix it.

We are rapidly running out of choices as to how we fix it. This is not an easy problem. Every year we have tried to fix it by what I call the SOS plan, same old, same old. Cut doctor fees, cut hospital reimbursements and say that we have fixed it. As an example, in this year's budget are recommendations to save about $115 billion from the Medicare Program using the SOS method. This means we will cut reimbursements to doctors and hospitals.

I note that in the testimony we will hear today and the papers that will be presented to the committee that the Office of Inspector General of the Health and Human Services Administration estimate that the net overpayments in the program for Medicare fee-for-service benefits for fiscal year 1996 were $23.2 billion. That is net overpayments for 1 year. If you multiply that by five, you come up with about the exact amount we are supposed to save out of Medicare over the next 5 years, in fact, a little bit more.

So, the point is that if we could just correct all of the overpayments, then we could get the same amount of savings that we are getting by cutting reimbursements to doctors and hospitals. I would think that preventing overpayments would make a great deal of sense.

But that is not possible when Medicare intermediaries review only 3 percent of all claims that are sent to Medicare. It is our responsibility as Members of Congress to improve upon that, because we used to look at over 50 percent of claims. Now we look at 3 percent. No wonder over 5 years it is about $116 billion that are sent out in overpayments because we do not do enough to audit claims.

So the purpose of this hearing is to find out how we can better manage what is indeed a very important program and hopefully this committee will be able to come up with some good suggestions. I thank you for having the hearing.

[The prepared statement of Senator Breaux follows:]

PREPARD STATEMENT OF SENATOR JOHN BREAUX

Thank you Mr. Chairman. This is a hearing that is long overdue. In recent months, we have heard how the home health benefit is out of control and today, we will learn why.

Medicare, which pays for 60 percent of all home health care delivered in the United States, has seen spending for the benefit skyrocket from $2.6 billion in 1989 to $17.7 billion in 1996. As we will hear today, home health care is viewed as one of the most fraud-prone Medicare benefits. As we consider ways to save the Medicare trust fund, we must first look at ways to end fraud.

As part of its reconciliation bill, Congress is expected to call for a prospective payment system for home health care. By moving the Medicare home health benefit from a cost-based payment system to one established prospectively, some of the types of fraud today's lead witness committed against Medicare will not be possible. However, some savvy criminals will always try to find a way to scam any system, so I look forward to hearing how we can avoid fraudulent behavior as we change the payment system.

As we are passing out blame for the problems we will hear about today, we must accept our responsibility for the rapid increase in home health expenditures. Before 1980, beneficiaries could qualify for home health care under Part A only after a minimum three-day hospital stay and were limited to 100 visits. OBRA 1980 revoked those policies, allowing more enrollees to qualify for services and permitting more visits. While the vast majority of beneficiaries receiving home health care truly need it, some don't, and it appears that some home health operators are taking advantage of that.

The fact that there are problems with oversight of the Medicare home health benefit is, unfortunately, not new. Numerous GAO reports over the years—with titles such as "Need to Hold Home Health Agencies More Accountable for Inappropriate Billings"—have made it clear that claims are inadequately reviewed by the Medicare claims-processing contractors, which are ultimately overseen by the Health Care Financing Administration.

At today's hearing, the GAO and the Inspector General of the Department of Health and Human Services will give us new information on the extent of home health fraud. For example, we will hear that 40 percent of the total services provided by home health care providers in four selected States should not have been paid. That is shocking information.

I am glad that we will not be hearing only about problems at today's hearings, but also about solutions. I am confident that the people we have assembled here today can help us come up with a plan for combating home health fraud.

I am especially interested in hearing from my State's Secretary of Health and Hospitals, Bobby Jindal, who has lead the way in curbing Louisiana's Medicaid spending on improper home health care. Secretary Jindal has taken an aggressive stance against fraud. For example, since October 1995, 15 home health agencies have been excluded in Louisiana because of abuse, fraud, poor business practices or a lack of quality services. Jindal's leadership against fraud has resulted in an $8 million reduction in Medicaid spending over the last two years in Louisiana.

I hope we can continue our bipartisan work and take what we learn today and craft a solution that will protect those providers who are being honest and those beneficiaries who truly need to use the benefit.

The CHAIRMAN. If my staff got the names right, this is the order we will go. Senator Enzi, Senator Collins, Senator Wyden, Senator Glenn, and then Senator Hagel.

Senator Enzi.

OPENING STATEMENT OF SENATOR MIKE ENZI

Senator ENZI. Thank you, Mr. Chairman. I appreciate your holding this hearing concerning the mounting fraud and abuse that plagues our Nation's home health care system. This is a very serious problem, indeed. It has been pointed out how that could take care of the deficit in the program over the next 5 years.

Americans are becoming more and more aware of how their hard-earned tax dollars end up in the pockets of cheats and swindlers. Nothing gets the blood circulating faster than seeing a news report illustrating health care fraud and abuse. Make no mistake, these folks are out there. The immediate good question on the minds of taxpayers is, What is our Government doing about it?

Federal agencies, of course, have intensified their efforts over the past few months to identify, prosecute, and penalize providers and others involved in fraudulent activities related to Medicare, Medicaid, and other health programs. I firmly believe that these efforts are the result of the numerous media reports documenting examples of fraud and abuse, increased attention to the issue by Con-

gress as well as reports by the General Accounting Office and more concern by the recipients.

These efforts, however, must be broadened if any real progress is to be made. The General Accounting Office estimates that health care fraud and abuse ranges from 5 to 10 percent of total health expenditures under both public programs and private insurance programs. That is a staggering figure.

Mr. Chairman, I would ask that my entire statement be included in the record and would conclude by saying that I am pleased that Congress and the administration value the importance of combating fraud and abuse. It is critical, however, that we do not hit the brakes before the light turns red. This is a complex problem that requires carefully crafted legislation as well as cooperation from the home health care providers.

Many legislative remedies have and are being considered, but they are only treatments. The cure for this plague has not yet been found. I am hopeful that these hearings and Congress and the administration and the home health care providers will continue to work together in finding that cure. Thank you, Mr. Chairman.

The CHAIRMAN. Your entire statement will be included in the record.

[The prepared statement of Senator Enzi follows:]

PREPARED STATEMENT OF SENATOR MICHAEL B. ENZI

Thank you, Mr. Chairman. I appreciate your holding this hearing concerning the mounting fraud and abuse that plagues our nation's home health care system. This is a very serious problem, indeed. Americans are becoming more and more aware of how their hard-earned tax dollars end up in the pockets of cheats and swindlers. Nothing gets the blood circulating faster than seeing a news report illustrating health care fraud and abuse. Make no mistake, these folks are out there. The immediate question on the minds of taxpayers is, "What is our Government doing about it?"

Federal agencies have intensified their efforts over the past few months to identify, prosecute, and penalize providers and others involved in fraudulent activities related to Medicare, Medicaid, and other health programs. I firmly believe that these efforts are the result of numerous media reports documenting egregious examples of fraud and abuse, increased attention to the issue by Congress, as well as reports from the General Accounting Office (GAO) highlighting the need to address this problem. These efforts, however, must be broadened if any real progress is to be made. GAO estimates of health care fraud and abuse range from 5 to 10 percent of total health expenditures under both public programs and private insurance plans. This is a staggering figure!

In 1995, Congress included numerous provisions that aggressively targeted health care fraud and abuse in the Budget Reconciliation bill. This bill proposed an entirely new program that would encourage beneficiaries to report cases of fraud and abuse to Federal authorities; a new criminal statute for health care fraud with specific criminal penalties for theft, embezzlement, false statements and other crimes against health care plans; a new anti-fraud and abuse program to coordinate Federal and State efforts in this area; additional resources for investigators, auditors, and prosecutors; increased civil monetary penalties for over-billing and unnecessary services that are billed to Medicare and Medicaid; tough sanctions on Medicare HMO's that fail to comply with their contractual obligations (including quality of care); and, a new database for tracking final adverse actions taken against health care providers. These are very significant steps that go a long way towards discouraging and preventing abuses of the Medicare and Medicaid Programs. Although this legislation was not signed into law, I do believe that it was the catalyst for bills currently being considered by Congress.

The Health Insurance Portability and Accountability Act was signed into law last year. This important measure includes a fraud and abuse control program as well as revisions to existing sanctions for fraud and abuse. Such sanctions include mandatory exclusions from participation in Medicare and State health care programs; establishment of a minimum period of exclusion for certain individuals and entities

subject to permissive exclusion from Medicare and State health programs; permissive exclusion of individuals with ownership of control interest in sanctioned entities; sanctions against practitioners and persons for failure to comply with statutory obligations; intermediate sanctions for Medicare HMO's; additional exception to anti-kickback penalties for risk-sharing arrangements; as well as a criminal penalty for fraudulent disposition of assets in order to obtain medical benefits. I am pleased to say that these revisions are now law.

Although many provisions are already being enforced, fraud and abuse continues to spoil our nation's home health care system. Congress will begin debate as early as this week on the current Budget Reconciliation Act. There are several anti-fraud and abuse penalties and program integrity safeguards included in this bill that would provide additional exclusion and civil monetary penalty authority; improvements for protecting the integrity of Medicare through surety bonds and accreditation and requirements to furnish diagnostic information; and require that all skilled nursing facilities bill for all Part B services. In addition, the Medicaid Program provisions in this bill would include a number of anti-fraud, waste and abuse reforms including a ban on spending for nonhealth-related items; a requirement that suppliers of durable equipment provide full disclosure of information and a surety bond; a requirement for a surety bond for home health agencies; conflict of interest safeguards to Federal and State personnel; the ability of States to refuse to enter into agreements with individuals or entities convicted of felonies. The bill would also require the Health Care Financing Administration to develop mechanisms to monitor and prevent inappropriate payments made on behalf of individuals who are "dually eligible" for Medicare and Medicaid and monitor the coordination of care for these individuals. States would also provide programs to protect beneficiaries in managed care. Moreover, individuals or entities would not be allowed to improperly use the bankruptcy code to avoid exclusion or Medicaid debts. These additional provisions, I believe, are necessary and should become law.

I do not believe that legislation alone can control fraud and abuse. Health care providers must have a comprehensive understanding of the law. The addition of internal self-audits by providers must accompany the Government's efforts to minimize the risk of illegal activities. It is important that home health providers as a whole do not inherit a negative image from a handful of criminals. The National Association for Home Care has helped put individuals and providers of services who have evidence of fraudulent conduct in touch with the Department of Health and Human Services Office of Inspector General. The addition of such assistance to the process allows the Office of Inspector General to target its resources on the "bad actors." We must first focus our attention on the most egregious cases of fraud. That's where the big bucks are. After that, we can concentrate on the smaller, less egregious cases that often occur due to heavy paperwork requirements.

I am pleased that Congress and the Administration value the importance of combating fraud and abuse. It is critical, however, that we don't hit the brakes before the light turns red. This is a complex problem that requires carefully crafted legislation as well as the cooperation from health care providers. Many legislative remedies have and are being considered, but they're only treatments. A cure for this plague has not yet been found. I am hopeful that Congress and the Administration, and home health care providers will continue to work together in finding that cure.

The CHAIRMAN. Senator Collins.

OPENING STATEMENT OF SENATOR SUSAN COLLINS

Senator COLLINS. Thank you very much, Mr. Chairman. I want to thank you for holding this hearing this afternoon. You have been a real leader in the effort to combat waste and fraud and abuse in the Medicare budget, particularly the home health care program.

As the chairman knows, ferreting out waste, fraud, and abuse in the Medicare budget is a very difficult task. We often wish that there were a line item entitled "waste, fraud, and abuse" that we could simply strike from the budget and be done with it. But it is essential that we resolve this problem if we are going to meet the home health care needs of millions of Americans who depend upon this very important program.

Home health care agencies provide invaluable services that have enabled a growing number of the most vulnerable Medicare bene-

ficiaries to avoid premature institutionalization and to stay just where they want to be, in their own homes. As a consequence, the number of Medicare home health care beneficiaries has more than doubled in recent years and Medicare home health spending has soared from $2.7 billion in 1989 to $17.1 billion in 1996.

Mr. Chairman, as we review this issue, I think it is important for us to keep in mind that there are a number of legitimate reasons for this growth in home health spending. There are increasing numbers of frail elderly with multiple chronic health care problems. In fact, the largest segment of the elderly population that is growing most rapidly is the oldest of the old, those 85 years old or older, and they are the most frequent users of home health services.

In addition, hospitalized Medicare patients are being discharged quicker and, some would say, sicker and in need of more home health services. Technological advances have made possible a level of care in the home that previously was available only in hospitals or other institutions.

The real question before this committee this afternoon is not whether this rapid growth in home health services has been appropriate but rather whether it has been effectively and efficiently managed so as to ensure the quality of the services and to protect against unscrupulous providers. The testimony that we will hear this afternoon demonstrates clearly that it has not.

At a time when home health care costs and utilization have been on the rise, controls and oversight of the program remain virtually nonexistent. We have all heard accounts of fraud and abuse in the home health industry. The chairman participated in hearings that I held last month before the Permanent Subcommittee on Investigations in which he contributed very valuable testimony and in which we heard of Medicare paying for gourmet popcorn, for luxury automobiles, and for care delivered to phantom patients. That is the kind of fraudulent and abusive practice that costs the Medicare Program billions of dollars every year.

As the ranking minority member mentioned, GAO's latest estimate and the Department of Health and Human Services Inspector General's estimate is that we are losing an astronomical $23 billion to unscrupulous providers.

The fact is that few home health care claims are reviewed and payment is often made without question. Medicare rarely checks to see whether patients are eligible, whether they are actually homebound and in need of home health services, or even whether they received services for which Medicare has been billed.

Beneficiaries, on the other hand, have been led to believe that Medicare certification amounts to the "Good Housekeeping Seal of Approval" for home health agencies. As we will hear this afternoon, that is simply not the case. In the hearings held before the PSI Subcommittee, we learned of former cab drivers, convicted drug felons, and other people without backgrounds easily getting certified for home health care services. Once the certification is granted, it too often amounts to a lifetime membership. Very few providers, in fact, less than three-tenths of 1 percent in 1996, were involuntarily terminated from the program.

Clearly, reforms are necessary to improve the administration of home health benefits and to protect Medicare from fraud and abuse. However, Mr. Chairman, as we proceed, it is very important that we not lose sight of the fact that this is a program that serves our most vulnerable Medicare beneficiaries. Home health care users tend to have out-of-pocket costs that are much higher than the overall Medicare population. They also tend to be poorer, sicker, older, and more likely to live alone.

We must tighten up this program. We must eliminate the waste, fraud, and abuse that plagues it if we are to continue to have the resources necessary to service this most vulnerable of populations.

I look forward to hearing the testimony, and again, I thank you for your leadership.

[The prepared statement of Senator Collins follows:]

PREPARED STATEMENT OF SENATOR COLLINS

Mr. Chairman, thank you for calling this afternoon's hearing to examine the increasing incidence of fraud and abuse associated with the Medicare home health benefit.

America is growing older. It is not just that there are more Americans over 65. It is also that older Americans are living longer. Americans 85 and older—our oldest old—are the fastest growing segment of our population. This is also the population most at risk of the multiple and interacting health problems that can lead to disability and the need for long-term care.

Home health agencies provide invaluable services that have enabled a growing number of these vulnerable Medicare beneficiaries to avoid premature institutionalization and stay just where they want to be—in their own homes. As a consequence, the number of Medicare home health beneficiaries has more than doubled from 1.7 million in 1989 to 3.9 million in 1996, and Medicare home health spending has soared from $2.7 billion in 1989 to $17.1 billion in 1996.

Mr. Chairman, there are a number of legitimate reasons for this growth in home care spending. There are increasing numbers of frail elderly with multiple, chronic health problems. Hospitalized Medicare patients are being discharged quicker, and technological advances have made possible a level of care in the home that previously was only available in hospitals and other institutions.

I think that the real question before the Committee this afternoon is not so much whether this rapid growth in home health services has been appropriate, but rather, has it been effectively managed. The testimony we will hear this afternoon demonstrates that clearly it has not.

At a time when home health care costs and utilization have been on the rise, controls and oversight of the program remain virtually nonexistent.

We have all heard the accounts of fraud and abuse in the home health industry—stories about Medicare paying for gourmet popcorn, for luxury automobiles, or for care delivered to "phantom patients." The Chairman delivered valuable testimony at a hearing of the Permanent Subcommittee on Investigations that I chaired last month where we heard testimony about these and other kinds of fraudulent and abusive practices that cost the Medicare program billions of dollars every year. At that hearing we learned that an astounding 14 percent of all Medicare spending is the result of improper payments, which amounts to an astronomical $23 billion a year.

The fact is that few home health claims are reviewed and payment is made without question. Medicare rarely checks to see whether patients are eligible, whether they are actually homebound or in need of home care, or even if they have received the services for which Medicare has been billed.

Beneficiaries have been led to believe that Medicare certification amounts to a "Good Housekeeping Seal of Approval" for home health agencies. As we will hear this afternoon, this is simply not the case. Virtually anyone can be certified as a Medicare home health provider. No prior health care experience is required, and applicants are rarely if ever turned away. As a result, there are examples of taxi-cab drivers, pawn shop owners, bartenders, and even convicted drug felons—all being certified as home health providers by Medicare.

Moreover, Medicare certification amounts to a "lifetime membership." Once certified, home health providers are rarely dropped from the program, regardless of their compliance with Medicare health and safety requirements or attention to pa-

tient care. In fiscal year 1996, only about three tenths of a percent of home health agencies were involuntarily terminated from the program.

Clearly, reforms are necessary to improve the administration of the home health benefit and to protect Medicare from fraud and abuse. However, I am concerned that we not lose sight of the fact that this is a program that serves our most vulnerable Medicare beneficiaries. Home health users tend to have out-of-pocket health care costs that are much higher than the overall Medicare population. They also tend to be poorer, sicker, older, and more likely to live alone.

While tighter program controls are clearly necessary, we should therefore take care to make certain that our efforts to control costs and utilization do not unduly restrict or limit access to this important benefit for those Medicare beneficiaries who truly need home care services.

Again, thank you for calling this hearing Mr. Chairman, and I look forward to the upcoming testimony.

The CHAIRMAN. Thank you, Senator Collins.
Senator Wyden.

OPENING STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you, Mr. Chairman. I, too, want to commend you for the excellent work that you have done. It is quite clear that these oversight hearings are an absolutely key component of rooting out this fraud and abuse and I want you to know, Mr. Chairman, I am very much in support of your efforts.

Mr. Chairman and colleagues, in my view, the paying of home health claims today is sort of like Dodge City before the marshals showed up. There are essentially no rules and anything goes.

Mr. Chairman, going back to my days with the Gray Panthers, where I served before I was elected to the Congress, I have noticed a pattern here that may help us to deal with these frauds in a more comprehensive way. What you have is a situation where those that would exploit the elderly and would exploit these programs look for areas of big growth, and obviously home health care has been such an area. They read the rules and they look for the loopholes, and they try to exploit the new technologies. We saw a bit of that on the tape.

I guess the question then becomes, Mr. Chairman, given the fact that we have watched some of these sleazy characters exploit one program after another, Medigap one year, home health another year, the question becomes, what are some of the key tools that we can look at in order to root this out? There are two tools that I would like to see us examine and that I am going to focus on today.

One is it seems to me when you have someone who, on a repeated basis, exploits these programs and rips them off, they ought to be kicked out of the program. Kicked out forever. I note that the General Accounting Office said in their report that home health agencies repeatedly cited for serious deficiencies are rarely terminated or otherwise penalized. It would seem to me that if you are engaged on an ongoing basis in ripping off these programs, you ought to be permanently kicked out. Or, as we call it in Washington, debarred from the program and not allowed to participate in the future.

The second area that I hope we will examine is whether more can be done to empower the consumer to help us identify and fight these frauds. As you know, Mr. Chairman, several documents are made available to seniors, the Part A benefits notice, the Part B explanation of Medicare benefits, but I am not convinced that

enough is being done to empower the consumer to help in the identification of these frauds.

It would seem to me with the experts that we have today we ought to ask about debarring. We ought to ask about kicking these people out of the program for all time. We ought to examine new ways of fighting fraud, perhaps by giving a share of any fraud found, a kind of bounty, as some have called it, to those who identify these frauds.

This is a bipartisan matter and I look forward to working with you and all our colleagues to address this issue. Even more importantly, to see if we can come up with a set of tools so that, when we wall off this area of health care, we do not just find in 6 months that these crooks who are not exactly technological simpletons have just gone on to some other area where they exploit seniors and taxpayers. I thank you for the time.

[The prepared statement of Senator Wyden follows:]

PREPARED STATEMENT OF SENATOR WYDEN

Mr. Chairman, I'd like to thank you and our Ranking Minority Member, Mr. Breaux, for holding this hearing on a very important issue.

I have emphasized again and again that Medicare needs to be modernized and protected for the coming generations of retirees. This Congress has demonstrated that there is a bipartisan interest in preserving and modernizing Medicare, and an acknowledgement that doing so requires difficult decisions: At what age should someone receive Medicare? Should we means-test Medicare benefits? If so, to what extent? And so on.

The Inspector General estimated this program last year lost $23 billion through waste, fraud, and abuse—on this issue it's somewhat easier to find common ground. Everyone condemns it, and rightfully so. While we must never pretend that addressing waste, fraud, and abuse is enough to "save" Medicare, we need to structure the program such that it minimizes incentives to cheat the system—and maximizes the penalties for those who do. Furthermore, I believe that our best partners in policing the system are the beneficiaries themselves—our seniors who receive Medicare. We need to enlist their help in identifying and eliminating waste, fraud, and abuse in Medicare. I would like to propose that we consider a bounty system where smart Medicare consumers are rewarded for their efforts—they should get a share of the savings to the Government whenever they identify abusive or fraudulent practices.

I understand that the False Claims Act already provides a vehicle for sucking fraud out of the system by allowing beneficiaries to sue on behalf of the Government and be rewarded when they are successful. Still, just because something stays out of the courts does not mean that the sharp-eyed beneficiary deserves nothing when the Health Care Financing Administration (HCFA) collects a re-payment. Last year's Kennedy-Kassebaum legislation created a program that shares some repayments with the beneficiary. But, we must ensure that this program offers strong enough incentives to report fraudulent behavior. Indeed, we may need to offer a higher percentage of the repayment to the beneficiary.

Perhaps more importantly, if beneficiaries are going to be blowing the whistle on waste, fraud, and abuse, they need information, maybe more information than they are currently receiving. Only when Medicare consumers are empowered with the right information can they make a difference. I am currently investigating to what extent this information is available to our beneficiaries. If they don't have it, we need to get it to them. Is their Part A "Benefits Notice" of their Part B "Explanation of Medicare Benefits" complete enough, and user-friendly enough to allow them to help us on the fraud-fighting front?

The home health benefit that we are examining today is particularly prone to abuse.

As currently structured Medicare makes the benefit entirely open-ended. As a result, Medicare gets billed too often for a vaguely-defined service, effectively adding long-term in-home care to the benefits package. The solution is not, as some propose to saddle the frail elderly—the sickest of all Medicare beneficiaries—with copayments that reduce the use of the home health benefit.

We must ensure that home health agencies provide the benefits when necessary, and do not provide them when they are not necessary. We can do this without bur-

dening our seniors. And, we can help ourselves by enlisting our seniors in the quest to identify fraud, as I've said. Still, that's just one part of the equation.

The other part I addressed is the Medicare Modernization and Patient Protection Act, S. 386. There I suggested payment refinements that would force home health agencies to spend their Medicare dollars responsibly—and suggested that we eventually introduce prospective, episode-based payment for home health providers.

This would ensure that the home health benefit is not abused by unscrupulous home health agencies, which regard it as an open-ended, in-home, long-term care benefit paid by Medicare. We don't have to rely on our sickest and frailest beneficiaries to pay for home health. Instead, we can ensure that home health agencies do not have the incentive—or the ability—to rip off Medicare.

Our beneficiaries can and will police the health care system for Medicare fraud. They should be rewarded for doing so—whether they find it in home health or other places in Medicare. We must make sure that they have the tools to be savvy consumers, and are able to blow the whistle when it needs to be blown.

That said, Mr. Chairman, I look forward to learning more from today's witnesses.

The CHAIRMAN. You obviously know I agree with you on the very strong point you made on empowering the consumers.

Senator Hagel.

OPENING STATEMENT OF SENATOR CHUCK HAGEL

Senator HAGEL. Mr. Chairman, thank you. I have a statement that I will submit for the record. I look forward to the testimony of our witnesses this afternoon and appreciate your leadership on this issue. Thank you.

The CHAIRMAN. Thank you, and your statement will be included in the record, as everyone's will be if you have a statement beyond your opening oral comment to make.

[The prepared statement of Senator Hagel follows along with prepared statements of Senators Glenn and Burns:]

PREPARED STATEMENT OF SENATOR HAGEL

Thank you, Mr. Chairman. I appreciate your calling today's important and timely hearing. I look forward to hearing from our panelists this afternoon as they discuss ways to spot and weed out fraud and abuse in the Medicare home health care system.

This hearing will help to shed light on some of the schemes used to defraud Medicare—schemes that cost beneficiaries and taxpayers alike billions of dollars each year. It will help to expose the depth of fraud in home health care and reveal numerous deficiencies in the current system. It will help us to inform our constituents on ways they can work together with Congress and the enforcement community to reduce and deter fraud in home health care. Most importantly, this hearing will help us to find and develop long term solutions to this problem.

Unfortunately, home health care has become a cash cow for unscrupulous providers. The easing of certification requirements, expansion of home health care coverage, and the absence of adequate review mechanisms have resulted in a system riddled with waste, fraud and abuse. This is unacceptable. This is also a rapidly growing problem. The number of home health care beneficiaries increased from 1.7 million in 1989 to 3.9 million in 1996. At an average of 72 visits per beneficiary in 1996, the total number of home health care visits this year may well exceed 280.8 million. Greater reliance on home health care means greater opportunities for dishonest providers.

The Department of Health and Human Services (HHS) alarmingly reports that 40 percent of total claims submitted by home health care agencies in New York, Illinois, Texas, and California should not have been paid—a loss in these States alone of about $2.6 billion dollars. Similar conditions likely exist throughout the Nation. In fact, HHS found that problem providers account for roughly 18 percent of total Medicare home health spending in the U.S.

To make matters worse, a recent Government Accounting Office (GAO) report revealed that few problem providers have been removed from the system. In fiscal year (FY) 1996 alone, only 3 percent of all certified agencies were terminated. Most of these were so-called "voluntary" terminations arising from mergers or closures.

Only a small fraction of these providers (0.3 percent) were actually terminated for breaking the rules.

Clearly, we need to overhaul this system. Common sense reform proposals include moving to prospective payment and requiring the bonding of new home health agencies and existing problem agencies. In addition, we must seriously consider instituting regular follow-up investigative audits for abusers, as well as requiring providers to pay an application fee to cover the cost of on-site inspection. This would help to ensure that providers are legitimate before they can enter into the Medicare program.

We must work hard to solve this problem. There is no room for fraud or abuse of any kind in Medicare. This program already faces substantial financial challenges. However, if we can solve problems like this one, we will go a long way toward helping revitalize the Medicare system for beneficiaries and honest providers alike.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF SENATOR GLENN

Mr. Chairman, I look forward to today's hearing of the Senate Special Committee on Aging to look at ways to ensure that Medicare home health expenditures are paying for needed care for older Americans, not to make fraudulent providers wealthy.

The Medicare home health benefit is receiving a great deal of attention due to the rapid increase in expenditures for home care. As we will hear today, too much of this increase is due to Medicare fraud on the part of home health care providers. I look forward to hearing from today's witnesses on the estimated amount of overpayments Medicare makes due to fraud and abuse in the home health program, and on recommendations for remedying the current situation. This is an issue that we are also looking into over on the Governmental Affairs Committee, on the Permanent Subcommittee on Investigations.

There are many legitimate reasons for the increase in Medicare spending for home care, such as earlier hospital discharges, the ability to provide more intensive services at home, and our increased longevity. Although today's hearing focuses entirely on fraud and abuse, we must keep in mind the importance of home health care to Medicare recipients and their caregivers, and to the savings that can be achieved by the appropriate use of this benefit.

Finding effective solutions for eliminating fraud and abuse in the Medicare home health benefit will free up resources that can be used to provide necessary home health services for our growing elderly population. This is an important issue today and as we plan ahead to meet the challenges presented by the aging of our society.

I look forward to hearing from today's witnesses and thank you for being with us today.

PREPARED STATEMENT OF SENATOR BURNS

I want to thank Chairman Grassley for holding this hearing on the vitally important issue of abuse and fraud by Medicare-certified home health agencies. This is also a very timely hearing as Congress is on the verge of addressing, in part, the problems with Medicare's home health payment policy by mandating a prospective, or fixed, payment system. Such a system played a key role in bringing Medicare hospital payments under control, and it should be adopted for home health services as soon as possible.

We are privileged to receive testimony from the General Accounting Office and the Inspector General's Office of the Department of Health and Human Services on the waste and abuse in the home health area. This testimony is shocking. Home health services will account for nearly $18 billion in Medicare payments this year, or nearly 10 percent of Medicare's costs, compared with $3.5 billion in 1990. While we don't know for sure how much of the $18 billion is due to fraud and abuse, we can get a pretty good picture based on what the IG's testimony refers to as "problem providers." The IG found that 25 percent of home health agencies in New York, Florida, Illinois, Texas, and California were problem providers, meaning they met one or more of the criteria indicating possible fraud or abuse. These criteria include submitting inappropriate costs, not submitting costs on time, submitting claims for services not provided, having certification deficiencies, and having been referred to the Office of Inspector General by the regional home health intermediary. We can assume that if one quarter of the home health agencies in the five largest States

are problem providers, there is a comparable number of problem providers in other States as well.

The GAO testimony pinpoints the fundamental problem with Medicare's home health program: nearly any home health agency can become Medicare certified, and once certified, practically no agency is kicked out of the Medicare Program. If an agency is found to be out of compliance with the certification standards, it can simply implement corrective actions, and usually no follow-up survey is made to ensure compliance. In fiscal year 1996, according to the GAO, 0.3 percent of certified agencies were involuntarily terminated by Medicare. If we are going to get a handle on home health abuse, Medicare must implement and enforce rigorous certification standards and permanently terminate problem agencies.

Medicare provides much-needed home health services to millions of Americans who would otherwise receive higher cost treatments in hospitals or nursing homes. Yet the entire industry is under a cloud created by those agencies that cheat Medicare. In Montana, as in other parts of rural America, home health care is a godsend to seniors who don't have easy access to a health care facility and who would prefer to stay at home when possible. Home health fraud and abuse directly affects those seniors who receive substandard care, but all seniors suffer when the integrity of the home health program is cast into doubt. Today's testimony highlights the key problem areas, and I look forward to working with Chairman Grassley and members of the Committee to fix this program and ensure that seniors get quality health care.

The CHAIRMAN. I want to now introduce our first witness, Ms. Jeanette Garrison. Ms. Garrison is here with us today to speak about home health care fraud and to do it from the point of view of an insider. Ms. Garrison has been very gracious, and I thank you for that, in agreeing to come before us today to give us insights that we would otherwise not have regarding the home health care industry and in particular Healthmaster, the corporation that she began, nurtured, and that was ultimately sold as a result of home health care fraud in which she was engaged.

Ms. Garrison, welcome and thank you very much.

STATEMENT OF JEANETTE G. GARRISON, CONVICTED HOME HEALTH CARE FELON

Ms. GARRISON. Thank you, Senator. I want to thank the committee, the Senate Committee on Aging, for allowing me this opportunity to testify before each of you today.

My name is Jeanette Garrison. I am a nurse by training. I am married to Joseph Garrison, a retired anesthesiologist. We met, worked, and raised our family near Augusta, GA. I was the chair of the board of Healthmaster, a Medicare paid home health care company.

I also am a convicted felon. I pleaded guilty in July 1995 to 10 counts of Medicare fraud. My company and I have repaid the Federal and State Government $16,500,000. I currently am serving a 33-month sentence in a Federal prison. I am before you today because I firmly believe in home health care and believe that home health care is important. I know that by my actions, I have abused the system. I am sorry for what I have done and I would like to help fix the system so that people can continue to receive home health care.

During the mid-1970's, we had in our family two elderly relatives who needed home health care. One was not sick enough to justify putting her in a nursing home but was not well enough to take care of her own personal needs in her home. The other was too sick to be in a nursing home but did not need to be in the hospital. I searched all over the Augusta area looking for services that would

provide home health care for these elderly relatives. I could not find anyone who would provide the kind of services these elderly relatives needed in their homes. With my nursing background, I found myself as their home health care provider.

Dissatisfied with the lack of home nursing services in Augusta, I decided to start a home health care company. With the support of Dr. Garrison, in 1976, I started what then was known as Health Help Services. Health Help Services was a nonprofit company that initially had me as its only employee in a tiny office with a single chair, a folding table, and a telephone. In 1977, I began providing to others the home nursing services that I had been providing to our relatives.

It was not long before I had a group of patients and a full schedule of home nursing visits. I then hired another nurse, who, by the way, still works for the successor to Healthmaster, and she built up a full patient load. When each of us had a full load, we added another nurse, and so on. In our first full year of operations, 1978, Health Help Services had served 325 patients and made over 7,600 visits.

Health Help Services continued to grow very quickly, both by internal growth and later by acquiring other home health care agencies. By the mid–1980's, Health Help Services had eight agencies in three States and was providing several hundred thousand visits to patients. We had grown from just having nurses and office managers to having lawyers, accountants, and reimbursement specialists on our payroll. Working with our advisors, we made the decision to convert Health Help Services to a for-profit company. The new for-profit company was named Healthmaster.

Healthmaster continued to grow at a rapid pace, and there is a chart. By 1994, the last full year in which I was involved in Healthmaster, it had 22 agencies and 100 branch offices in 5 States. Approximately two million visits were made by 2,700 employees. Revenues were around $100 million. Payroll alone every 2 weeks was around $1,800,000, which was more than the total revenues Health Help Services had back in 1978.

A home health care company does not exist in a vacuum. It needs offices out of which to operate. It must have a source of medical supplies. Patients need medical equipment. A pharmacy must provide prescription drugs. Employees must be provided health insurance coverage for their own needs. All of this must be done in accordance with regulatory requirements imposed by each State and by the Federal Government.

It also is true that because Medicare is on a cost-based system, the home health care agency itself is not going to be a big money maker for the owner. The owner can receive a very good income. I myself received at the end $300,000 a year in salary. But because of the reimbursement system, there is not much equity in the home health care business itself. Instead, a large home health care agency owner can earn the biggest return from the supporting companies. This is what we did with Healthmaster.

As I told you, I am a nurse. The professionals I hired, the lawyers, accountants, and reimbursement specialists, showed me how to create wealth through providing the supporting services, and the

middle chart will show you basically the corporate structure and all the private companies that were set up as a spin-off.

The CHAIRMAN. For my colleagues, you have it at the end of her statement.

Ms. GARRISON. We created a real estate limited partnership to buy office space and then rent to Healthmaster. We created a pharmacy. An equipment and supply business was established to serve the individual needs of Healthmaster's nurses and patients. A health maintenance organization was formed and was made available to employees with Healthmaster paying the premiums.

All of these steps were legitimate on the surface and created wealth for me as an owner and, if properly monitored and reported, created no problems. Indeed, these steps, if legitimately pursued, actually brought costs down incurred by Healthmaster. They actually saved money for the Medicare and Medicaid Programs. The complexity of the system, however, made it possible for fraud and abuse to take place.

I pleaded guilty in July 1995 to 10 counts of Medicare fraud. The court found in sentencing that the offenses to which I pleaded guilty cost the Government over $1,200,000. This loss and more have been repaid and I am serving a 33-month sentence in Federal prison. I have been in prison since November 1995.

The most significant offenses of which the court found me financially responsible were, what I will call shared employee services and pleasure trips. There also were other improper practices at Healthmaster, and I will describe those. These offenses arise out of the potential for abuse when a company grows large in size and the ability of an outside auditor to uncover the abuses is diminished.

Let me begin with shared employee services. As I mentioned, with the growth of Healthmaster, a complex group of businesses developed. Among the businesses, Healthmaster was the certified home health care provider. About 95 percent of Healthmaster's revenue came from Medicare reimbursement. For the most part, the other companies did not participate in Medicare. Despite this, I would direct employees who were paid by the Medicare reimbursed company to go work at the private companies. If the health maintenance organization needed a nurse, I would simply tell one of Healthmaster's nurses to go help out. Because the nurse continued to be paid by Healthmaster, in essence, Medicare was paying for this nurse to work at one of our private companies.

When we were smaller, we kept track of the sharing of employees and would adjust Healthmaster's reimbursement request. As we got larger, the tracking process stopped. The result was that Medicare paid over $750,000 for employees who were working for non-Medicare companies.

I also am determined to be responsible for seeking reimbursement for pleasure trips provided to employees. Over the years, Healthmaster took groups of managers on trips as a reward for good performance. We called them management meetings, but in reality, they were pleasure trips. The trips were to New York, Nashville, and Las Vegas. Healthmaster paid the air fare, hotel room, and meals. Healthmaster then got reimbursed by Medicare for the cost of these trips. These trips cost Medicare approximately $135,000.

Another abuse at Healthmaster involved the acquisition of another home health care agency. After Healthmaster bought the agency, Healthmaster was told it could not get reimbursed for the costs of the acquisition. To get around this, Healthmaster put the former owners on its payroll. Even though they did not work for it, these former owners each got paid $80,000 per year by Healthmaster. This cost the Medicare Program approximately $1,500,000.

These are just some examples of what went wrong at Healthmaster. Some of the other problems which resulted in other former Healthmaster senior managers being convicted of Medicare fraud are too complex to describe in this testimony. The fraud and abuse involved was made possible through the complex structure that was set up. There was nothing wrong with the way the structure was set up, but it created the opportunity for massive abuse.

I have had a fair amount of time to think about how the Medicare Program can prevent fraud and abuse such as that which took place at Healthmaster. I hope these thoughts are of some benefit to the committee.

First, people who become providers in Medicare Programs should be required to know what is reimbursable and what is not, both before they become providers and to continue to be aware as they participate in the program. When I started out, it was very simple and we were small. As we got larger and more complex, I just left reimbursement issues up to others and did not keep up with what the requirements were.

Second, senior managers of all providers should be required to certify that the cost reports submitted to Medicare are correct. Right now, just one person must certify the cost reports. If all senior management was required to put their names on the dotted line, greater internal accountability would occur. The providers would better police themselves if senior management all knew they would be accountable. For example, I do not remember signing cost reports for the last 10 years or so at Healthmaster.

Third, the Government audit teams can be improved in at least three ways. First, it was my perception that the auditors were not always sufficiently knowledgeable about Medicare reimbursement and areas of concern to be able to identify improper reimbursement practices.

Second, the audit teams seem to change from year to year, so there was no real continuity or consistency. The better the auditors understand their provider, the better they will be able to know where to look.

Third, the auditors need to look not just at the home health agency itself but at the overall structure.

As I described, the home health care agency is not where an owner can make money. It is in the companies surrounding the home health agency that big profits can be made. Audit teams need to look more closely not just at the transactions between the provider and the related party but also at the financial activities of the related parties as an integrated business.

Finally, one of the features about Healthmaster about which I am proud is that despite all its other problems, there was never a claim that it abused the actual provision of care. I firmly believe

that because we had strong local clinical management at each of the agencies, the visits we claimed were made. The services claimed to be rendered on a visit were rendered. The quality of care provided was top notch.

I have observed that when there is not strong local clinical management or local clinical management at all, the potential for abuse increases. We are working with a vulnerable consumer. Requiring agencies to have local clinical management in place will help reduce the abuse on the clinical side of the program.

I hope these thoughts are of some benefit to you today. I wish I were here before you as something other than an example of someone who abused the system. I want to take this opportunity to apologize to you and to the American people for what I have done. Thank you.

[The prepared statement of Ms. Garrison follows:]

BEFORE THE SENATE COMMITTEE ON AGING

TESTIMONY OF JEANETTE G. GARRISON

I. STATEMENT OF INTRODUCTION

My name is Jeanette Garrison. I am a nurse by training. I am married to Joseph Garrison, a now retired anesthesiologist. We met, worked, were married and raised our family near Augusta, Georgia. I was the Chair of the Board and President of Healthmaster, Inc., a Medicare paid home health care company. I also am a convicted felon. I pleaded guilty in July 1995 to ten (10) counts of Medicare fraud. My company and I have repaid the federal and state government sixteen million five hundred thousand dollars ($16,500,000.). I currently am serving a thirty-three (33) month sentence in a federal prison. I am before you today because I truly believe home health care is important. I know that by my actions I abused the system, I am sorry for what I have done, and I would like to help fix the system so that people can continue to receive home health care.

II. BACKGROUND FOR THE CREATION OF HEALTHMASTER

During the mid-1970s we had in our family two elderly relatives who needed care. One was not sick enough to justify putting her in a nursing home but was not well enough to take care of all her own needs. The other was too sick to be in a nursing home but did not need to be in a hospital. I searched all over the Augusta area looking for services that would provide home health care to these elderly relatives. I could not find anyone who would provide the kind of services these elderly relatives needed in their homes. With my nursing background I found myself being their home health care provider.

Frustrated with the lack of a home nursing service in Augusta, I decided to start one. With the support of Dr. Garrison, in 1976 I started what was then known as Health Help Services. Health Help Services was a non-profit company that initially had me as its only employee and a tiny office with a single chair, a folding table, and a telephone. In 1977 I began providing to others the home nursing services that I had been providing to our relatives.

It was not long before I had a group of patients and a full schedule of home nursing visits. I then hired another nurse (who, by the way, still works at the successor to Healthmaster), and she built up a full patient load. When each of us had a full load, we added another nurse, and so on. In our first full year of operations, 1978, Health Help Services had 325 patients and made over 7,600 visits.

Health Help Services continued to grow very quickly, both by internal growth and later by acquiring other home health care agencies. By the mid-1980s Health Help Services had eight (8) agencies in three (3) states and was providing several hundred thousand visits to patients. We had grown from just having nurses and an office manager to having lawyers, accountants, and reimbursement specialists on our payroll. Working with our advisors, we made the decision to convert Health Help Services to a for-profit company. The new for-profit company was named Healthmaster.

Healthmaster continued to grow at a rapid pace. [CHART] By 1994, the last full year in which I was involved with Healthmaster, it had twenty-two (22) agencies and one hundred (100) branch offices in five (5) states. Approximately two million (2,000,000) visits were made by the two thousand seven hundred (2,700) employees. Revenues were around one hundred million dollars ($100,000,000). Payroll alone every two weeks was around one million eight hundred

thousand ($1,800,000), which was more than the total revenues Health Help Services had back in 1978.

III. THE CREATION OF A COMPLEX GROUP OF BUSINESSES

A home health care company does not exist in a vacuum. It needs offices out of which to operate. It must have a source of medical supplies. Patients need medical equipment. A pharmacy must provide prescription drugs. Employees must be provided health insurance coverage for their own needs. All of this must be done in accordance with regulatory requirements imposed by each individual state and by the federal government.

It also is true that because Medicare is on a cost-based system, the home health care agency itself is not going to be a big money maker for the owner. The owner can receive a very good income — I myself received at the end three hundred thousand dollars ($300,000) a year in salary — but, because of the reimbursement system, there is not much equity in the home health care business itself. Instead, a large home health care agency owner can earn the biggest return from the supporting companies. This is what we did with Healthmaster.

As I told you, I am a nurse. The professionals I hired — the lawyers, accountants and reimbursement specialists — showed me how to create wealth through providing the supporting services. [CHART]

We created a real estate limited partnership to buy office space and then rent it to Healthmaster. We created a pharmacy. An equipment and supply business was established to serve the specific needs of Healthmaster's nurses and patients. A health maintenance organization was formed and was made available to employees with Healthmaster paying the

premiums. All of these steps were legitimate on the surface and created wealth for me as an owner. and if properly monitored and reported. created no problems. Indeed. because these steps. if legitimately pursued. actually brought down costs incurred by Healthmaster. they actually saved the Medicare and Medicaid program money.

The complexity of the system. however. made it possible for fraud and abuse to take place.

IV. WHAT WENT WRONG

I pleaded guilty in July 1995 to ten counts of Medicare fraud. The Court found in its sentencing that the offenses to which I pleaded guilty cost the government over one million two hundred thousand dollars ($1.200.000). This loss. and more. has been repaid. and I am serving a thirty-three (33) month sentence in federal prison. I have been in prison since November 1995.

The most significant offenses for which the Court found me financially responsible were what I will call "shared employee services." and "pleasure trips." There also were other improper practices at Healthmaster that I will describe. These offenses arise out of the potential for abuse when a company grows large in size and the ability of an outside auditor to uncover the abuses is diminished.

Let me begin with "shared employee services."

As I mentioned, with the growth of Healthmaster a complex group of businesses developed. Among these businesses, Healthmaster was the certified home health care provider. About ninety-five percent (95%) of Healthmaster's revenues came from Medicare reimbursement. For the most part, the other companies did not participate in Medicare. Despite this, I would direct employees who were paid by the Medicare reimbursed company to go work at the private companies. If the health maintenance organization needed a nurse, I would simply tell one of Healthmaster's nurses to go help out. Because the nurse continued to be paid by Healthmaster, in essence Medicare was paying for this nurse to work at one of our private companies.

When we were smaller, we kept track of this sharing of employees and would adjust Healthmaster's reimbursement requests. As we got larger the tracking process stopped. The result was that Medicare paid over $750,000 for employees who were working at non-Medicare companies.

I also was determined to be financially responsible for seeking reimbursement for pleasure trips provided to employees. Over the years Healthmaster took groups of managers on trips as a reward for good performance. We called them management meetings, but in reality they were pleasure trips. The trips were to New York City, Nashville and Las Vegas. Healthmaster paid for the airfare, hotel rooms and meals, and even gave the employees some spending money. Healthmaster then got reimbursed by Medicare for the cost of these trips. These trips cost Medicare approximately one hundred thirty-five thousand dollars ($135,000).

Another abuse at Healthmaster involved the acquisition of another home health care

agency. After Healthmaster bought the agency. Healthmaster was told it could not get reimbursed for the cost of the acquisition. To get around this, Healthmaster put the four former owners on its payroll. Even though they did no work for it, these former owners each got paid eighty thousand dollars ($80,000) per year by Healthmaster. This cost the Medicare program approximately one million five hundred thousand dollars ($1,500,000).

These are just some examples of what went wrong at Healthmaster. Some of the other problems, which resulted in other former Healthmaster senior managers being convicted of Medicare fraud, are too complex to describe in this testimony. The fraud and abuse involved was made possible through the complex corporate structure that was set up. There was nothing wrong with the way the structure was set up, but it created the opportunity for massive abuse.

V. POSSIBLE SOLUTIONS

I have had a fair amount of time to think about how the Medicare program can prevent fraud and abuse such as that which took place at Healthmaster. I hope these thoughts are of some benefit to the Committee.

First, people who become providers in the Medicare program should be required to know what is reimbursable and what is not, both before they become providers and to continue to be aware as they participate in the program. When I started out it was very simple and we were small. As we got larger and more complex, I just left reimbursement issues up to others and did not keep up with what the requirements were.

Second, senior managers of all providers should be required to certify that the cost reports submitted to Medicare are correct. Right now just one person must certify the cost

reports. If all of senior management was required to put their names on the dotted line, greater internal accountability would occur. The providers would better police themselves if senior management all knew they would be accountable. For example, I do not remember signing a cost report for the last ten years or so of Healthmaster's operations.

Third, the government HCFA audit teams can be improved in at least three ways. First, it was my perception that the auditors were not always sufficiently knowledgeable about Medicare reimbursement and areas of concern to be able to identify improper reimbursement practices. Second, the audit teams seemed to change from year to year so there was no real continuity or consistency. The better the auditors understand a provider, the better they will be able to know where to look. Third, the auditors need to look not just at the home health agency itself, but at the overall structure.

As I described, the home health agency is not where an owner can make money. It is in the companies surrounding the home health agency that the big profits can be made. Audit teams need to look more closely not just at the transactions between the provider and the related party, but also at the financial activities of the related parties as an integrated business.

Finally, one of the features about Healthmaster about which I am proud is that despite all its other problems, there was never a claim that it abused the actual provision of care. I firmly believe that because we had strong local clinical management at each of our agencies, the visits we claimed were made were made. The services claimed to be rendered on a visit were rendered. The quality of the care provided was top notch. I have observed that when there is not strong local clinical management, or local clinical management at all, the potential for abuse increases. We are working with a vulnerable consumer. Requiring agencies to have local

clinical management in place will help reduce the abuse on the clinical side of the program.

I hope these thoughts are of some benefit to you. I wish I were before you as something other than an example of someone who abused the system. I want to take this opportunity to apologize to you and the American people for the mistakes I made.

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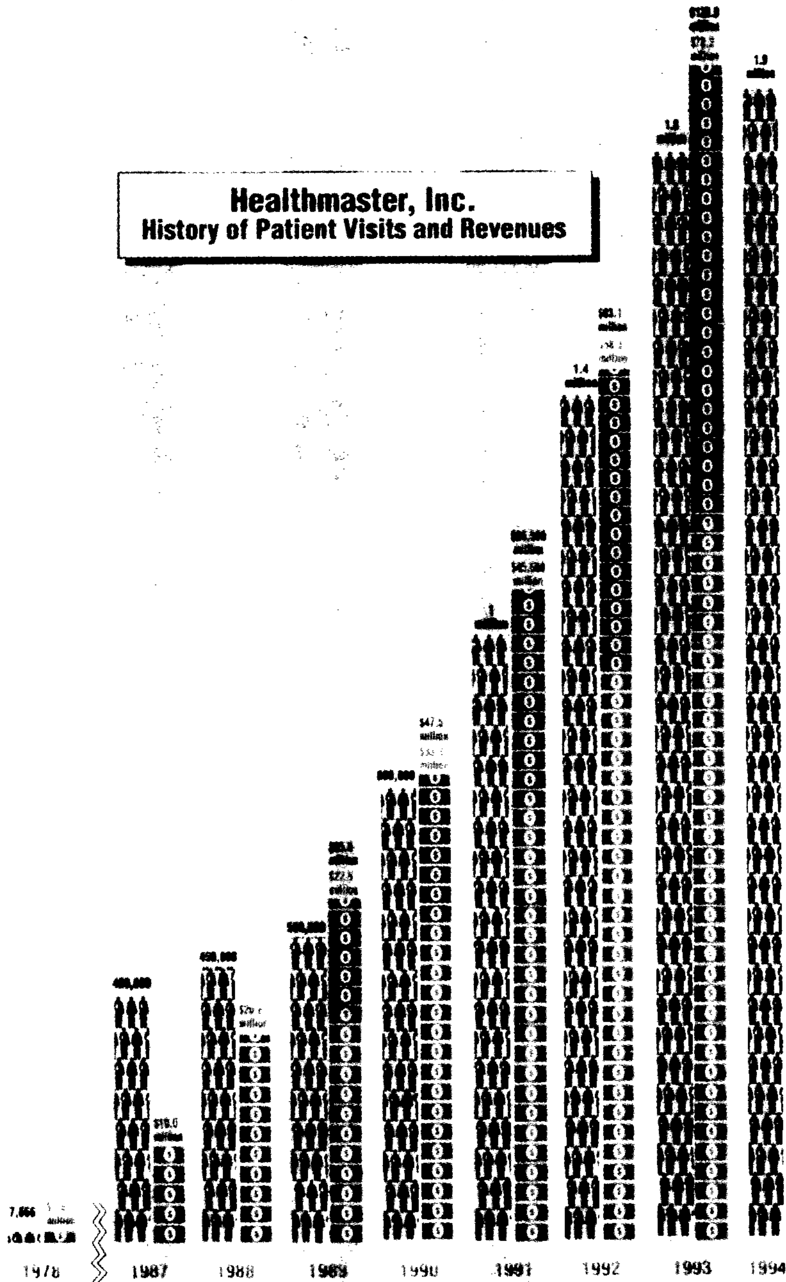
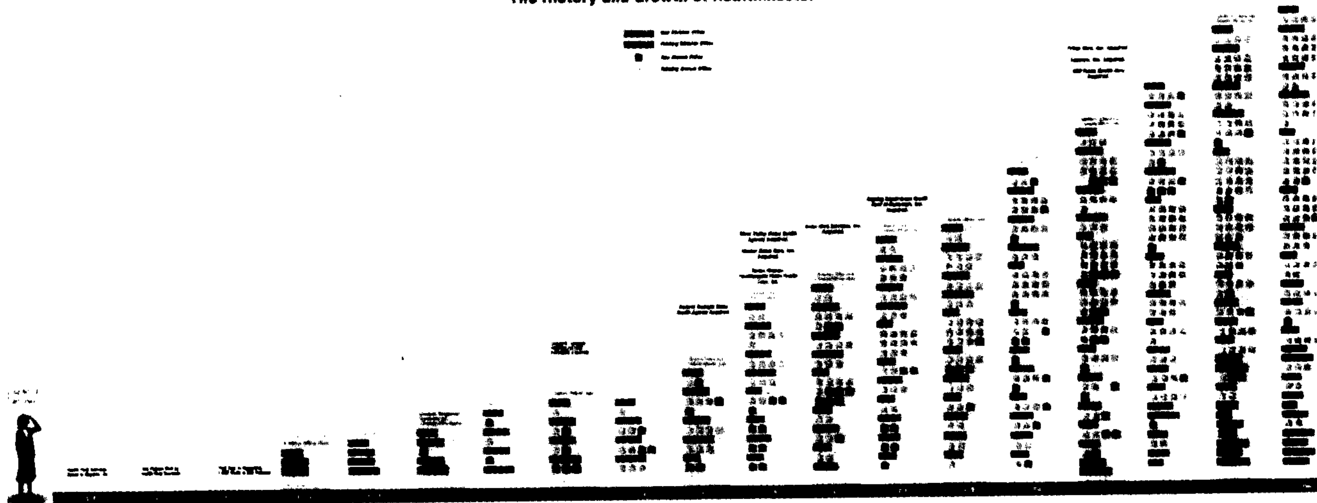
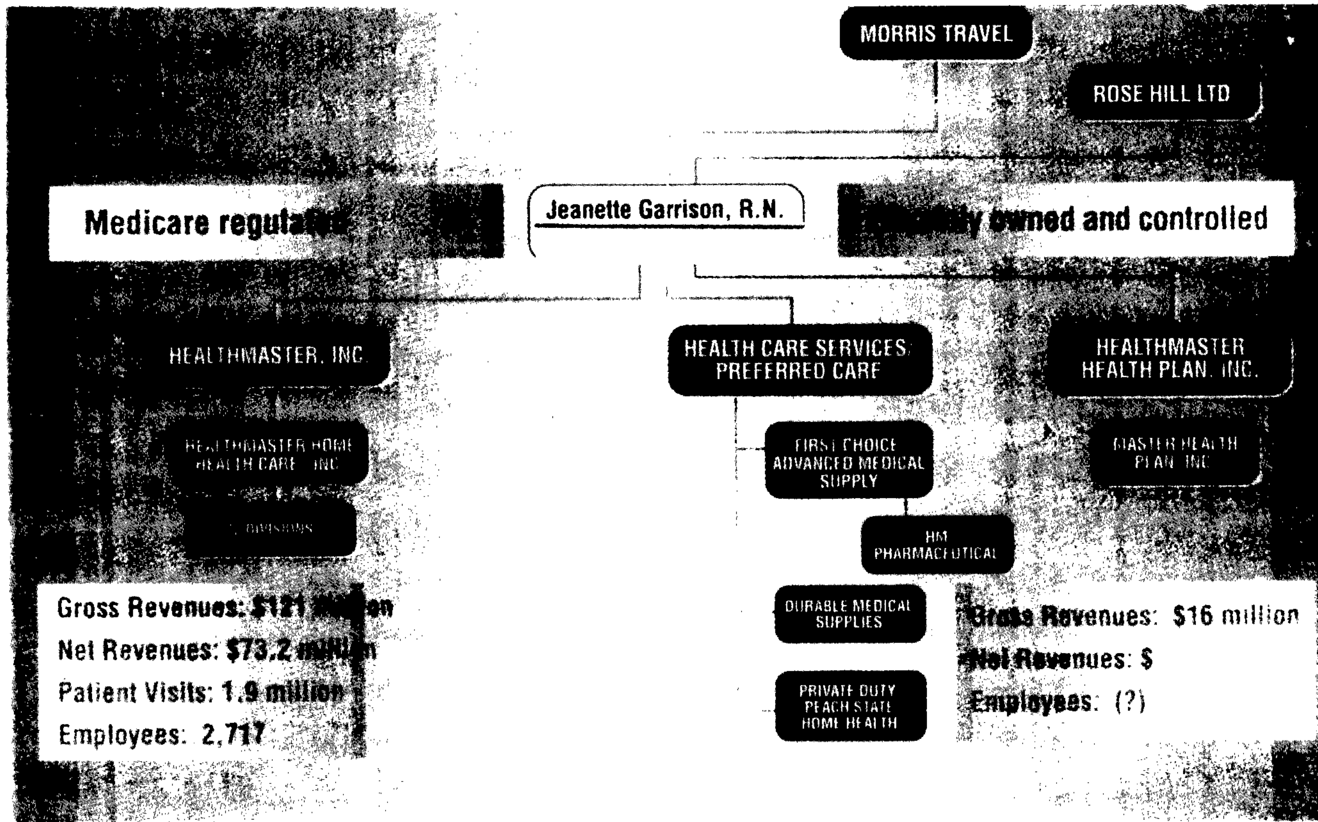

Healthmaster, Inc.
History of Patient Visits and Revenues
1.4 million
1978
1987
1988
1989
1990
1991
1992
1993
1994

The History and Growth of Healthmaster




MORRIS TRAVEL
ROSE HILL LTD
Medicare regula
Jeanette Garrison, R.N.
owned and controlled
HEALTHMASTER, INC.
HEALTH CARE SERVICES/
PREFERRED CARE
HEALTHMASTER
HEALTH PLAN, INC.
HEALTHMASTER HOME
HEALTH CARE, INC.
FIRST CHOICE
ADVANCED MEDICAL
SUPPLY
MASTER HEALTH
PLAN, INC.
HM
PHARMACEUTICAL
Gross Revenues: $121
Net Revenues: $73.2
Patient Visits: 1.9 million
Employees: 2,717
DURABLE MEDICAL
SUPPLIES
PRIVATE DUTY
PEACH STATE
HOME HEALTH
Gross Revenues: $16 million
Net Revenues: $
Employees: (?)

The CHAIRMAN. Obviously, your testimony is a great deal of benefit to us and we thank you for being a brave person and coming and telling us. We obviously have a great deal to learn from you.

I am going to ask the timer to keep track of the questions for 5 minutes apiece and we will have 5-minute rounds. I will ask questions and we will go the same way we did in our order of appearance.

We obviously cannot thank you too much for sharing your story with us and with the American people. I want to begin by asking you as an individual who knows the system and the flaws that are in the system, how big is the problem of waste, fraud, and abuse in the health care business?

Ms. GARRISON. Senator Grassley, over the 4 years that were in question with Medicare, we did $160,000,000 business or so with the Federal Government. Of that, we paid the Government $16,500,000 back. Basically, I would say that is roughly 10 percent, and it would not surprise me if it was not 10 percent overall.

The CHAIRMAN. That is your company. Could you extrapolate for us, then, whether you think that that would be a problem throughout the country?

Ms. GARRISON. I certainly think it would be a problem throughout the country.

The CHAIRMAN. So it is a very big problem?

Ms. GARRISON. Yes, sir, very big.

The CHAIRMAN. Not just in your area or with your company but throughout the country?

Ms. GARRISON. Throughout.

The CHAIRMAN. You have recommended several proposals, including that senior managers of all providers be required to sign the cost reports. I would like to have you explain why you think that that would help.

Ms. GARRISON. As a matter of taking responsibility for one's actions. In our situation in Healthmaster, our accountants, lawyers, reimbursement accountants, CPA's, professed ignorance when the problem came up. I think that if everybody would have to sign on the dotted line, they would definitely take a more active role in making sure that all the costs were legitimate and reimbursable.

The CHAIRMAN. You made an interesting observation about ensuring that Government auditors look at the whole entity. Could you explain what you mean by that?

Ms. GARRISON. Unless the auditors look at all the outside companies that are related to the home health care agency.

The CHAIRMAN. You are thinking about your——

Ms. GARRISON. Yes, sir.

The CHAIRMAN. As an example, these are dealing with home health care and these are kind of non—you can go over there if you like.

Ms. GARRISON. Basically, this management company, this company was a certified home health care agency. It had the 22 divisions and over 100 offices in the five States. This was all the private side. The private here was your private duty nursing around the clock, your medical supply company that supplied to the physicians' offices and also to the home health care agency and nursing home. This was the pharmaceutical company which was private. It

did the IV therapy, which is still private. The durable medical company that delivered the medical equipment and whatever else they needed and also sold medical equipment. This was a separate division on your hourly basis, whatever they needed on the private insurance.

The CHAIRMAN. Basically, the fraud that comes from the subsidiary issues rather than the non-health issues or the main home health care agency is where most of the fraud can come?

Ms. GARRISON. Yes, sir. For the allocation purposes, they would not know unless they reviewed these books of the allocation or whether people thought this company was working in this company and basically the Medicare Program was sharing the entire cost.

The CHAIRMAN. Normally they were not reviewing those on the right?

Ms. GARRISON. That is correct, sir.

The CHAIRMAN. There are about 10,000 home health care agencies in the United States right now. Some are big and some are small and most are doing a good job in giving the Government its money's worth. If we were to develop a program of onsite reviews where accountants, management types, and lawyers went in to visit the agency and related organizations if they exist, what are the characteristic type of home health agencies would you target? In other words, from your experience and how you were able to hide the fraud that came from diverting money from Medicare into something else, where would you tell these auditors to go?

Ms. GARRISON. To the fast-growing, hospital-based agencies that have captive affiliated services. Basically, you will have a hospital-based agency that has a captive audience that they can transfer into their affiliated service companies.

The CHAIRMAN. As you know, we spend millions upon millions on home care reviews and on paperwork. From your testimony, it does not look like we are doing such a great job using these resources that we have. What should we do differently? What should we stop doing and what should we do more of from your experience?

Ms. GARRISON. I think from the auditors' standpoint, more interviews directly with in-house managers. Also the regulations regarding reimbursable and allowable items should be simplified for the providers to understand, clarify.

The CHAIRMAN. One of the things that we are considering is the prospective payment system. In fact, if we get an agreement this week with the White House, that could be enacted yet in final stage by the Congress. Do you think that such a prospective payment system would prove effective?

Ms. GARRISON. I think it would be very effective. I think most of your dollars in a prospective pay system would basically go to your first-line managers and your in-home caretakers. Certainly, it would be based—I would think the patient's needs should be based on care rather than reimbursement.

The CHAIRMAN. If there was only one law that you could enact regarding waste, fraud, and abuse in the home health care system, what would it be?

Ms. GARRISON. The system is so complicated. I think definitely if you could clarify your rules and regulations where the providers could be educated on a continuing basis.

The CHAIRMAN. That answer you just gave me, and then I will go to Senator Breaux, that answer you just gave me, is that from your experience that you yourself did not understand the rules or the people that were working for you did not understand the rules? You said in your statement that you did not pay too much attention to what was going on and you relied upon your help. Are you saying they did not understand or you did not understand or both?

Ms. GARRISON. I think, here again, if each person that is involved in preparing the cost reports, I think if you held them responsible by a certificate of accuracy, that they would become more aware and would learn what is reimbursable and what is not.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman.

Thank you, Ms. Garrison, for being here. You have really blown the cover off of every home health care group in the country that is trying to scam the system. I think that your testimony is very important in the sense of providing the Government with information as to how systems of fraud are operating and we thank you for that.

This is a program that really has grown faster than wild weeds in terms of the number of people getting into it. It is easy to understand why if you want to be unscrupulous. That is not to say that there are not literally thousands of home health providers who are doing the right thing with this program.

How did you get into the program? Was it difficult to get approved by Medicare and by your State before you went into the business or was it fairly easy?

Ms. GARRISON. It was very difficult. At that time, in 1978, the State of Georgia did not have a certificate of need for home health care agencies and basically you had to be a not-for-profit to participate in the health insurance program. Basically, we incorporated in 1976 as a not-for-profit and it took until 1978 for any reimbursement, and basically I had to meet the 13 conditions for participation in the health insurance program.

Senator BREAUX. So you were approved both by Medicare and got a Medicare number——

Ms. GARRISON. Yes, sir.

Senator BREAUX [continuing]. You were also approved by the State of Georgia?

Ms. GARRISON. Yes, sir.

Senator BREAUX. How many times were you audited by either Medicare or by the State of Georgia to see whether you were doing things properly?

Ms. GARRISON. We were audited yearly by both the Federal Government and also by the State.

Senator BREAUX. So every year there was a separate audit by someone from Medicare and someone from the State?

Ms. GARRISON. Yes, sir. There was an onsite audit of every year, to my knowledge, that we were in operation.

Senator BREAUX. In further blowing the lid off of all of this, how did they not find what you were doing for such a long period of time?

Ms. GARRISON. Basically, before that time, if there were any questions on what was reimbursable, usually the intermediary

would disallow it and they would go back and recap it and not allow you that amount. But——

Senator BREAUX. What happened, just so I may understand the process, what alerted the auditors as to the fact that there may be more than just mistakes with this situation with Healthmaster? Did somebody internally say, look, this is illegal, not only mistakes?

Ms. GARRISON. There was an ex-employee that worked for us that went to work for one of the major competitors in our State and she, in turn, notified the Attorney General of the State of——

Senator BREAUX. So the audit system under which you were audited every year——

Ms. GARRISON. Yes, sir.

Senator BREAUX [continuing]. Really did not catch anything that raised a red light to the sufficiency of looking at it from a criminal standpoint?

Ms. GARRISON. No, sir.

Senator BREAUX. Do you think that the Government's system of review is inefficient or was yours a special case of being able to camouflage some of these expenditures?

Ms. GARRISON. I do not think that our company was a special case. I think that the system itself is set up that is based on cost and when you have a system that your cost is astronomical, you can go up to $100 or so on a visit and you get reimbursed for your cost. There is no incentive to be efficient in any of your delivery of services.

Senator BREAUX. So the way that Healthmaster was able to make a profit was not so much through the per patient charges, but through the suppliers that you dealt with?

Ms. GARRISON. That is correct, sir, because every year under Healthmaster, we lost money because the system is set up not to make money. Basically, people look for other ways to make a profit.

Senator BREAUX. So while you lost or did not make money with Healthmaster per se, what was the largest amount of profit that Healthmaster received in your most profitable year from the other services that you provided?

Ms. GARRISON. It was very minimal under Healthmaster because basically it did 95 percent of its business with Medicare and the remainder was Medicaid and in neither of those programs do you make any money.

Senator BREAUX. How much was your fine? I understand that it was a huge fine.

Ms. GARRISON. Our fine was $16.5 million. We paid $15 million to the Federal Government and one-point-something to the State. Our company was sold and it brought $54,700,000.

Senator BREAUX. I notice, and I say for my colleagues on the committee, someone from my State gave me this over the weekend, reference materials on how a nursing home facility can increase profits with x-ray services. I have here a sample letter that each facility can use to write to HCFA, saying that their operation requests permission to gross up radiology from the current cost reporting year. This is an example of how the services, the add-ons that these Medicare providers are able to keep piling onto their op-

erations, they are used to increase profits with unnecessary services.

I think that you have been very helpful. I think that this is a further clarification of the problem. I tried to make the point that only about 3 percent of claims were being audited and that obviously is a problem, but here is a facility that was audited every year, she is telling us, both by the Federal Government and by the State Government and still had the situation occur.

Thank you very much.

The CHAIRMAN. Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman.

Ms. Garrison, I really appreciate the candor and the information that you are sharing with us on this. Were any of the other businesses, the peripheral businesses, were any of those audited?

Ms. GARRISON. By the Federal Government?

Senator ENZI. By the Federal Government, yes.

Ms. GARRISON. They were audited on investigation.

Senator ENZI. But only at that point?

Ms. GARRISON. That is correct, sir.

Senator ENZI. So you are telling us that at the present time, there is not any right for them to go into the private businesses even though they may have a relationship to the home health provider?

Ms. GARRISON. As far as I know, sir.

Senator ENZI. You mentioned that somebody that had gone to work for another company tipped them off on it. How long did the investigation take, then?

Ms. GARRISON. I was notified February 9, 1994, that they were going to start an investigation into Healthmaster and our attorneys notified the State and Federal Government and welcomed them to come in. We provided office space for the Federal Government and had legal counsel on staff at Healthmaster to assist them. We turned over our books, computer tape. They investigated for 8 months, approximately 8 months. In January, basically I started a plea agreement, and then in March they indicted me and we started renegotiating a plea agreement and finally finalized it in July 1995.

Senator ENZI. These would be considered normal transactions, though, between a home health center and other businesses supplying services?

Ms. GARRISON. Yes, sir. There is nothing wrong with shared services if you keep up your time schedules and back out your amount of time that you are using your employees through your private companies and we had been tracking that. But as we got larger, somewhere along the line, the ball dropped and basically it was my responsibility to see that it was done and I did not.

Senator ENZI. Is it typical for the home health agencies to have, which would be set up, then, on a nonprofit basis because they have to be, to have these peripheral businesses, and those, I assume, are for profit, right?

Ms. GARRISON. Yes, sir.

Senator ENZI. So most of the organizations would probably have a similar arrangement?

Ms. GARRISON. Probably.

Senator ENZI. Without the interconnecting audits, then, while there is not encouragement for the shared services to drop the ball, as you put it, it could actually be encouraging to people to do that. When something is not checked on, it is easy to have it overlooked. Is that the impression that you think might be industry-wide?

Ms. GARRISON. Yes, sir.

Senator ENZI. Do you feel that everybody in the industry is being audited on an annual basis in home health care?

Ms. GARRISON. I could not answer that. I think if you are over a certain amount, I do not think small mom and pops are audited on a yearly basis. I think the large agencies are.

Senator ENZI. I thank you for answering the questions and also for the entire list of suggestions that you gave and I yield back any further time.

The CHAIRMAN. Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

I want to follow up on a question that Senator Breaux raised with you about the fact that you were repeatedly audited. What was your relationship with the auditors? Did you provide them with any inducement to give you a clean audit report?

Ms. GARRISON. I never worked with the auditors. We had CPA's and CPA reimbursement specialists that worked with the auditors that prepared the cost report, so basically I was on the clinical side and the field, on the operational side, and a lot of times I never knew when they arrived or when they left. But as far to my knowledge, no.

Senator COLLINS. It was my understanding that some of the auditors involved were granted immunity, that they had, in fact, received some sort of monetary inducements to give a clean audit. Is that incorrect?

Ms. GARRISON. To my knowledge, Senator, I am not aware of that. I know we always had a big-eight firm also audit our companies and there were always auditors in and out.

Senator COLLINS. It is troubling to me, if there were repeated audits and the kind of abuse and fraud that was going on was not picked up. I mean, that certainly raises a serious question for us as far as how effective the audits were.

Senator BREAUX. They were auditing the wrong thing.

Senator COLLINS. Exactly. Let me ask you a question, and that is, what finally led the Government to file charges against you? How were you caught?

Ms. GARRISON. Basically, a former employee that went to work for our competitor went to the Attorney General and basically told him of the bonuses that were given to employees.

Senator COLLINS. So essentially, the reason you were caught was that a former employee went to the authorities?

Ms. GARRISON. That is correct.

Senator COLLINS. If that had not happened, do you believe that you could have continued to operate the way you have been operating?

Ms. GARRISON. That is correct.

Senator COLLINS. You raise an interesting point for us to consider when you talk about the overlapping ownership. Do you think

that makes it much easier to hide inappropriate charges when the home health care agency is affiliated with a number of companies?

Ms. GARRISON. That is correct, because basically you have to keep up with your time schedules and your time cards if you utilize an employee from your Medicare-certified agency. Otherwise, the Medicare company is picking up the cost, the benefits, and the salary of that employee if you send them over somewhere else. But it had always been common among myself, if they call and a nurse did not show up, I had sent a nurse over or I told someone to see if they had a nurse to go over. Basically, there was about $770,000 over the 4 years that was shared services and of that, it was about 10 employees involved.

Senator COLLINS. One of the aspects of your testimony that really troubles me is that you clearly started out with noble intentions. You had elderly relatives of your own who could not get the home health care services that they needed. You were a nurse so you decided to go into this business. I am curious what happened to cause you to go astray, if you will. Was it just that it was too easy to rip off the system? Was it that the controls were so lax and the opportunities so great that it was just there waiting to be taken advantage of?

Ms. GARRISON. We grew at a rapid pace. We also, at that time, we hired attorneys, accountants, and reimbursement specialists, one that had worked for the Federal intermediary before, and he was responsible for the cost report, for all of the schedules, and basically, I left that up to the people that I hired, the professionals, and I did not monitor it closely enough.

Senator COLLINS. Did you think that you were doing anything out of the ordinary? Did you think you were doing something wrong or did you think you were operating the way that your competitors were operating?

Ms. GARRISON. I felt like we were operating according to all the standards of a home health care agency at that time.

Senator COLLINS. One of your recommendations is for us to make sure that when people enter this field that they have a better understanding of what the rules of the game are, if you will. Was there any sort of training or any sort of certification process that you had to go through to acquaint you with the rules, to make sure that you understood the reimbursement policies?

Ms. GARRISON. When we started out in 1978 as a small company, I hired an outside reimbursement specialist that came through and actually did the projections for Medicare. As we got larger, I hired in-house CPA's, an in-house CPA that was a reimbursement specialist to prepare the cost reports. We had three attorneys on staff, one that dealt with nothing but rules and regulations for Federal and State Government.

Senator COLLINS. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Collins.

Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman.

Ms. Garrison, it seems to me what you are saying about the Government auditors is that they really did not know what they were doing. If that is the conclusion, then it does not matter if you get inspected twice a month. It says right here in paragraph 2 on page

7, "the auditors were not always sufficiently knowledgeable about Medicare reimbursement and areas of concern to be able to identify improper reimbursement practices." Now, is that at the heart of the problem, that they just really are not on top of what these reimbursement issues involve?

Ms. GARRISON. Senator, I think you find with a lot of intermediaries and with the rapid growth of the home health care industry that you will see auditors go to work for an intermediary and within a year or so they are recruited by the home health care industry because they are out there desperate for knowledge of what is reimbursable and what is allowable and the interpretations of the guidelines are very complex, because the way you interpret a guideline and the way I interpret it is totally different. So I think you see a lot of transit going through the intermediary and coming out and due to that, they are always new every year.

Senator WYDEN. I think that is right. In my experience, what happens when somebody actually gets on top of these rules, somebody hires them away. I think that is an important point to make.

Turning to the question of getting kicked out of the program for a flagrant violation. It is my understanding that even if you engage in a pattern of these kinds of abuses, what happens is you file the corrective action and a statement and then you just go about your business. Do you think that is an area that needs to be changed and there needs to be more of a deterrent; a message sent that if you engage in these flagrant violations, you are going to be booted out of the program. Should we have this rather than just allowing violators to file one of these corrective statements and go about your business?

Ms. GARRISON. I think the corrective action, and with some agency reviewing and giving continuing education and reviewing the agency, I think most home health care providers would adhere to the corrective action plan and improve those services. There are two parts of a home health care agency. There is the clinical part that is actually the delivery of care and it is the management part which deals with your finances and your reimbursement.

You will find, and based from my experience being a nurse, I am concerned about the care of the patient and making sure the visit is made and making sure everything is taken care of there. With me, I left the other up to the accountants and the attorneys and I accept the responsibility that I did not follow up.

Senator WYDEN. My concern is, and you stated it well, that, yes, the vast majority of these providers are honest and responsible, but it is pretty clear that there are some real rip-off artists. At some point we have to have a deterrent where people get kicked out of this program and are not just in a position to file yet another statement and go about their business.

The last question I want to ask you involves how we might get the family and the patients more involved in trying to watchdog the payment of these plans. Let me be very specific. My experience from working with seniors in my days with the Gray Panthers is that it is hard for some of them to be involved in identifying fraud. But a lot of them have families and kids who are professionals and business people and the like. I wonder if you have any thoughts on

how it might be possible to better empower the consumer and the family to be in a position to watchdog some of these claims.

Ms. GARRISON. From a local area, I think a local watchdog group could assist in oversight. A peer committee at the local level involving physicians, public health could review the quality of care on a monthly basis at random.

Senator WYDEN. Are the families getting the right documents and the right statements from Medicare so that they can better review the payment of some of these claims, in your opinion?

Ms. GARRISON. From a home health care standpoint, when we submit the costs to Medicare and our charges, the charges are always, should I say, inflated, because you get reimbursed your cost, so you are always going to have your charges higher than your actual costs.

Senator WYDEN. What is——

Ms. GARRISON. So from the patients' standpoint, I really do not know what they received as far as their bill.

Senator WYDEN. But you are not aware that they get anything where there is cost-based reimbursement?

Ms. GARRISON. No, sir.

Senator WYDEN. My concern is that in managed care so much of this abuse that has been documented has been in the area of cost-based reimbursement and I do not get the sense that the patient, the family, or someone in a position to help bring to the attention of the Government or Senator Grassley or this committee is getting enough useful information. I think that is a big part of the problem.

We thank you for your service. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Hagel.

Senator HAGEL. Mr. Chairman, thank you.

I, too, wish to add my thanks, Ms. Garrison, for your appearance today. I was struck throughout your testimony at the theme, which should not surprise any of us, complexity of the system, largeness of the system, captive affiliated services, no incentive to be more efficient and accountable, lack of competition, and other terms that you referenced as to what is wrong.

Obviously, when there is a bigger and bigger pot of money, the larger, the more complex the program, the more opportunity for waste, fraud, and abuse, and I think that is a given with any program, so my question is this. How much should we take out of the Federal Government? Would we improve Medicare if we eliminated the Federal Government, if we took it all back to the States and to the locales? It stands to reason, and I think this is really the essence of your testimony, that without accountability, without responsibility, we are going to have a problem. We can put new audits in and we can find new programs and we can even take your captive companies and eliminate those, but without accountability, and that accountability is best where it is closest to the people, we are still going to have a problem. Would you range out for us, Ms. Garrison, on your thoughts?

Ms. GARRISON. Based from my experience in the other programs we participated in, in the early years, we had an alternative home health program that was a demonstration project where they paid

the company, like, I think it was $450 a month to maintain a patient in the home and this was on a local level. So basically, we took the home health aide and placed her in the home 5 days a week with a nurse supervising her at no charge. We maintained those patients on a weekly and monthly basis for that fee.

The local State monitored this system, not on a post-review but on a concurrent review, meaning that they were in the home at random and spot checked, and I think this is what it is all about, is providing the care to the patients in the home at the lowest possible cost to any program.

Senator HAGEL. How best do we monitor that? Do you believe that we should go all the way to the States and locales and give them the complete responsibility, or should the Federal Government have some responsibility?

Ms. GARRISON. I think the States can monitor the program more closely at the local level than the Federal Government.

Senator HAGEL. Do you see a role for the Federal Government?

Ms. GARRISON. Overall in monitoring the States in their delivery of care.

Senator HAGEL. So that would shift considerably from what we have now. Do you believe in your particular case that if there would have been stronger local State accountability for your companies, do you think that would have led to a different conclusion and a different turn of events for you?

Ms. GARRISON. I do, sir, because basically if you are paid on a prospective pay, the incentive there is to be very cost effective. You still have to pay your service people that are delivering your care and you are certainly going to pay them because you want that care delivered. So once you have paid them, there is not the cushion in between your costs and the cap because our cost was very low per visit because basically you get the same cost per visit for a home health aide as you do for a nursing visit.

So the volume of visits that we were producing decreased our cost to around $20, $30 a visit where our max was maxed out at $98 or $100. We could have gone right up to the cost cap. I mean, we could have spent money everywhere and still have had enough to go to the cost caps.

So if you are paying on the prospective pay, you know this is what you are going to receive. You have to pay your essentials, which is rent, and you have to pay your service people, so I think that it certainly would cut down on your fraud and abuse.

Senator HAGEL. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Just a couple of follow-ups. Thank you, Mr. Chairman.

Ms. Garrison, the person that you said in effect became the whistleblower that was in your employment——

Ms. GARRISON. Yes, sir.

Senator BREAUX [continuing]. Who then left your employment and went somewhere else, did that employee go to work for ABC Home Health Care?

Ms. GARRISON. Yes, sir.

Senator BREAUX. That was headed up by Jack Mills?

Ms. GARRISON. Yes, sir.

Senator BREAUX. Where is Jack Mills now?
Ms. GARRISON. Senator, to my knowledge, I think he is in prison.
Senator BREAUX. Is he in prison for Medicare fraud?
Ms. GARRISON. That is correct, sir.
Senator BREAUX. The other question I have is you said that you were operating as a nonprofit home health care agency?
Ms. GARRISON. In 1978.
Senator BREAUX. While there was not a lot of profit in the company, it seems to me it was a very, very good deal. In 1992, the record has you as the President and Chief Executive Officer earning a salary, benefits, and bonuses of $658,584. Is that about correct?
Ms. GARRISON. I have it on my W–2's, but if the record states that it is.
Senator BREAUX. So while the operation in the early round of questioning was not making a lot of money, it was a very good deal, was it not?
Ms. GARRISON. Yes, sir.
Senator BREAUX. Thank you.
The CHAIRMAN. Did you have another question?
Senator WYDEN. Mr. Chairman, just on that point with Senator Breaux. My understanding, and you all are on Finance and may be up on it, is what Senator Breaux is saying is you can have somebody who takes in $3 or $4 million in terms of gross revenue, pays these extraordinary sums out in salaries, pays only a couple hundred thousand dollars for patient care, and at the end of the day you are still a nonprofit operation because you have, in effect, paid out what you have taken in. So I think it is an important point to make.
The CHAIRMAN. I think also she is saying that the big money is in these for-profit organizations, not in the health care delivery, the private companies.
Senator Enzi has another question.
Senator ENZI. I have just another quick question here. In your testimony, you mentioned that you had paid the Federal Government $16.5 million, that you and your company had paid $16.5 million.
Ms. GARRISON. Federal and State.
Senator ENZI. When I went back through the lists of the different things, I found the $750,000 for the employees——
Ms. GARRISON. Shared services.
Senator ENZI [continuing]. The $135,000 for the trip bonuses——
Ms. GARRISON. Pleasure trips.
Senator ENZI [continuing]. Then the $1.5 million for the——
Ms. GARRISON. Acquisition.
Senator ENZI. Yes, for the acquisition costs. What category would the other money have fallen in?
Ms. GARRISON. It was in payroll expense.
Senator ENZI. Can you be more specific?
Ms. GARRISON. In insurance and that some of the other senior managers were involved in fraud.
Senator ENZI. I was just hoping to get a little more detail on the $12 million there that is left out.

The CHAIRMAN. I will ask the last question, then. If you had a word of advice to the people of America who are doing what you did for a while, rip off the home health care system, what sort of advice would you have for them?

Ms. GARRISON. I would tell them to stop immediately. Put in a compliance plan and notify the Government.

The CHAIRMAN. We thank you very much. You are welcome to stay for the other two panels, but we thank you very much for your contribution to this legislative process, to our oversight and our efforts here to make sure that honest people who are in the health care business are going to stay in the home health care business and deliver a quality product for the taxpayers because we know that what you do, what they do is an important service.

Ms. GARRISON. Thank you, sir.

The CHAIRMAN. I will call panel 2 now. Our first panelist is George Grob. He is deputy inspector general for Evaluation and Inspections of the Office of Inspector General of the Department of Health and Human Services. He is accompanied today by John Hartwig, deputy inspector general for Investigations.

We have also Leslie Aronovitz of the General Accounting Office. Ms. Aronovitz is the Manager of the Chicago Field Office, who will provide us with, among other things, detailed findings of its recently completed evaluation on the home health care certification process used by the Health Care Financing Agency.

I am going to call in the order that I called you. We will start with you, Mr. Grob.

STATEMENT OF GEORGE F. GROB, DEPUTY INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC; ACCOMPANIED BY JOHN HARTWIG, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC.

Mr. GROB. Mr. Chairman and members of the committee, before I begin my testimony, I would like to introduce my colleague, Jack Hartwig, who is the deputy inspector general for Investigations. He will be available, if you wish, to answer questions about the case you just heard perhaps from the Government's point of view.

Mr. Chairman, we are here to talk about home health, a very important program of which 1 out of every 10 of Medicare's 38 million beneficiaries currently avail themselves. It is a program that you and I are going to want when our turn comes, too. But I have to tell you, and I have to emphasize, the program is out of control, and very badly so. We have issued about 20 reports on this program from our office in the last 3 or 4 years and today we are issuing two more that I think dramatically portray both the depth of the problem and provide a pretty good explanation at least for some of the causes of it. I believe you all have copies of these reports.

Before I summarize those reports for you, I think it is good to remember and get in perspective a point made earlier about the fact that this is a big program and it is growing fast. Now, the

numbers I am using are from the fiscal year, not the calendar year, and you see there almost $17 billion in 1996. Current estimates as we close that year out are going to drive that number over $17 billion, well over five times the amount that we were spending in 1990.

Our first report is an audit that was performed in four of the largest States in the country, Texas, California, New York, and Illinois. It was a hands-on audit, not just a paper audit. Our auditors visited the patients at their homes, they talked to their physicians, and they had medical experts come in and look at the medical records of these patients.

What they found was that during a 15-month period, 40 percent, and that is the summary on the top chart you see there, 40 percent of the visits that Medicare paid for in these four States during that period should not have been paid according to Medicare rules. This was a loss in those four States alone of $2.6 billion out of the $6.7 billion that Medicare paid during those 15 months. The payments that should not have been made were for services that were not medically necessary, to patients that were not homebound, to patients with service plans that did not have adequate physician authorization, and in a very few cases where the documentary evidence did not support that any service had been provided.

How could this happen? What is going on here? There are, of course, lots of reasons. Some are related to the role the physician plays in supervising the care of these patients, and as several of you have alluded to, to the knowledge that the patients themselves have of the services that are available to them. But clearly, one of the problems has to do with the providers of the services.

So the question we began to ask ourselves is, who is submitting those bills? What companies are submitting that much request for money that should not be paid? So we undertook our second study, which was a study of what we call "problem providers." We consulted with the Medicare fiscal intermediaries to define what we might call a problem provider for the purpose of this study.

I think you might be appreciative of the fact that investigations take a long time, so I am not going to tell you that all of our problem providers are guilty of crime because I cannot prove that in every case. However, we came up with a definition that defined a problem provider as someone who repeatedly submits false bills, such as the kind that we just described, or inflated cost reports, or who owe Medicare a lot of money or who submit unauditable reports or who have been referred for investigation either to our office or to the integrity units of these fiscal intermediaries.

The results are summarized on the second chart. Now, this was in five States, the same as the first study, but we added Florida. Twenty-five percent of the providers that we looked at were found to be problematic by this definition. We were also amazed to find that for these 25 percent of providers in those five States, they had received 45 percent of the Medicare dollars that had been spent in those States.

To get a better idea of what was happening, we took a random sample of 60 of them and we used whatever sources of information we could find to look behind what was going on and here is what

we found, something very similar to what the previous witness described.

A first characteristic was that these companies were involved in a web of related businesses, often unreported, businesses which provided medical supplies, nurse registries, retirement homes, and sometimes companies, for example, that would rent space to them. These are companies we found who sometimes sold patients to other Medicare providers, sometimes for $1,000 each, companies with ghost employees whose salaries were paid but who did not provide work, companies who paid exorbitant salaries to family members, such as a husband and wife team that each got $200,000 and their daughter got $100,000, one with a nephew full-time in college who still had time to earn $250,000 from that agency for helping them with their computer system.

These 60 providers, randomly selected, owe Medicare $321 million, of which $63 million will never be recovered because these companies have declared bankruptcy, and yet these were companies with previous bankruptcies, poor credit records, and sometimes prior criminal conviction.

My colleague from the General Accounting Office will report reasons why the certification system used by the Health Care Financing Administration does not detect or deal with these kinds of problems, and I can tell you that if you read our report further, you will see it says the same thing. They are entirely consistent with one another.

We have made through the years lots of recommendations to the Congress and to the Health Care Financing Administration on these matters to restructure the program, to stop the intake of problem providers, and to improve the control processes. Many of these proposals are now under consideration of the Congress. We are happy to see that. We urge prompt action because that is what is going to be needed to prevent the annual loss of billions of dollars from this program. Thank you.

[The prepared statement of Mr. Grob follows:]

Medicare: Home Health Benefit

Testimony of George F. Grob
Deputy Inspector General
for Evaluation and Inspections
HHS Office of Inspector General

Hearing before the
Senate Special Committee on Aging

July 28, 1997

June Gibbs Brown, Inspector General
Department of Health and Human Services

Testimony of
George F. Grob
Deputy Inspector General
for Evaluation and Inspections
HHS Office of Inspector General

Good morning, Mr. Chairman. I am George Grob, Deputy Inspector General for Evaluation and Inspections, Department of Health and Human Services. I am here today to talk about Medicare's home health benefit. This is an extremely valuable program, one that provides much needed medical care for elderly and disabled individuals in the place that most of them want to be--their homes. Sadly, I must tell you--in fact I must emphasize--that this program is out of control.

Today the Inspector General is releasing two new reports which highlight some of the major problems in this program. The first study, conducted in four of the nation's most heavily populated States. revealed that 4 out every 10 home health visits paid for by Medicare should not have been paid. The second, conducted in the five largest States, found that 1 of every 4 home health agencies certified to participate in the program has abused or defrauded Medicare or misappropriated Medicare funds. We have every reason to believe that similar conditions exist in other States. Resources and systems needed to control costs and prevent abuse are inadequate. All this for a program whose expenditures reached $16.9 billion last year.

The problems of fraud, waste, and abuse associated with the home health benefit are well known. We in the Office of Inspector General have reported on these problems frequently in the last several years through a large body of work including audits, investigations, inspections, and congressional testimony.

We are not alone in this assessment. The General Accounting Office has also issued important reports on this subject. To its credit, the Health Care Financing Administration has taken administrative action and proposed legislation to reduce vulnerabilities. This Congress is now considering bills in both chambers which would make fundamental changes in the way Medicare pays for home health, hoping to limit inappropriate expenditures through a prospective payment system, interim payment limits, and other approaches similar in principle to the methods used to stop excessive growth of Medicare hospital payments years ago. Major reform proposals have even been advanced by those in the industry who are knowledgeable about the current state of the home health program.

We are encouraged by the consensus that seems to be developing around the idea of instituting major structural reforms of this program. But we also wish to emphasize that structural reforms alone will not be enough to prevent the fraud and abuse that is at least partially to blame for losses which this program is experiencing. It will also be necessary to keep unsuitable home health care providers from ever participating in the program and to improve program controls that will prevent inappropriate expenditures while ensuring the availability of services and the quality of care. Legislation which will deal with these aspects of the problem is also pending before this Congress. However, some weaknesses are not addressed, particularly those related to the approval of plans of care, the trustworthiness some home health agencies, and the availability of resources needed to supervise the program.

A Rapidly Growing Benefit

By way of background, let me first summarize some basics about the home health benefit then briefly describe the problems it faces.

Medicare Part A pays for home health services for beneficiaries who are homebound, in need of care on an intermittent basis, and under the care of a physician who both establishes a plan of care and periodically reviews it. Beneficiaries receive numerous services including part-time or intermittent skilled nursing care; home health aide services; physical, speech and occupational therapy; medical equipment and supplies; and medical social services. To receive home health services beneficiaries must be: homebound; under a physician's care; and need part-time or intermittent skilled nursing care or therapy services. The benefit is unlimited as long as the services are considered medically necessary.

The Health Care Financing Administration (HCFA) contracts with six regional home health intermediaries to administer the home health program. These intermediaries are responsible for: processing claims and making payments for home health services; acting as a liaison between HCFA and home health agencies; and administering payment safeguard activities.

The home health benefit is one the fastest growing components of the Medicare program. The $16.9 billion in expenditures in FY 1996 is five times the $3.5 billion spent in 1990. At this level, home health expenditures now account for 8.8 percent of total Medicare spending compared to 3.5 percent in 1990. The Congressional Budget Office estimates that spending for home health services surpass $30 billion by 2002.

The reasons for the rapid growth of home health expenditures are numerous. Some of the growth is appropriate and expected due to demographics, court cases which have liberalized coverage of the benefit, technological advances such as infusion therapies which can be provided at home and a trend toward providing more care in the community rather than in institutions. However, the lack of effective program controls also contributes significantly to the growth.

Fraud, Waste, and Abuse

Unfortunately, fraud, waste and abuse, and the lack of effective payment controls also contribute significantly to the high growth rates of home health expenditures.

Unjustifiable Payment Variation: In past reports, we have identified extreme variation in payments to home health agencies. For example, we compared high, medium, and low cost home health agencies based on their average reimbursement per beneficiary. In FY 1993, lower cost home health agencies (those which provided less than the national average of visits per episode) averaged 30 visits per episode, whereas the higher cost agencies provided 85. One year later, the lower cost agencies provided 33 visits per episode, while the average for the higher cost agencies jumped to 102. We found no reasons for these differences. For example, there were no differences in beneficiary characteristics, medical conditions, or in the quality of care provided.

Improper Payments. We have also issued a series of reports identifying an exceptional level of inappropriate payments made under this program. The first of two reports we are releasing today, "Review of Medicare Home Health Services in California, Illinois, New York and Texas," brings this problem out very clearly. The study reviewed 250 claims accounting for 3,745 services from a randomly selected sample of home health agencies in the four heavily populated States in the report's title. For these cases, our auditors interviewed beneficiaries, family members, knowledgeable acquaintances, and certifying physicians and obtained medical review by Medicare's home health intermediary personnel. They found that in those four States, 40 percent of the total services provided during the 15-month period ending March 31, 1996 did not meet Medicare reimbursement requirements. This represents a Medicare loss of $2.1 to $3.1 billion of the $6.7 billion of the universe of claims represented by the sample.

- **Unnecessary Services.** 793 services (21 percent) were not reasonable and necessary. For example, claims submitted for one beneficiary indicated that the beneficiary had received 9 skilled nursing services, 5 physical therapy services, and 31 aide visits during one month. Medical review staff determined that in fact no skilled nursing services had been provided and that the physical therapy services were not medically necessary. With no allowable skilled services, the aide services are also not medically necessary or reasonable. (Under Medicare rules, aide services are only allowable in conjunction with skilled services.) Thus none of these services were allowable.

- **Patients Not Homebound.** 499 services (13 percent) went to beneficiaries who were not homebound. According to intermediary medical personnel, the beneficiaries, or their families, these beneficiaries could leave home without considerable effort. Records for one beneficiary indicated the beneficiary was frequently not home for scheduled nursing visits, went shopping daily, and would visit his daughter in another State on weekends.

- **Inadequate Physician Authorization.** 239 services (6 percent) were for services that did not have valid physician orders. For some of these claims, the physicians had not signed the plans of care or the plans of care were incomplete. In some instances, the plans of care were signed and dated after the services were performed. Other times, the plans of care were signed by someone other than the physician.

- **No Supporting Documentation.** 8 services (less than 1 percent) were for services without supporting documentation. In these cases, the records showed no evidence the home health services were performed.

The findings of this report support the findings of our earlier audits which were focused on specific home health agencies in Florida, Pennsylvania, and California. These audits revealed error rates--the percent of the home health visits paid for by Medicare but which did not meet Medicare reimbursement requirements--from 19 to 64 percent. As in our most recent report, we found visits that were not reasonable or necessary, patients who were not homebound, visits which were not documented or even provided to Medicare beneficiaries, and improper or missing physician authorizations or forged physician signatures.

Problem Providers

The second report we are releasing today, "Home Health: Problem Providers and Their Impact on Medicare," tells us that too many inappropriate providers are allowed to deliver Medicare home health services.

For this inspection, we developed a definition of what it means to be a problem provider using input from HCFA and the fiscal intermediaries. Problem providers are those who have significant deficiencies with regard to one or more of the following criteria:

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

We found that 25 percent (698 of 2,729) of home health agencies in New York, Florida, Illinois, Texas, and California met our definition of a problem provider. Reimbursement to these agencies is significant, totaling $2.5 billion or 45 percent of total home health expenditures in these States in 1995.

To learn more about the similarities of these problem providers we selected a random sample of 60 for a more detailed examination. We gathered data from the following sources: 1) audit, medical review, and program integrity files maintained by the intermediaries; 2) public records regarding business ownership, criminal convictions, and related information maintained by an on-line data base; and 3) files and databases maintained by the Office of Inspector General, HCFA, and State licensing and certification agencies.

Common characteristics among problem home health agencies include:

- **Higher Cost.** These agencies tend to be newer to the Medicare program, for-profit, provide more visits per patient, receive higher average reimbursement per patient and serve more chronic patients than other agencies in the State. Nearly two thirds of our sample providers have an average reimbursement per patient that is higher than the national average of $4,438. One-third of the agencies have an average patient reimbursement that exceeds $7,000.

- **Owners With Questionable Backgrounds.** Some owners of problem home health agencies have little or no health care experience. Many have backgrounds in completely unrelated businesses, for example: trucking, real estate, accounting, and the beauty industry. The current certification process does not require any background checks into the owner's credit or financial history, criminal records or past work experience. As a result we found instances

where owners had filed bankruptcy, defaulted on loans, failed to pay Federal or State taxes, or had been found guilty of criminal wrongdoing.

- **Small, Family-Owned Corporations.** Problem home health agencies tend to be closely-held corporations, owned by a small number of individuals. Frequently they are family-owned with many employing or contracting with other relatives for agency services. Sometimes the relatives performed little or no work. In one instance, an owner's nephew was paid $250,000 to maintain the agency's computers. However, he was a full time college student during this time.

  The use of relatives in a business is not in and of itself illegal or unethical. On the contrary, a long tradition of building businesses has relied on this approach. However, in the Medicare home health program, this greatly increases the risk of fraud. This is because a portion of Medicare's payment is based on costs incurred and reported by the home health agency. The use of relatives increases the possibility of deliberate collusion to make false claims or to intermingle private and programmatic expenses. This is illustrated in the example above as well as in others provided later in this testimony.

- **Related Businesses.** Many of these agencies have an intricate series of business links with other home health agencies or businesses that provide services for the agency. We found some of the agencies did not disclose information about their relationship to durable medical equipment, health consulting, retirement homes or nurse registry businesses.

- **Medicare As Primary Source of Income.** Problem agencies have very few assets. On average, cash on hand and fixed assets amounted to only one-quarter of their total assets. Furthermore, 75 percent of the providers derived more than 90 percent of their income from Medicare.

Some of these characteristics taken by themselves appear to be harmless. However, taken together we begin to see a picture of a group of providers who are able to generate large profits with very little jeopardy to themselves or their businesses. We are greatly concerned that these home health agencies pose a serious risk to the home health program and the Medicare trust fund. One illustration of this is that the 60 problem agencies in our sample have combined outstanding debt of $321 million. Individual agency overpayments range from $100,000 to several million dollars.

A synopsis of some of the investigative cases completed by the Office of Inspector General over the past two years also illustrates the vulnerability of the Medicare home health program to these problem providers.

- The Chief Executive Officer and his wife and co-owner of a home health agency were convicted of conspiracy to defraud Medicare. They were accused of filing cost reports that included personal expenses (e.g., family vacations to Mexico, golf club memberships, and a car for a son in college), and ghost employees. They were also charged with mail fraud, paying kickbacks, making false statements, witness tampering, money laundering, and submitting false tax returns. The defendants were sentenced to 90 months and 32 months incarceration, respectively. These individuals and the company will pay $255 million fines, restitutions, and other penalties.

- The owner of home health agency was sentenced to 5 years probation and ordered to repay $119,000 for defrauding the Medicare program. The owner included in Medicare cost reports the expenses of a costume shop she owned and a magazine she produced monthly. Fraudulent expenses charged included payroll, leases, telephone service, and advertising.

- The owner of a home health agency entered a settlement agreement to pay $493,000 in civil damages and penalties for submitting false Medicare claims. Investigation found that over a 9-month period, the agency billed Medicare for home health services for patients who were not homebound, and for services not rendered.

Inadequacy of Traditional Controls

Traditionally the program has looked to the home health intermediaries, certifying physicians, beneficiaries, and service providers to control utilization of the benefit. Both of these reports highlight the inadequacy of these existing controls over the benefit.

- **Physicians.** Physicians did not play a strong role in determining need for or appropriate level of home health services for beneficiaries. Home health agencies performed these activities. In the four-State audit whose results we are publishing today, we interviewed 136 physicians who had signed the plans of care associated with the unallowable claims found in our review. In 11 cases, the physicians signed the plans of care without having knowledge of the patient's condition. In 82 cases, the physicians said they were not aware of the homebound requirement.

- **Intermediaries.** The sheer volume of claims and limits on financial resources prevents Medicare's intermediaries from reviewing home health agency claims. Currently, intermediaries target only about 3 percent of all claims, including home health claims, for review. This is a significant reduction from 1988 when intermediaries were asked to review 50 percent of home health claims.

  By way of contrast, private insurance companies, particularly health maintenance organizations, exercise much closer scrutiny of home health services. Even for Medicare beneficiaries, home health organizations do better than Medicare's intermediaries in terms of controlling costs. For example, we found that health maintenance organizations provide home health care for Medicare beneficiaries for only one-fourth the cost of the Medicare fee-for-service program. They do this by using case managers to review and approve patient care. The case managers work with physicians to plan care and write orders, review and approve both initial and continuing visits, review medical necessity, track and report outcomes, and participate in quality assurance activities such as clinical record reviews, team meetings, and case conferences. Lack of resources prevent Medicare intermediaries from routinely engaging in such activities.
- **Beneficiaries.** We found that at the time this work was conducted beneficiaries were unaware of specifically which home health services were claimed on their behalf. However, in October

1996, intermediaries were required to begin issuing a "Notice of Utilization" to beneficiaries. We hope that providing this information will enable beneficiaries to help in detecting fraud.

Recommendations

As I noted in my introduction, the Health Care Financing Administration has moved to limit vulnerabilities in the Medicare home health program. The "Notification of Services" just mentioned is one example of this. Others include: the use of State Survey and Certification Review teams to identify actual or potential fraud while they are on site examining compliance of home health agencies with Medicare's conditions of participation; elimination of the use of periodic interim payments; and undertaking development of a new provider enrollment application form and a new data base of ownership data. The President has sent to the Congress proposals to adopt a prospective payment system for home health and, in a separate bill on fraud, waste, and abuse, to strengthen authorities to keep unsuitable providers from participating in the program. Committees of both the Senate and the House of Representatives have also developed such proposals and are now considering them in the context of a broad reconciliation bill.

Clearly, much needs to be done to get this program under control. Even the passage of major legislation such as that which is now pending before the Congress will not solve all the problems we are now facing.

We propose a three part strategy to deal with the problems we have encountered: 1) restructure the payment system to eliminate inappropriate incentives which unnecessarily increase cost and utilization; 2) prevent unscrupulous providers from gaining entry into the program; and 3) improve program controls such as eligibility determination and approval of plans of care and services. A variety of options are available for all three parts of this strategy, some of which will require legislation or additional resources. For the purpose of handy reference, I offer the following recommendations pertaining to these strategies. Some are drawn from the two reports we are issuing today, others from earlier reports and testimony.

Restructure the Payment Method. We strongly support the idea of a prospective payment system for home health. This approach would authorize a fixed payment per episode for each patient in need of home health services. It eliminates incentives in the current payment system to increase profits by unnecessarily increasing the number of visits provided to a patient. Unfortunately, a prospective system may take some time to develop, whereas the need for structural reform is immediate. We have to find a way to avoid building in to the final system the explosive growth of costs and utilization which we are now experiencing. We have recommended other payment changes that could be used until a prospective payment system has been adopted. Options include: visit caps or limits; cost limits per beneficiary; benefit targeting; limits on expenditures per beneficiary; and beneficiary copayments.

Keep Problem Providers Out of the Program. Unfortunately, structural reforms may do little to protect the program from truly unscrupulous providers. It is important that the program take steps that will enable HCFA to identify problem providers and prevent them from abusing the program as well as prevent problem providers from entering the program. Our recommendations include:

- requiring that each home health agency obtain a surety bond equal to the amount of anticipated Medicare billings during its fiscal year. The cost of the bond should not be considered a reimbursable expense for Medicare cost reporting purposes.

- requiring "application fees," so that new and existing home health agencies are required to pay for their initial certifications, comprehensive on-site reviews, and recertification.

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

- developing a data bank of owners, principals, and other home health agency officials and related organizations so that their activity can be cross-referenced to identify potentially fraudulent practitioners and businesses.

- requiring that all home health agency owners and principals provide their individual Social Security numbers and Employer Identification numbers when they submit an application to become Medicare providers. This will make it possible for HCFA to review the applicants background for such things as criminal behavior or prior administrative sanctions before deciding whether the agency should certified for participation in the Medicare program.

- prior to certification, assuring that new home health agencies are financially sound and have adequate fiscal record keeping capabilities and that their owners and principals are qualified and trustworthy.

- conducting more extensive background checks to determine the suitability of, and, if appropriate, refusing to enroll, any agency 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.

- precluding the discharge of Medicare debts through bankruptcy.

Improve Program Controls. Even with competent, trustworthy providers, the day to day management of this benefit will be a daunting task that will require the attention of everyone involved in it--home health agencies, fiscal intermediaries, certifying physicians, even beneficiaries and their families. Following are some specific improvements needed in current program operations:

- ensuring that patients are truly homebound, such as by:

- strictly applying the definition of "homebound;"
- requiring beneficiaries to certify their "homebound" status; and
- developing additional guidance and definitions for defining "homebound" status.

□ improving physician supervision of home health services, in particular:

- requiring the patient's physician to examine the patient before ordering home health services and to see the patient at least once every 60 days;
- ensuring that the treating physician establish the plan of care and specifically prescribe the type and frequency of services needed; and
- better educating physicians on Medicare eligibility requirements so they do not have to rely on the home health agency's determination.

□ having intermediaries perform more focused medical reviews, with physician and beneficiary interviews to verify services.

□ continuing to provide beneficiaries with notifications of services provided and using feedback from the beneficiaries to target abusive home health agencies for focused medical review.

Conclusion

In summary, Mr. Chairman, the Medicare home health program is in trouble. Prompt action is needed on a broad front to prevent the loss of billions of dollars a year in inappropriate payments.

I am well aware how trite such a statement can sound. But even those of us accustomed to reading a daily fare of audits, inspections, and investigations on numerous subjects are profoundly worried about the potential dollar losses in the home health program. Our studies, conducted over several years now, have consistently, relentlessly reminded us of the seriousness of the problems we are facing. Studies conducted independently by the General Accounting Office have reached similar conclusions. Reforms and better controls are needed, not to prevent Medicare beneficiaries from receiving services which they need, but to ensure that they will always be able to do get them. We thank you for holding this hearing, and I welcome your questions.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

RESULTS OF THE OPERATION RESTORE TRUST AUDIT OF MEDICARE HOME HEALTH SERVICES IN CALIFORNIA, ILLINOIS, NEW YORK AND TEXAS

JUNE GIBBS BROWN
Inspector General

JULY 1997
A-04-96-02121

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date: JUL 28 1997

From: June Gibbs Brown
Inspector General

Subject: Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas (A-04-96-02121)

To: Bruce C. Vladeck
Administrator
Health Care Financing Administration

This final report provides you with the results of our audit of Medicare Home Health Services in California, Illinois, New York and Texas. The audit was performed under the auspices of Operation Restore Trust (ORT).

OBJECTIVE

The audit objective was to determine whether Medicare payments to home health agencies (HHA) met Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Our review disclosed that 40 percent of the total services contained in 146 of 250 HHA claims reviewed did not meet Medicare reimbursement requirements. Our sample was selected from claims approved for payment by fiscal intermediaries servicing California, Illinois, New York and Texas during the 15-month period ended March 31, 1996. The services did not meet Medicare reimbursement requirements because:

- 793 services contained in 65 claims were for services not reasonable and necessary. The unnecessary services included skilled or aide services that, in the opinion of intermediary medical personnel, were not medically necessary. For example, in many cases the home health nurses provided no skilled service, only observation and assessment of the patients' condition.

- 499 services contained in 46 claims were for services to beneficiaries who were not homebound. According to intermediary medical personnel, the beneficiaries or their families, these beneficiaries could leave home without considerable effort. One beneficiary told us he went shopping on a daily basis during the elapsed time HHA services were provided to him.

- 239 services contained in 31 claims were for services that did not have valid physician orders. These services were performed without evidence of timely written or verbal physician approval. For example, we found instances where (1) there was no signature on the plan of care; (2) the plan of care was signed

and dated after the services began; or (3) the plan of care was signed by a nurse, an office manager, a physician's assistant or a doctor's secretary in the name of the physician. Also, in some instances the plan of care did not include an order for a skilled service.

- 8 services contained in 4 claims were for services without supporting documentation. The HHA had no documented evidence that the services were performed.

We estimate for the 15 months ended March 31, 1996, the intermediaries approved unallowable claims with charges totaling about $2.6 billion out of the 4 State universe of $6.7 billion.

In order for home health services to be covered by Medicare, beneficiaries must be:

- confined to their homes;
- under the care of a physician; and
- in need of skilled nursing services on an intermittent basis or skilled physical, speech, or occupational therapy.

We believe there are several reasons why inappropriate claims were submitted by HHA providers and approved by intermediaries. These reasons include:

- Physicians did not always review or actively participate in developing the plans of care they signed. They relied heavily on HHAs to make homebound determinations and develop the plans of care for home health services.
- At the time of our review, beneficiaries were not aware of the cost of the home health services. We believe, had the beneficiaries been aware of the cost, they may have questioned the intermediary about services claimed on their behalf. As of October 1, 1996, the Health Care Financing Administration (HCFA) took steps to improve on this by instructing the Regional Home Health Intermediaries (RHHI) to generate a beneficiary notification system for home health services.
- Medical reviews of claims for HHA services were not effective in curbing abuse. The HCFA, as a result of funding constraints, instructed intermediaries to reduce medical reviews and focus on aberrant providers. The intermediary medical review effort was reduced because the reviews resulted in low denial rates and were therefore considered ineffective. However, the reviews will continue to produce limited results because the focused medical reviews do not include beneficiary and physician interviews.

Since 1990, the Medicare expenditures for HHA services have increased dramatically from about $3.3 billion to an estimated $16.9 billion for 1996. We believe the results from our work strongly support the need for major changes in providing and paying for HHA services. Based on joint work with HCFA, we believe implementing such recommendations as the following will help address the abuses we have noted in the HHA program.

We therefore recommend HCFA:

- Consider the following alternatives in restructuring the home health reimbursement methodology: (1) a prospective payment system; (2) placing limitations on the number of visits; (3) establishing a system of pre-authorizations; (4) establishing a copayment; and (5) a case management system.

- Emphasize the definition of homebound in the Medicare HHA Manual and include additional guidance on the standards for defining "considerable and taxing effort" and "infrequent or for periods of relatively short duration."

- Revise Medicare regulations to require the physician to examine the patient before ordering home health services. Also, HCFA should require the patient to see the recertifying physician at least once every 60 days. The HCFA should ensure the treating physicians establish the plan of care and specifically prescribe the type and frequency of home health services needed. Also, an outreach program should be established to re-educate the physicians on the home health eligibility requirements so they do not have to rely on the HHA determination.

- Require intermediaries reviewing claims to continue to notify beneficiaries when HHA claims are paid on their behalf and use information provided by the beneficiaries to target abusive HHAs for focused medical review.

- Instruct intermediaries to augment focused medical reviews with physician and beneficiary interviews to verify services were provided and properly prescribed.

In its written response to our draft report, HCFA concurred with four of the five recommendations. The HCFA agreed in principle with the other recommendation, and is continuing to examine the issue. The complete text of HCFA's response is presented as Appendix D to this report.

BACKGROUND

Operation Restore Trust

The Secretary of the Department of Health and Human Services initiated ORT to address growing concerns over rising costs in the health care industry. The ORT concentrated on benefits for: home health, nursing homes, hospices, and durable medical equipment in five States - California, Florida, Illinois, New York, and Texas. Together, these states account for a large percentage of the Nation's Medicare and Medicaid beneficiaries. This audit focused on the home health services in California, Illinois, New York, and Texas.

Under the auspices of ORT, the Office of Inspector General (OIG) previously conducted a statewide review of HHA services in Florida and has reviewed HHA services provided by individual HHAs in Texas, Florida, California and New York. The ORT Project has initiated proposals presented in the President's Budget that will improve program integrity and oversight activities.

Home Health Services

Home health services allow people with limited mobility to live independently while still receiving professional health care services. An HHA is a public or private organization that is primarily engaged in providing skilled nursing care and other therapeutic services in the home on a visiting basis.

During our review, HHAs were reimbursed on an interim basis under the periodic interim payment (PIP) or the estimated cost methods. Payments under both methods approximate the cost of covered services rendered by the provider. Interim payments are adjusted to actual costs based on annual cost reports.

Authority and Requirements for Home Health Services

The legislative authority for coverage of home health services is contained in § 1814, § 1835, and § 1861 of the Social Security Act; governing regulations are found in Title 42 of the Code of Federal Regulations (CFR); and HCFA coverage guidelines are found in the Intermediary Manual.

Home health is one of the fastest growing segments of health care. In 1995, Medicare paid $15.1 billion for home health services nationwide. The HCFA, Office of the Actuary estimates expenditures will exceed $27.2 billion in the year 2000.

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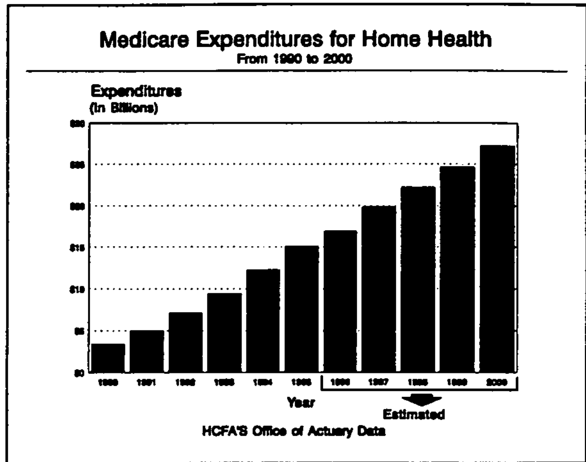
According to data provided by HCFA, in 1995 approximately 28[1] percent of all HHA reimbursements nationwide were to HHAs servicing California, Illinois, New York and Texas.



Intermediary Responsibility

The HCFA contracts with intermediaries, usually large insurance companies, to assist them in administering the home health benefits program. The principal intermediaries for HHAs in California, Illinois, New York, and Texas are Blue Cross of California, Health Care Service Corporation, United Government Services, and Palmetto Government Benefits Administrators, respectively. The alternate intermediary for the four States is IASD Health Services Corp. In addition to the principal and alternate intermediaries, there were other intermediaries that processed less than 10 percent of the HHA claims in the four ORT States.

The intermediaries are responsible for:

- processing claims for HHA services,
- administering payment safeguard activities,
- performing liaison activities between HCFA and HHAs,
- making interim payments to HHAs, and
- conducting audits of cost reports submitted by HHAs.

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[1] This figure represents fee-for-service home health reimbursements and does not include services provided by health maintenance organizations.

SCOPE

The objective of our audit was to determine whether Medicare payments to HHAs in the four ORT States met Medicare reimbursement requirements.

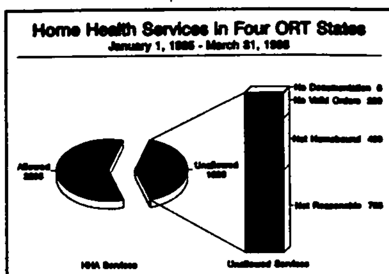
Our sample was selected from the claims processed by the principal intermediary for each State and the alternate intermediary for the four ORT States. Including only the principal and alternate intermediaries, we simplified the sampling plan and assured that we had over 90 percent of the HHA charges included. During the 15 months ended March 31, 1996, the 5 fiscal intermediaries approved for payment 4,787,911 HHA claims from the 4 ORT States with about $6.7 billion in charges. We reviewed a statistical sample of 250 claims with $374,143 in charges. Appendix A contains the details on our sampling methodology. Appendix B contains the results and projection of our sample. We used applicable laws, regulations, and Medicare guidelines to determine whether the services claimed by the HHAs met the reimbursement requirements.

Generally, for each of the 250 claims, we interviewed the beneficiary, family member or a knowledgeable acquaintance. We also interviewed the physician who certified the plan of care. We obtained supporting medical records maintained by the HHAs for the 250 claims and requested the intermediaries' medical review personnel to determine whether the beneficiaries were homebound and the services were medically necessary.

We did not review the overall internal control structure of the intermediaries or of the Medicare program. Our internal control review was limited to information obtained during a prior audit of HHA claims in Florida. During our audit in Florida, we obtained an understanding of three of the five intermediaries' claims processing systems such as pre and post-payment reviews of claims and provider audit activities. During our audit we discussed current policies and procedures with representatives from all five intermediaries. We did not test the intermediaries' internal controls because the objective of our review was accomplished through substantive testing.

Our audit was made in accordance with generally accepted government auditing standards. Field work was performed in California, Illinois, New York and Texas and included visiting the HHA's administrative offices, physicians' offices and beneficiaries' residences. The field work was conducted from July 1996 to January 1997.

DETAILED RESULTS OF REVIEW



Our audit showed 1539 of the 3745 services included in 146 of the 250 claims in our random sample did not meet the Medicare reimbursement requirements. For the population of HHA claims processed by the five intermediaries for California, Illinois, New York and Texas, we estimate 40 percent of the services contained in the claims did not meet Medicare reimbursement requirements. The percentage was computed using a stratified cluster sampling methodology. See Appendices A and B for the details on our sampling results.

Based on a stratified random sample, we estimate the five intermediaries approved claims for payment with charges totaling approximately $2.6 billion that did not meet Medicare reimbursement requirements.

We believe there are several reasons why inappropriate claims were submitted by HHA providers and approved by intermediaries. These reasons include:

- Physicians did not always review or actively participate in developing the plans of care they signed. They relied heavily on HHAs to make homebound determinations and develop the plans of care for home health services. Medicare regulations do not require physicians to personally examine beneficiaries or review medical records before signing certifications stating beneficiaries need home health care.

- At the time of our review, beneficiaries were not aware of the cost of the home health services. We believe, had the beneficiaries been aware of the cost, they may have questioned the intermediary about services claimed on their behalf. As of October 1, 1996, the HCFA took steps to improve on this by instructing the RHHI to generate a beneficiary notification system for home health services.

- Medical reviews of claims for HHA services were not effective in curbing abuse. The HCFA, as a result of funding constraints, instructed intermediaries to reduce medical reviews and focus on aberrant providers. The intermediary medical review effort was reduced because the reviews resulted in low denial rates and were therefore considered ineffective. However, the reviews will continue to produce limited results because the focused medical reviews do not include beneficiary and physician interviews.

Criteria for Certification of Home Health Services

Title 42 CFR § 424.22 states: "Medicare Part A or Part B pays for home health services only if a physician certifies and recertified..." that "(iii) A plan for furnishing the services has been established and is periodically reviewed by a physician who is a doctor of medicine..." and "(iv) the services were furnished while the individual was under the care of a physician...." The regulations require a physician to sign a plan of care that serves as a certification that the services are medically necessary and the beneficiary is homebound. However, the regulations do not require the same physician perform all the responsibilities nor do they provide guidance to determine the meaning of "under the care of a physician."

In an effort to make physicians more accountable for certifying an individual meets the requirements for home health services, Congress added Section 232 to the Health Insurance Portability and Accountability Act of 1996. Public Law 104-191, § 232 states, "any physician who executes a document ...with respect to an individual knowing that all of the requirements referred to ... are not met with respect to the individual shall be subject to a civil monetary penalty..."

Services Not Reasonable and Necessary

Our review disclosed 793 services included in 65 claims were for services that were not reasonable and necessary. These claims included services for skilled and aide services that were determined to be medically unnecessary by the intermediaries' medical review personnel.

Section 3116.1 of the Medicare Intermediary Manual (MIM) states the beneficiary's health status and medical need as reflected in the plan of care and medical records provide the basis for determination as to whether services provided are reasonable and necessary.

The MIM § 3118.1 further states a service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. Where a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct supervision of a licensed nurse, the service cannot be regarded as a skilled service although a skilled nurse actually provides the service.

The HCFA Publication 11, § 206.2 states in order to be considered for coverage, home health aide services must be: medically reasonable and necessary, provided to a homebound beneficiary, rendered under the supervision of a registered health professional, in conjunction with skilled services, and rendered when there is no family member or support system able, available or willing to provide these services.

The unallowable services included claims for skilled nursing services not considered reasonable or medically necessary by the intermediaries' medical experts. For example, one

beneficiary received two nursing visits for congestive heart failure for which the intermediary's medical review staff determined were not necessary.

In another case, a beneficiary received 9 skilled nursing services, 5 physical therapy services and 31 aide visits during 1 month. The intermediary's medical review staff concluded no skilled services were performed, only caregiver services. Also, the physical therapy was unnecessary. Therefore, because there were no allowable skilled services provided, the aide services were also not reasonable and necessary.

The physicians who certified home services on 33 of the 65 claims that included services not reasonable and necessary, stated the HHAs determined the type and frequency of home care for the beneficiaries. The physician involvement in the preparation of plans of care was limited to signing the forms prepared by the HHAs.

Services To Beneficiaries Who Were Not Homebound

Our review disclosed 499 services included on 46 claims were for services to beneficiaries who were not homebound. We found Medicare reimbursement criteria regarding the homebound status of the beneficiaries was not always met because physicians did not make this determination.

Title XVIII of the Social Security Act, § 1861(m) established home health services could be provided to beneficiaries who are confined to their home (homebound). The MIM § 3117.1 states a beneficiary will be considered homebound:

(a) if a health condition restricts his ability to leave his place of residence except with the aide of supporting devices (i.e. crutches, canes, wheelchairs, special transitional equipment, or the assistance of another person), or

(b) if he has a condition which makes leaving his home medically contraindicated. An individual does not have to be bedridden to be considered homebound. However, a normal inability to leave home requiring a considerable and taxing effort from the beneficiary must exist.

During our interviews, the beneficiaries, their families, or HHA records indicated the beneficiaries could leave their homes without considerable effort at the time HHA services were provided. For example:

- HHA records for one beneficiary indicated the beneficiary was frequently not home for scheduled nursing visits, went shopping on a daily basis and on weekends would visit his daughter who lived in another State.

- One beneficiary stated she was not physically homebound but needed custodial care. However, she was able to leave her home on a regular basis for non-medical reasons. In fact, she was attending a social club once a week.

- One beneficiary stated after she switched to a new physician closer to her home, the physician immediately signed her up for home health services. She further stated, other than arthritis in her hands, she had no restrictions in her routine activities such as shopping and getting groceries.

Interviews of 43 physicians who signed plans of care for beneficiaries who were not homebound disclosed 30 physicians relied on the HHA to prepare the plan of care with little or no input from physicians. Six physicians signed plans of care including homebound certifications for patients they were not familiar with and 25 physicians were not aware of the homebound requirements for HHA services. In addition, after reading the criteria for homebound status, six physicians did not think their patients were homebound.

Services Without Valid Physician Orders

Our audit showed 239 services included in 31 claims were for services that did not have valid physician orders. For these claims, the physicians had not signed and/or dated the plans of care or the plans of care were incomplete. In some instances, the plans of care were signed and dated after the services were performed. In other instances, the plans of care were signed by a nurse, an office manager, a physician's assistant or a doctor's secretary in the name of the physician.

Medicare regulations require a plan of care and a certification of medical necessity be signed by the same physician and the individual receiving the care be under the care of a physician.

Services on one claim for five nursing visits and seven aide visits were unallowable because the physician never signed the recertification plan of care. In another case, eight services were considered unallowable because the physician's assistant signed the plan of care rather than the physician. In addition, the physician was not familiar with the beneficiary. Two physicians who signed the plans of care were not familiar with the patients.

Services Not Documented

Our review showed eight services included in four claims were for services that were not documented. In these cases, the HHA records showed no evidence the home health services were performed.

Title 42 CFR § 409.42 (e) states that services must be furnished by, or under arrangements by, a participating HHA. Section 484.48 further requires, "A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains ...activity orders; signed and dated clinical and progress notes..." Section 484.48 also requires records to be maintained for 5 years after the month the cost report is filed.

Effect

We estimate during the 15 months ended March 31, 1996, the intermediaries approved unallowable claims with charges totaling about $2.6 billion out of the 4 State universe of $6.7 billion.

Causes

The unallowable home services disclosed by our review occurred because of the inadequacy of existing controls to ensure claims approved for payment were for allowable services. The HCFA relied on the treating physicians to ensure services were provided only to eligible beneficiaries. However, the physicians abdicated their responsibility to the HHAs. Additionally, because of funding constraints HCFA reduced the intermediaries' medical review requirements for home health claims. We also found beneficiaries did not receive notice of Medicare benefits for home health services, and thus, did not provide the intermediary with feedback regarding services claimed by providers.

Inadequate Physician Involvement

The Medicare program recognized the physician would have an important role in determining utilization of services. The law requires payment can be made only if a physician certifies the need for services and establishes a plan of care.

In court decisions, the U.S. District Courts have relied heavily on the physician's certifications under the "treating physician rule." This rule has been the turning point in court cases where home health services, previously disallowed by the intermediaries and administrative law judges, were allowed by the court. The rule places a significant reliance on the informed opinion of a treating physician, even if contradicted by substantial evidence, because the treating physician is considered to be more familiar with the patient's medical condition than other sources.

We interviewed 136 physicians who signed the plans of care associated with the unallowable claims found in our review. Our audit disclosed too often the physicians' involvement in home health care was limited to signing plans of care prepared by the HHAs without proper

evaluation of the patients to assess their needs and homebound status. We found HHAs were determining the need, type, and the frequency of home health services without physician participation.

The physicians' interviews disclosed inadequate involvement in the preparation of plans of care or the determination of homebound status. For example:

- In 11 instances, the physicians signed the plans of care without having knowledge of the patients condition.

- In 82 instances, the physicians were not aware of the homebound requirement for home services.

- In 88 instances, the physicians relied on the HHA to prepare the plan of care.

Currently, Medicare does not require physicians to personally examine their patients before signing certifications for home care. Thus, the failure of physicians to personally examine their patients does not render the home care unallowable. However, we believe the lack of physician involvement in the assessment of their patients' needs and homebound status was a leading cause of the unallowable services disclosed by our review. Public Law 104-191, § 232 made physicians more accountable for certifying individuals met the requirements for home health services and subjected them to civil monetary penalties.

The certification signed by the physicians clearly states the physician considered the beneficiary homebound. However, our review showed the physicians deferred to HHAs on the homebound determination.

Intermediaries' Limited Review of Home Health Claims

We found most claim documentation from providers appeared to be legitimate and could on the surface withstand medical review. However, most of the problems we found with HHA claims were detected when we interviewed beneficiaries and physicians. In our opinion, HCFA needs to develop procedures for intermediaries to contact beneficiaries to verify services were provided and to contact physicians to verify whether services were ordered.

We also found HCFA limited the claims reviewed each year by the fiscal intermediaries. For example, in 1988, HCFA required the intermediaries to review 50 percent of all HHA claims. By 1995, HCFA had reduced the intermediary's target review efforts to 3.2 percent and the minimum acceptable review level of 1 percent. In 1996, HCFA required the intermediaries to set their own goals for medical review in their budget request.

Medical reviews of claims for HHA services were not effective in curbing abuse. The HCFA, as a result of funding constraints, instructed intermediaries to reduce medical reviews and focus on aberrant providers. The intermediary medical review effort was

reduced because the reviews resulted in low denial rates and were therefore considered ineffective. However, we believe the reviews will continue to be ineffective because the focused medical reviews do not include beneficiary and physician interviews.

Beneficiaries Not Aware of HHA Services Claimed on Their Behalf

We also found at the time of our review, the intermediaries did not notify beneficiaries of the claims submitted by the providers. Thus, beneficiaries did not know what the HHAs were claiming on their behalf and did not provide feedback to the intermediaries on unnecessary home services.

For services other than home health, Part A intermediaries and Part B carriers are required to notify beneficiaries of actions taken on their behalf (MIM Sec.3718 and Medicare Carrier Manual Sec. 7000). Medicare Benefit Notices and Explanation of Medicare Benefits are sent by intermediaries and carriers to provide beneficiaries with a record of services billed to Medicare and information about coinsurance, deductibles, limits of services, and disallowed charges. The beneficiaries did not receive benefit notices for home health services because there was no Medicare requirement for deductibles, coinsurance, or lifetime limit of services.

A pilot study conducted by Aetna Florida in Fiscal Year 1995 indicated providing home health service information to beneficiaries aided in the detection and deterrence of fraudulent billing practices for home health services. As a result, HCFA instructed the RHHIs to generate a beneficiary notification system for home health services effective October 1, 1996. The beneficiary notification contains the number and type of visits claimed by the HHA during the month on behalf of the beneficiary. The notification requests the beneficiary contact the intermediary if the information is not correct.

CONCLUSIONS AND RECOMMENDATIONS

The results of this review and our previous eligibility reviews (see Appendix C) have identified systemic problems inherent in the Medicare HHA program. These problems included HHA services: (1) that were not reasonable and necessary, (2) provided to beneficiaries who were not homebound, (3) that did not have valid physician orders, (4) that were not provided, and (5) that were not documented.

The nature of the delivering of a service in a home setting makes the benefit vulnerable to fraud and abusive activity. The large increases in HHA expenditure growth has outpaced HCFA's ability to adequately fund program integrity and oversight activities. Since 1990 the Medicare expenditures for home health services have increased dramatically from about $3.3 billion to an estimated $16.9 billion for 1996. We believe implementing our recommendations below will help to address the abuses we have noted in providing for home health services. Our Office of Evaluation and Inspections will be issuing a report

shortly that further discusses changes that should be considered based on their evaluation work.

In the President's Fiscal Year 1998 proposed budget, payment reforms are proposed to help limit overutilization and bring some control to the home health benefit. The budget also presents additional reform which will lead to a prospective payment system for HHAs. Our audits indicate that actions such as those proposed by the President are needed to help curtail the overutilization and inappropriate use of HHA services.

The HCFA currently has a demonstration project underway to test an HHA prospective payment system. This system is focused on making payments based on a per episode of care. The approach involves determining the amount or volume of HHA services needed based on the diagnosis that indicated the need for skilled intermittent home based care.

We recommend HCFA:

- Consider the following alternatives in restructuring the home health reimbursement methodology: (1) a prospective payment system that is based on expenditure levels that correct for known problems; (2) placing limitations on the number of visits that could be made to a beneficiary; (3) establishing a system of pre-authorizations for home health services if a pre-established limit per beneficiary was exceeded; (4) establishing a copayment that would be required of the beneficiary for each visit or after a certain level of visits were reached in a year; and (5) a case management system.

- Emphasize the definition of homebound in the Medicare HHA Manual and include additional guidance on the standards for defining "considerable and taxing effort" and "infrequent or for periods of relatively short duration."

- Revise Medicare regulations to require the physician to examine the patient before they order home health services. Also, require the patient to see the recertifying physician at least once every 60 days. The HCFA should ensure the treating physicians establish the plan of care and specifically prescribe the type and frequency of home health services needed. An outreach program should be established to re-educate the physicians on the home health eligibility requirements so they do not have to rely on the HHA determination.

- Require intermediaries reviewing claims to continue to notify beneficiaries when HHA claims are paid on their behalf and use information provided by the beneficiaries to target abusive HHAs for focused medical review.

- Instruct intermediaries to perform focused medical reviews augmented with physicians and beneficiary interviews to verify services were provided and properly prescribed.

In its written response to our draft report, HCFA concurred with four of the five recommendations. The HCFA agreed in principle with the other recommendation, and is continuing to examine the issue. The complete text of HCFA's response is presented as Appendix D to this report.

APPENDICES

APPENDIX A
(Page 1 of 2)

SAMPLING METHODOLOGY

OBJECTIVE

To determine if HHA services were provided as claimed, and if so, to determine if the services met Medicare reimbursement guidelines.

POPULATION

We used the universe of HHA claims approved for payment by the principal RHHI servicing California, Illinois, New York and Texas (ORT States) and the alternate RHHI for the 4 ORT States during the 15 months ended March 31, 1996 as follows:

Stratum Number	RHHI	State	Number of Claims	Charges
1	UGS	NY	891,502	$1,460,645,817.81
2	HCSC	IL	657,358	699,730,817.78
3	IASD Hlth Srvc	all	531,110	873,453,368.12
4	Palmetto	TX	1,631,195	2,120,026,308.57
5	BC-California	CA	1,076,746	1,555,141,147.16
TOTAL			4,787,911	$6,708,997,459.44

SAMPLE UNIT

The sample unit was a home health claim approved for payment for a Medicare beneficiary. An approved claim includes multiple visits and items charged for the home health services provided.

SAMPLE DESIGN

A stratified random sample was used.

SAMPLE SIZE

A sample of 50 claims from each stratum. There are five strata.

APPENDIX A
(Page 2 of 2)

ESTIMATION METHODOLOGY

Using the HHS-OIG-OAS Variable Appraisal Program, we projected the overpayment for services that either were not reasonable or necessary, not to homebound beneficiaries, did not have valid physician orders, or did not have documentation.

In addition, we projected the percentage of services that did not meet Medicare requirements. This projection was made using the HHS-OIG-OAS Stratified Cluster Attribute Appraisal Program. For this appraisal each claim was considered to be a cluster of services.

APPENDIX B

PROJECTIONS

RESULTS OF SAMPLE:

The results of our review are as follows:

Stratum Number	Number of Claims	Sample Size	Value of Sample	Number of Errors	Value of Errors	Number of Services	Services in Error
1	891,502	50	$60,910.33	28	$16,664.20	702	202
2	657,358	50	59,336.44	36	46,905.93	598	478
3	531,110	50	103,697.31	26	32,417.41	1,044	356
4	1,631,195	50	59,325.35	28	22,275.51	610	243
5	1,076,746	50	90,873.76	28	27,867.79	791	260
Total:	4,787,911	250	$374,143.19	146	$146,130.84	3,745	1,539

VARIABLES PROJECTIONS:

Errors Identified in the Sample	146
Value of Errors Identified in the Sample	$146,131
Point Estimate	$2,584,991,971
At the 90% Confidence Level:	
Lower Limit	$2,119,449,933
Upper Limit	$3,050,534,009

ATTRIBUTES PROJECTIONS:

Services in Sample	3,745
Number of Services in Error	1,539
Point Estimate	39.56%
At the 90% Confidence Level:	
Lower Limit	37.31%
Upper Limit	41.82%

APPENDIX C

HHA ELIGIBILITY REVIEWS
ERROR RATES ON REPORTS ISSUED TO DATE

HHA	Claims Reviewed	Claims In Error	Services In Error
Florida - A	100	40%	41%
Florida - B	100	32%	22%
Florida - C	100	24%	24%
Florida - D	100	32%	20%
Florida - E	100	44%	23%

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

DATE: JUN 27 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Operation Restore Trust Report: "Review of Medicare Home Health Services in California, Illinois, New York and Texas," (A-04-96-02121)

We reviewed the above-referenced report concerning whether Medicare payments to home health agencies (HHAs) met Medicare reimbursement requirements.

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

Attachment

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG)
Draft Report: "Results of the Operation Restore Trust
Audit of Medicare Home Health Services in
California, Illinois, New York, and Texas"
(A-04-96-02121)

OIG Recommendation #1
HCFA should consider the following alternatives in restructuring the home health reimbursement methodology: (1) a prospective payment system that is based on expenditure levels that correct for known problems; (2) placing limitations on the number of visits that could be made to a beneficiary; (3) establishing a system of pre-authorizations for home health services if a pre-established limit per beneficiary was exceeded; (4) establishing a copayment that would be required of the beneficiary for each visit or after a certain level of visits were reached in a year; and (5) a case management system.

HCFA Response
We concur. We agree the Medicare home health benefit is in need of some structural payment reforms. The Administration, in its fiscal year (FY) 1998 budget, proposed a number of home health payment reforms designed to achieve needed cost control, improve financial management, and control fraud and abuse. These reforms include the following:

(1) Prospective Payment System (PPS): The President's 1998 budget proposal would constrain growth in expenditures through an interim home health payment method until a fully prospective payment system is in place October 1, 1999. The interim home health payment method would establish an agency-specific annual dollar cap per beneficiary. Payment for services would be the lesser of actual costs, the revised per-visit cost limits, or the agency-specific per beneficiary annual cap. We are prepared to begin implementation of this system upon receipt of the necessary statutory authority.

The Administration is committed to implementing PPS for home health in 1999. The payment amounts would be case-mix adjusted. Currently, HCFA is conducting research to develop a case-mix adjuster to explain significant variation in costs per case. This would save billions of dollars and reduce incentives for overutilization.

(2) Placing limitations on the number of visits: Since visits are covered for eligible beneficiaries for as long as the visits are medically reasonable and necessary, limitations on the number of visits would require a statutory change. The interim home health payment method, an agency-specific per beneficiary cap, would provide an incentive to

control visits. Additionally, the President's budget proposal includes a provision that would allow the Secretary to apply a normative number of visits for specific conditions or situations. For example, HCFA could establish a normative number of aide visits for a particular condition, and deny payment for those visits that exceed this standard. Allowing the Secretary to establish more objective criteria will help HCFA gain further control over excessive utilization.

(3) Establishing pre-authorizations: This would require a change in the law.

(4) Establishing a copayment: HCFA is concerned about the impact that higher per beneficiary out-of-pocket expenses would have on poorer Medicare beneficiaries. Poorer beneficiaries spend a greater proportion of their income in out-of-pocket costs. Our proposed interim home health payment method should adequately curb growth in service use.

(5) Case Management System: While we would not oppose requiring case management of home health agency (HHA) services, this recommendation would require a change in the law. We recommend this approach be considered as part of PPS reform. There are many issues that would need to be addressed to design and implement such a system. One issue would be the cost of the system.

OIG Recommendation #2
Emphasize the definition of home bound in the Medicare HHA Manual and include additional guidance on the standards for defining "considerable and taxing effort" and "infrequent or for periods of relatively short duration."

HCFA Response
We concur. The FY 1998 budget proposal redefines the "homebound" definition by adding several calendar month benchmarks to emphasize that home health coverage is only available to those who are truly unable to leave the home.

OIG Recommendation #3
Revise Medicare regulations to require the physician to examine the patient before ordering home health services. Also, require the patient to see the recertifying physician at least once every 60 days. HCFA should ensure the treating physicians establish the plan of care and specifically prescribe the type and frequency of home health services needed. An outreach program should be established to re-educate the physicians on the home health eligibility requirements so they do not have to rely on the HHA determination.

Page 3

HCFA Response
We agree in principle that physicians should only certify home health care on the basis of personal knowledge of the patient's condition and also that recertifications should only be made when that knowledge is updated. At this time, we do not support the imposition of specific service requirements or time frames, but we are continuing to examine both coverage rules and conditions of participation in order to develop the discipline necessary to ensure proper certifications. We recommended language parallel to the Health Insurance Portability and Accountability Act of 1996 requirements that OIG cited be enacted for other benefits.

OIG Recommendation #4
HCFA should require intermediaries reviewing claims to continue to notify beneficiaries when HHA claims are paid on their behalf and use information provided by the beneficiaries to target abusive HHAs for focused medical review.

HCFA Response
We concur. HCFA conducted a four state pilot test of the Notice of Utilization (NOU) for home health services in March 1995. The NOU provides Medicare beneficiaries with information concerning home health services billed to Medicare by their HHAs. We initiated national implementation of the NOU in October 1996. As a result of the pilot, regional home health intermediaries are already using this process to identify providers that should be targeted for focused medical review.

OIG Recommendation #5
HCFA should instruct intermediaries to perform focused medical reviews augmented with physician and beneficiary interviews to verify services were provided and properly prescribed.

HCFA Response
We concur. HCFA instructs fiscal intermediaries to confirm pertinent information during the focused medical review process. This could include physician and beneficiary interviews. In fact, we believe the implementation of the NOU process for Medicare beneficiaries is an initial step in seeking beneficiary input in verifying services. We are currently considering options for national distribution of NOUs to physicians who prescribe home health services. This process will strengthen our efforts to validate services and ensure they are properly prescribed by the HHA.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HOME HEALTH: PROBLEM PROVIDERS AND THEIR IMPACT ON MEDICARE

JUNE GIBBS BROWN
Inspector General

JULY 1997
OEI-09-96-00110

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them. This statutory mission is carried out through a nationwide program of audits, investigations, inspections, sanctions, and fraud alerts. The Inspector General informs the Secretary of program and management problems and recommends legislative, regulatory, and operational approaches to correct them.

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To obtain a copy of this report, call the San Francisco Regional Office at 415-437-7900.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HOME HEALTH: PROBLEM PROVIDERS AND THEIR IMPACT ON MEDICARE

JUNE GIBBS BROWN
Inspector General

JULY 1997
OEI-09-96-00110

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

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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.

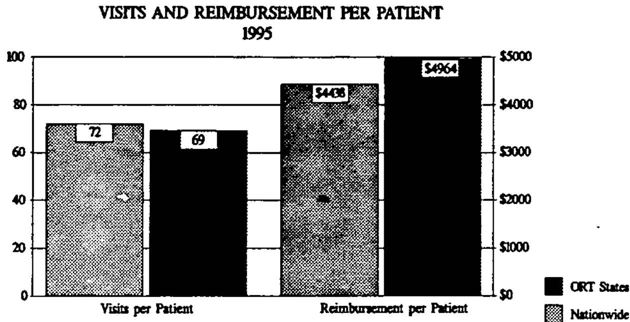
HHAs in ORT States mirror the nation

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.

VISITS AND REIMBURSEMENT PER PATIENT
1995



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 nome 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.

Undisclosed Related Organizations: 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.

Ghost Employees: 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.

Nonpatient-related Expenses: 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.

Discrepancies in Visit Counts: 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

State	Total Claims	Total Reimbursement	Total Patients	Total Visits	Average Reimbursement per Patient	Average Visits per Patient
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
TX	2,017,336	$1,762,784,352	245,223	28,492,559	$7,188	116
PA	921,427	$697,116,831	223,913	10,108,911	$3,113	45
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
OH	642,806	$466,023,099	145,721	7,770,724	$3,198	53
MI	478,751	$467,980,050	126,675	6,268,031	$3,694	49
MA	743,379	$565,869,870	120,494	11,237,546	$4,696	93
TN	741,475	$747,043,282	110,771	13,157,404	$6,744	119
NC	468,223	$330,028,822	99,146	5,534,482	$3,329	56
NJ	369,893	$293,786,448	98,482	4,188,451	$2,983	43
GA	588,527	$525,999,053	95,980	10,209,736	$5,480	106
MO	438,561	$318,538,153	94,108	4,946,663	$3,385	53
LA	897,294	$656,604,845	84,095	12,064,526	$7,808	143
AL	549,376	$453,834,415	81,565	9,766,686	$5,564	120
VA	318,982	$245,974,060	72,829	3,758,603	$3,377	52
IN	372,097	$312,954,991	71,141	5,592,118	$4,399	79
OK	495,363	$450,743,746	60,483	7,796,641	$7,452	129
KY	334,927	$211,726,968	59,623	3,977,675	$3,551	67
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

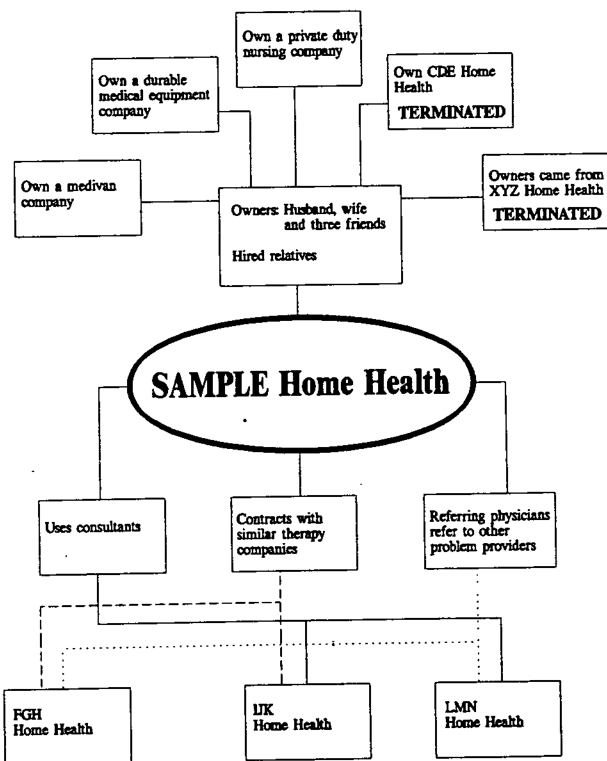
State	Total Claims	Total Reimbursement	Total Patients	Total Visits	Average Reimbursement per Patient	Average Visits per Patient
LA	897,294	$656,604,845	84,095	12,064,526	$7,808	143
OK	495,363	$450,743,746	60,483	7,796,641	$7,452	129
TX	2,017,336	$1,762,784,352	245,223	28,492,559	$7,188	116
TN	741,475	$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
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
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.

OIG Recommendation

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.

HCFA Response

We concur. We support this recommendation.

OIG Recommendation

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.

HCFA Response

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.

OIG Recommendation

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 [signature] 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.

Page 2 - June Gibbs Brown

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

MEMORANDUM TO: The Inspector General
Attention: June Gibbs Brown

FROM : John J. Callahan
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

The CHAIRMAN. Thank you.
Ms. Aronovitz.

STATEMENT OF LESLIE G. ARONOVITZ, ASSOCIATE DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, CHICAGO, IL

Ms. ARONOVITZ. Mr. Chairman and members of the committee, I am pleased to be here today as the committee examines fraud and abuse associated with Medicare's home health benefit, one of the fastest growing components of the Medicare Program, as you have heard.

We believe the foundation for protecting this benefit rests on controlling which home health agencies are allowed to bill Medicare and assuring that those agencies provide quality services for each Medicare dollar they receive. Only home health agencies that are surveyed and certified as meeting Medicare's conditions of participation and associated standards may be paid by Medicare for their services.

As a result of changes in Medicare law, regulations, and policy in the 1980's, more people are receiving home health services for longer periods of time. In turn, this has led to rapid growth in the number of home health agencies and those that are certified. I am not going to repeat some of the statistics that you have heard, but it is very striking to see the growth in this program since 1989.

Today, I will discuss the preliminary results of our ongoing review of Medicare's survey and certification process for home health agencies. Our final report to the committee this fall will address our results in greater detail.

We are finding that Medicare's survey and certification process imposes few requirements on home health agencies seeking to serve Medicare patients and bill the program. The certification of a home health agency as a Medicare provider is based on an initial survey so early in the agency's operations that there is little assurance that it is providing or even capable of providing quality care. Practically anyone who can meet State or local requirements to start a home health agency can virtually be assured of Medicare certification.

The Medicare statute does not require home health agency owners to have prior health care experience. For example, we found one owner whose most recent work experience was driving a taxicab and another who owned and operated a pawnshop in addition to his home health agency. There are also no capitalization requirements and a criminal background is not always a deterrent to certification.

We found other weaknesses in the certification process, as well. First, although there are 12 conditions of participation that home health agencies are supposed to meet, only six in whole or in part are actually reviewed. Let me focus on this chart. This lists all 12 conditions of participation. They include standards which are absolutely critical to assuring the quality of care for Medicare beneficiaries. However, only the conditions that are highlighted in green are reviewed. In addition to that, there is one standard on coordi-

nation of patient services that is reviewed and it is part of one of the conditions, condition No. 3, that is not highlighted.

So half of the conditions are actually not even looked at by the State surveyors in the initial survey. It is only if a home health agency demonstrates difficulty meeting those initial conditions that a more expanded survey would result.

In addition to that, we found that home health agencies' branch offices do not need to be independently certified and patients receiving services from staff in branch offices are rarely visited, so branch office staff can very often work independently even though they are supposed to be under the supervision and administration of their parent office.

Further, we found that home health agencies with rapid growth are more vulnerable to problems with their operations and are more likely to have difficulty meeting the conditions of participation. However, the criteria for deciding how frequently recertification should occur do not include a consideration of whether a home health agency is growing rapidly or maintaining a stable level of operations.

Moreover, once certified, there is very little likelihood of an agency being terminated from the program or in any way penalized, even when it has been repeatedly cited for not meeting Medicare's conditions of participation and providing substandard care. When surveyors find standards that are deficient, they will typically ask the home health agency to submit a corrective action plan, as I think Senator Breaux or Senator Wyden mentioned, but we found that surveyors often do not revisit the agency to verify that the home health agency implemented the plan and actually corrected the deficiencies.

For example, we found that last year in Illinois, surveyors did not revisit 13 of 21 home health agencies that had submitted plans to correct their deficiencies with Medicare standards. Home health agencies often continued to repeat deficiencies or correct them only to become deficient again and still maintain their certification. There are no intermediate sanctions short of termination and termination is considered a very drastic measure in the Medicare Program.

In conclusion, most home health agencies provide valuable services that enable a growing number of beneficiaries to continue living at home. I think it is really important that we say that because we are not in any way trying to do something to make home health care inaccessible to people who really need it or to reimburse agencies who are deserving and care about beneficiaries.

The certification, in effect, is Medicare's seal of approval on the services provided by a home health agency. However, we believe that the survey and certification process currently fails to provide beneficiaries with reasonable assurance that their HHA meets Medicare conditions of participation and provides quality care.

This concludes my prepared statement and I will be glad to answer questions.

[The prepared statement of Ms. Aronovitz follows:]

United States General Accounting Office

GAO

Testimony

Before the Special Committee on Aging, U.S.Senate

For Release on Delivery
Expected at 2:00 p.m.
Monday, July 28, 1997

MEDICARE HOME HEALTH AGENCIES

Certification Process Is Ineffective in Excluding Problem Agencies

Statement of Leslie G. Aronovitz, Associate Director
Health Financing and Systems Issues
Health, Education, and Human Services Division

GAO/T-HEHS-97-180

Mr. Chairman and Members of the Committee:

I am pleased to be here today as the Committee examines fraud and abuse associated with one of the fastest growing components of the Medicare program–the home health benefit. We believe the foundation for protecting this benefit rests on controlling which home health agencies (HHA) are allowed to bill Medicare and ensuring that they provide quality services for each Medicare dollar they receive.

Only HHAs that are surveyed and certified as meeting Medicare's conditions of participation and associated standards may be paid by Medicare for their services. As a result of changes in Medicare law, regulations, and policy in the 1980s, more people are receiving home health services for longer periods of time. This has led to rapid growth in the number of certified HHAs–from 5,700 in 1989 to almost 10,000 at the beginning of 1997. In some states, the number of HHAs has more than doubled. During this same period, Medicare payments for home health care jumped from $2.7 billion to about $18 billion and are estimated to reach $21.9 billion in fiscal year 1998.

Because of this Committee's concerns about whether the rapid growth of HHAs in the Medicare program has been effectively managed, you and Senator Breaux asked us to determine how Medicare (1) controls the entry of HHAs into the Medicare program and (2) ensures that HHAs in the program comply with Medicare's conditions of participation and associated standards. Today, I will discuss the preliminary results of our ongoing review of Medicare's survey and certification process for HHAs. In conducting our review, we obtained information from the Health Care Financing Administration's (HCFA) central office and regional offices in California, Illinois, Massachusetts, and Texas; state survey agencies in California, Maine, Massachusetts, and Texas; the offices of Medicare claims processing contractors, known as regional home health intermediaries, located in California, Iowa, Maine, and South Carolina; the Department of Health and Human Services' (HHS) Office of the Inspector General; and several industry groups. Our final report to the Committee this fall will address in greater detail the issues I am about to discuss.

In summary, we are finding that Medicare's survey and certification process imposes few requirements on HHAs seeking to serve Medicare patients and bill the Medicare program. The certification of an HHA as a Medicare provider is based on an initial survey that takes place so soon after the agency begins operating that there is little assurance that the HHA is providing or is capable of providing quality care. Moreover, once certified, HHAs are unlikely to be terminated from the program or otherwise penalized, even when they have been repeatedly cited for not meeting Medicare's conditions of participation and for providing substandard care.

BACKGROUND

HHS is charged with ensuring that HHAs meet conditions of participation in the Medicare program that are adequate to protect the health and safety of beneficiaries. As shown in table 1, Medicare has 12 conditions of participation covering such areas as patient rights; acceptance of patients, plans of care, and medical supervision; and skilled nursing services. Most conditions, in turn, comprise more detailed standards; for example, the skilled nursing condition has two standards--one addresses the duties of registered nurses and the other the duties of licensed practical nurses. The conditions and standards are further clarified in interpretive guidelines, which explain relevant statutes and regulations.

Table 1: Medicare's Conditions of Participation and Associated Standards for HHAs

Conditions of participation	Standards
Patient rights[a]	–Notice of rights –Exercise of rights and respect for property and person –Right to be informed and to participate in planning care and treatment –Confidentiality of medical records –Patient liability for payment –Home health hotline
Compliance with federal, state, and local laws; disclosure and ownership information; and accepted professional standards and principles[a]	– Compliance with federal, state, and local laws and regulations – Disclosure of ownership and management information – Compliance with accepted professional standards and principles
Organization, services, and administration	– Services furnished – Governing body – Administrator – Supervising physician or registered nurse – Personnel policies – Personnel under hourly or per-visit contracts – Coordination of patient services[a] — Services under arrangements – Institutional planning – Laboratory services
Group of professional personnel	– Advisory and evaluation function
Acceptance of patients, plan of care, and medical supervision[a]	– Plan of care – Periodic review of plan of care – Conformance with physician orders
Skilled nursing services	– Duties of the registered nurse – Duties of the licensed practical nurse

Therapy services	– Supervision of physical therapy assistant and occupational therapy assistant – Supervision of speech therapy services
Medical social services	
Home health aide services[a]	– Home health aide training – Competency evaluation and in-service training – Assignment and duties of the home health aide – Supervision – Personal care attendant: evaluation requirements
Qualifying to furnish outpatient physical therapy or speech pathology services	
Clinical records	– Retention of records – Protection of records
Evaluation of the agency's program	– Policy and administrative review – Clinical record review

[a]Conditions and standards reviewed during a standard survey.

Source: 42 C.F.R. 484.

Medicare–as authorized by title XVIII of the Social Security Act–can reimburse only those HHAs that have been surveyed and certified as being in compliance with its conditions of participation. This survey and certification process is administered by HCFA through state survey agencies–usually components of the state health departments. HCFA funds these survey agencies to assess HHAs against Medicare's conditions of participation and associated standards. Surveys are conducted on-site at the HHA and involve activities such as clinical records review and home visits with patients. HCFA's State Operations Manual provides guidance to state surveyors on conducting their surveys.

Once an HHA passes its initial survey and meets certain other requirements, HCFA certifies it as a Medicare provider and issues a provider number, which the agency uses to bill Medicare. To retain its certification, an HHA must remain in compliance with all of the conditions of participation. Each HHA is supposed to be recertified every 12 to 36 months following the same process used in the initial survey process, with the frequency depending upon factors such as whether ownership changed and the results of prior surveys. But complaints about HHA services may trigger an earlier survey. HHAs can lose their certification and be terminated from the program if they do not comply with one or more conditions; for example, an HHA providing substandard skilled nursing care that threatens patient health and safety can be terminated. However, HHAs not complying with a condition of participation can avoid termination by implementing corrective actions.

HHAs EASILY OBTAIN MEDICARE CERTIFICATION

Practically anyone who meets state or local requirements to start an HHA can be virtually assured of Medicare certification. It is rare that any new HHA is found not to meet Medicare's three fundamental certification requirements: (1) being financially solvent; (2) complying with title VI of the Civil Rights Act of 1964, which prohibits discrimination; and (3) meeting Medicare's conditions of participation. HHAs self-certify their solvency, agree to comply with the act, and undergo a very limited initial certification survey that few fail. Currently, HCFA certifies about 100 new HHAs each month.

Once an HHA meets state and local laws, regulations, and licensing requirements, Medicare imposes few additional restrictions to becoming certified. Title XVIII of the Social Security Act does not require HHA owners to have prior health care experience. For example, we found one owner whose most recent work experience was driving a taxi cab and another who owned and operated a pawn shop in addition to his HHA. Finally, there are no capitalization requirements, and a criminal background is not a deterrent to agency certification unless that criminal activity specifically prohibits the individual from Medicare participation.

Each certified HHA must provide skilled nursing services and one other covered service–physical, speech, or occupational therapy; medical social services; or home health aide services. HHAs can offer all of these services if they choose to do so. Only one of an HHA's services must be delivered exclusively by its staff; any additional covered services the HHA offers can be provided either directly or under contract with another health care organization that does not have to be Medicare certified.

During the initial certification process, surveyors conduct what is called a standard survey; this survey is required by statute to assess the quality of care and scope of services the HHA provides as measured by indicators of medical, nursing, and rehabilitative care. The standard survey addresses an HHA's compliance with 5 of the 12 conditions of participation plus one of the standards associated with a sixth condition that HCFA believes best evaluate patient care (see table 1). If surveyors identify substandard care during the standard survey, they are to conduct a more in-depth review of the HHA's compliance with the other conditions of participation.

These initial surveys often take place so soon after an HHA begins operating that surveyors have little information with which to judge the quality of care an HHA provides or the HHA's potential for providing such care. We found that initial surveys frequently are made when HHAs have served as few as one patient for less than 1 month and have not yet provided all the services for which they are to be certified. The surveyor may never see any patients or otherwise assess the care the HHA is providing, even though visiting patients is recognized by HCFA and state surveyors as the best way to evaluate an HHA's care. Furthermore, the HHA's are typically caring for non-Medicare beneficiaries

at the time of their initial survey; these patients may have medical conditions that differ from those of Medicare beneficiaries needing home health care.

The fact that the law allows this ease of entry into Medicare has probably contributed to the rapid growth in the number of Medicare-certified HHAs; it has also allowed some questionable agencies to participate in the program. For example:

- An individual with no experience in health care started her Texas HHA in the pantry of her husband's restaurant. Within 4 months of the HHA's certification, state surveyors started receiving complaints that the HHA had been (1) enrolling patients who were either ineligible for the Medicare home health benefit or who had been referred for care without a physician's orders and (2) hiring home health aides on the condition that they first recruit a patient. Approximately 10 months following initial certification, state surveyors substantiated the complaints and also found that the HHA was not complying with four conditions and multiple standards, including four standards that the HHA had been cited for violating during its initial survey. The surveyors also identified 13 cases in which they suspected the HHA provided unnecessary services or served ineligible beneficiaries; the surveyors referred these cases to the Medicare claims processing contractor. One month later, the surveyors conducted a follow-up survey and found that the agency had implemented corrective actions, as it had following its initial survey. No further surveys had been conducted at the time of our review.

- Another individual with no home health care experience started a California HHA, which was Medicare certified in 1992. Within 1 year of certification, state surveyors and the Medicare claims processing contractor received numerous complaints alleging that the HHA had served patients ineligible for the Medicare benefit, falsified medical records, falsified the credentials of the director of nursing, and used staff inappropriately. A recertification survey about 15 months after initial certification found that the HHA was not complying with multiple conditions of participation and had endangered patient health and safety. By September 1993, after Medicare had paid the HHA over $6 million, the HHA closed. The owner, a former drug felon, and an associate later pled guilty to defrauding Medicare of over $2.5 million.

HCFA regional office and state survey officials have acknowledged that the initial certification survey provides little assurance that an HHA can and will provide quality care. They believe that newly certified HHAs should be resurveyed after they are fully operational and that, at that time, they should also be assessed for compliance with all of Medicare's conditions of participation for all of the services the HHA provides. HCFA central office officials told us that, while they have the statutory authority to assess new HHAs against all of the conditions of participation at any time and it would be desirable to resurvey an agency several months after initial certification, this would require additional funding for state survey agencies–funding that they said is not available. Another alternative, also within HCFA's statutory authority, is to require that HHAs

seeking Medicare certification have treated a minimum number of patients. Several HCFA regional offices now suggest that an HHA should have cared for at least 10 patients at the time of its initial survey. However, HCFA central office officials said that this would not be a reasonable requirement for all HHAs seeking certification. In some rural states, 10 patients may represent an entire year's patient workload. Setting a 10-patient minimum on a national basis could therefore result in denying beneficiaries access to home health care services if they live in sparsely populated areas of the county, according to the HCFA officials.

MEDICARE'S RECERTIFICATION PROCESS CONTAINS SERIOUS WEAKNESSES

Medicare's recertification process does not ensure that only those HHAs that provide quality care in accordance with Medicare's conditions of participation remain certified. The primary problems are that (1) HHAs do not have to periodically demonstrate compliance with all of Medicare's conditions of participation; (2) surveyors do not fully review an HHA's branch office operations; (3) rapidly growing HHAs do not receive more frequent surveys, even though rapid growth has been linked to difficulties in complying with Medicare's conditions; and (4) HHAs repeatedly cited for serious deficiencies identified during a standard survey are rarely terminated or otherwise penalized.

HHAs Are Not Assessed Against All Conditions of Participation

HCFA initially certifies and then recertifies most HHAs without requiring them to ever demonstrate compliance with all the conditions of participation. Instead, HCFA asks the surveyors to initially limit their evaluation of HHAs to the standard survey and then expand the survey to the other conditions only if they find problems. As a result, HCFA and Medicare patients usually do not know whether an HHA is complying with conditions not included in the standard survey.

A recent Operation Restore Trust (ORT) project in California targeted 44 HHAs that provided unusually high numbers of services to their patients and received high levels of Medicare payments compared with their peers.[1] HCFA and state surveyors evaluated these HHAs against 11 of the 12 conditions of participation, rather than initially limiting their evaluation to the 5 conditions and 1 standard reviewed during a standard survey.[2]

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[1]ORT initially was a 2-year, multiagency effort in five states that targeted fraud and abuse by three types of Medicare providers: HHAs, skilled nursing facilities, and durable medical equipment suppliers. In May 1997, the Secretary of HHS announced that ORT would continue for another 2 years and include projects in 12 additional states.

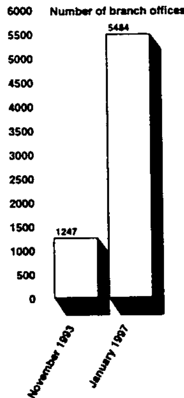
[2]This project did not cover HHA compliance with the condition regarding qualifications to furnish outpatient physical therapy or speech pathology services because none of the

HCFA and state surveyors identified a significant number of HHAs that were noncompliant with conditions typically excluded from review–conditions that address the HHA's operations and the care it provides to Medicare beneficiaries. Nearly three-quarters of the HHAs failed to comply with at least one of the conditions not covered in the standard survey, and 21 of the 44 HHAs either voluntarily withdrew their certification or had their certification terminated by HCFA. Although this project targeted HHAs suspected of problems, it does demonstrate that criteria other than those used in the limited standard survey may be better predictors of compliance with all the conditions of participation.

Branch Offices of HHAs Are Frequently Not Evaluated

HCFA defines a branch office of an HHA as a unit within the geographic area served by the parent office that shares administration, supervision, and services with the parent office. Since the mid-1980s, many HHAs have created branch offices. As shown in figure 1, about 2,200 HHAs operated nearly 5,500 branch offices in January 1997–over four times the number in November 1993. In Texas, for example, we identified 106 HHAs with 3 or more branches, and 1 HHA had 25 branch offices.

Figure 1: Growth in the Number of HHA Branch Offices



Source: HCFA's On-line Survey Certification and Retrieval System.

HHAs provided such services on an outpatient basis at their parent or branch offices.

Since they are considered to be an integral part of an HHA, branches are not required to independently meet the conditions of participation. Further, HCFA does not require surveyors to visit patients served by each branch office. Since new branch offices do not undergo an initial certification survey, HCFA cannot be assured that they meet Medicare's definition of a branch office. And, most importantly, not directly surveying branch operations means that quality of care issues within an HHA's overall operations may be missed. When branches have been surveyed because the HHA wanted to convert them to parent offices, significant problems have been found. Several examples follow:

- In California, surveyers found that one branch of an HHA cared for 581 patients over the 12 months ending September 1996–more than the average number of patients cared for by an HHA in the state during that time. Moreover, the branch was not complying with one condition of participation and the surveyers recommended denial of the HHA's initial certification. Among its problems was that the branch had no system in place to ensure that its contractor staff had the appropriate qualifications and licenses.

- Similarly, a branch office of a Massachusetts HHA had cared for 69 patients since the HHA's last survey. The branch was denied initial certification as a parent office because it failed to meet nine standards associated with several conditions of participation. For example, the surveyors found that the branch office, in 10 of 12 cases examined, did not follow the plan of care and provide services as frequently as ordered by a physician. At the time of our review, the HHA had not yet submitted its correction plan and had not been certified as a parent office.

While HCFA's guidance allows surveyors to conduct the entire recertification survey of an HHA at a branch office, state surveyors told us that this is seldom, if ever, done. Branch offices typically do not maintain all the personnel files or clinical information that surveyors need in their evaluation. As a practical matter, surveyors told us that they may not have time to conduct home visits with branch office patients and still finish the survey within their allotted time and resources.

No Thresholds Exist to Trigger More Frequent Surveys of Rapidly Growing Agencies

Increasing workload may necessitate changes in an HHA's operations; this, in turn, can affect its compliance with Medicare's participation requirements. While HCFA's criteria for setting survey frequency include many factors, they do not include consideration of whether an HHA is growing rapidly or maintaining a stable level of operations–information state surveyors generally would not have before conducting their survey.

New HHAs have the potential for rapid growth and, as a result, are more likely to have difficulties complying with Medicare's conditions of participation. As shown in table

2, we found that nearly one-fourth of the HHAs initially certified in 1993 in California and Texas received Medicare payments exceeding $1 million in 1994--their first full year of Medicare certification--and the average number of patients they treated in a year at least tripled between 1993 and 1995. For example, in 1993, one California HHA treated 11 patients and received $33,000 from Medicare; in 1995, the HHA treated 1,810 patients and received $12.7 million in Medicare payments. Also, the percentage of these rapidly growing HHAs cited for noncompliance with the conditions of participation exceeded the national norm. Nationwide, about 3 percent of all HHAs each year are cited for failing to meet Medicare's conditions of participation. In contrast, 40 percent of the high-growth HHAs in California and 11 percent of the high-growth Texas HHAs did not meet the conditions in their most recent surveys.

Table 2: Characteristics of High-Growth HHAs in California and Texas That Were Initially Certified in 1993

	California	Texas
Number of HHAs initially certified in 1993	116	174
Number of these HHAs that received more than $1 million in Medicare payments in 1994	30	44
Average Medicare payments to these HHAs in 1995	$2.9 million	$3 million
Change in average number of patients treated between 1993 and 1995 by these HHAs	Quadrupled	Tripled
Percentage of these HHAs that did not meet conditions of participation in latest survey	40	11

HCFA issued its survey frequency criteria in May 1996, after legislation authorized it to increase the maximum interval between surveys from 15 months to 3 years. As previously noted, HCFA's criteria consider factors such as an HHA's prior survey results, changes in ownership, and complaints. By not considering an HHA's rate of growth when setting survey frequency, however, HCFA is missing an opportunity to more quickly identify and correct compliance deficiencies. Such information is available from Medicare contractors and HCFA.

Few HHAs Are Involuntarily Terminated

Once certified as a Medicare provider, an HHA is virtually assured of remaining in the program even if repeatedly found to be violating Medicare's conditions of participation and associated standards. There are no penalties short of termination because HCFA has not developed intermediate sanctions as it was authorized by the Congress to do a decade ago. HCFA officials told us that they wanted experience with the skilled nursing facility intermediate sanctions, which became effective in July 1995, before implementing intermediate sanctions against HHAs.

Until the advent of ORT, the likelihood of an HHA's being terminated from the Medicare program was remote. In fiscal years 1994, 1995, and 1996, about 3 percent of all certified HHAs were terminated, and most of these were voluntary terminations arising from either mergers or closures. Only about 0.1 percent of all certified HHAs in fiscal years 1994 and 1995 and 0.3 percent in fiscal year 1996 were involuntarily terminated as a result of noncompliance with the conditions of participation. California accounted for almost half of the 32 involuntary terminations nationwide in 1996, with 8 of its 15 involuntary terminations that year stemming from the ORT project.

To terminate an HHA, the surveyors must find that it did not comply with one or more conditions and remained out of compliance 90 days after a survey first identified the noncompliance.[3] If an HHA threatened with termination takes corrective action and state surveyors verify through site visits that this action has brought the HHA back into compliance, HCFA will cancel the termination process.

Under Medicare's termination procedures, HHAs remain in the program, to the potential detriment of beneficiaries, even if they repeatedly fail to comply with Medicare's conditions of participation.

- In California, for example, an HHA's second recertification survey revealed that the HHA was deficient in meeting five standards, three of which had been identified in the previous year's survey and supposedly corrected. Several months later, at this same HHA, an ORT survey team found eight conditions and numerous standards not met. When this HHA was resurveyed 5 months later, the surveyors found that it was back in compliance with all conditions but that it had yet to meet seven standards. Most of these deficiencies in meeting standards had been cited in the preceding surveys, and some had existed for a long time. For example, for the three most recent surveys, this HHA had been cited for not following physicians' orders in the written plan of care. The HHA remains certified despite its repeated problems.

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[3]If the deficiency jeopardizes patient health and safety and is considered immediate and serious, HCFA places the HHA on an accelerated termination timetable.

- Moreover, on a Texas HHA's first recertification survey, 1 year after initial certification, the state surveyor found four standards not met and referred several cases of possible fraud to the Medicare contractor. Within 10 months of that survey, state surveyors resurveyed the HHA and found it was not in compliance with seven conditions of participation, and the previously cited deficiencies in meeting standards had not been corrected. HCFA issued a termination letter, but within 2 months of the last survey the HHA had corrected the deficiencies, and the termination process was halted. On a complaint investigation 6 months after the deficiencies had been corrected, the surveyors found the HHA was again out of compliance with three of the same seven conditions. On this most recent survey, the surveyors attributed the death of one patient directly to this HHA. At the time her attorney advised her to surrender her state license and Medicare certification, the owner/operator of this HHA had already hired a nurse consultant to bring the HHA back into compliance.

HHAs are not threatened with termination if they are complying with the conditions of participation but are violating one or more standards and subsequently submit a corrective action plan. But surveyors often do not revisit the HHA to verify that it has implemented the plan and actually corrected the deficiencies. For example, Illinois surveyors did not revisit 13 of 21 HHAs that had submitted plans to correct their violations of Medicare's standards.

Because of circumstances such as those discussed above, the threat of termination has little, if any, deterrent value. The Congress, recognizing that HCFA should have more enforcement options than that of terminating an HHA, enacted provisions in the Omnibus Budget Reconciliation Act of 1987 to address this issue. These provisions authorized the Secretary of HHS to impose intermediate sanctions for a period not to exceed 6 months on HHAs violating Medicare's conditions of participation. If the HHA continued to violate conditions after that 6-month period, it was to be terminated from the program. The act required the Secretary of HHS to develop and implement, not later than April 1, 1989, a range of intermediate sanctions that were to include civil monetary penalties for each day of noncompliance, suspension of Medicare payments to the HHA, and HCFA's appointment of a temporary manager to manage the HHA. HCFA proposed alternative sanctions for HHAs in August 1991 but never finalized its implementing regulations. Therefore, the only alternative currently available to HCFA to penalize deficient HHAs is to terminate them from the program.

CONCLUSIONS

HHAs provide valuable services that enable a growing number of beneficiaries to continue living at home. Accompanying this increase in beneficiaries have been sharply increasing Medicare payments and rapidly rising numbers of certified HHAs. HCFA's HHA survey and certification process, however, fails to provide beneficiaries with reasonable assurance that their HHA meets Medicare's conditions of participation and

provides quality care. Yet, certification represents Medicare's "seal of approval" on the services provided by an HHA.

Our ongoing work suggests that it is simply too easy to become Medicare certified. Before they are certified, HHAs do not have to demonstrate a sustained capability to provide quality care to a minimum number of patients for all types of services. And because the requirements are minimal, HCFA certifies nearly all HHAs seeking certification. While many HHAs are drawn to the program with the intent of providing quality care, some are attracted by the relative ease with which they can become certified and participate in this lucrative, growing industry. HHAs can remain in the program with little fear of losing their certification. Most will never have to demonstrate compliance with all of the participation conditions, and, even if they are found out of compliance, temporary corrective actions are sufficient to allow them to continue to operate.

These problems suggest that HCFA needs to pay closer attention to how it surveys and certifies HHAs. We expect that our upcoming report will contain specific recommendations on how HCFA can strengthen the survey and certification process so that it provides greater assurance that only those HHAs that provide quality care in accordance with requirements participate in Medicare.

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Mr. Chairman, this concludes my prepared statement. I would be pleased to respond to any questions you or Members of the Committee may have.

(101501)

The CHAIRMAN. Thank you very much.

I think I am going to start with you, Mr. Hartwig, if I could, because you were involved in the Healthmaster case and before we get too far away from the testimony of Ms. Garrison, I think maybe you can help us understand that case from the perspective of the investigation and prosecution. Tell us a little bit about your relationship with the Healthmaster case.

Mr. HARTWIG. The Healthmaster case was investigated by a number of agencies, including the Office of Inspector General, the Federal Bureau of Investigation, and the Internal Revenue Service on the Federal side and the Georgia Attorney General's Office and the Georgia Bureau of Investigation on the State side, a very lengthy and labor-intensive investigative effort.

The CHAIRMAN. Obviously, all the information we received from her was very insightful. Also, I understand that there was some money laundering involved. She did not touch on that. Would you tell us about that?

Mr. HARTWIG. Ms. Garrison was actually convicted with two other executives of Healthmaster. One of those executives received a prison sentence in excess of 12 years. The other was sentenced to an 8-year Federal sentence.

One of the two related party transactions that I do not believe Ms. Garrison testified to related to the Workman's Compensation Program at Healthmaster and the Healthmaster's health insurance program for their own employees. On the Workman's Compensation Program, evidence showed that the defendants had interjected a sham entity, if you will.

Healthmaster self-insured their Workman's Compensation Program. They paid their Workman's Compensation claims themselves. The defendants were able, because of their control of Healthmaster, to insert a corporation between Healthmaster and its employee claimants. In doing so, they charged a commission to Healthmaster to perform services on Workman's Compensation when, indeed, the evidence at trial showed that there were no services performed.

In structuring those transactions, the defendants used a number of banks, including banks in the Grand Cayman Islands, to help not only disguise payments but also to launder the funds back to the United States, these commission services, and also to help maintain the secrecy of their transactions. I think over a 3-year period, the defendants were able to skim $1.7 million in profits from that Workman's Compensation area alone.

In addition, Healthmaster used an HMO subsidiary as its health insurer for its employees. Once again, the defendants created a company between Healthmaster and those HMOs and charged Healthmaster commissions to purportedly perform services in that health insurance program when, again, we believe no services were performed. Again, the transactions were again structured through a number of banks to help disguise the payments and the profits were again split amongst the defendants.

The only client of both those entities was Healthmaster alone, and on the health insurance end, they were able to divert about $1 million of Healthmaster funds. Of course, the Medicare Program was picking up all of those payments through the cost reports.

The CHAIRMAN. Could you give us some idea from the standpoint of cost and maybe the personnel that were involved in how long it took to bring this case against Healthmaster, all those resources that went into it, if you have got a handle on that?

Mr. HARTWIG. Resources on any health care are extensive. I think our statistics show the average health care case takes about 3 years from the time a complaint comes into the office until an individual is convicted. In the cases of both Healthmaster, which is a very complicated institutional case, Mr. Mills and ABC was brought up earlier, those cases actually take longer. I think in the ABC area, it took about 5 years. I think in this case, the investigation took over 4 years, requiring not just numerous prosecutors but also a number of auditors from the State and Federal level and numerous investigators to run down the extensive leads and to trace the extensive finances.

I might just say one other thing, and the auditors from Aetna were brought up earlier today and the witness had testified about the auditors at Aetna. The defendants were charged in the indictment with obstructing a Federal auditor and it had to do with their dealings with the Aetna auditors, obstructing a Federal audit, as well, although they were not convicted of that charge.

The CHAIRMAN. Mr. Grob, one of your charts had a figure that is very scary. About 40 percent of the total services paid for in the four States where your office had examined home health care providers, that that should not have been paid, I think was your statement. It is just for those four States. Do you have reason to believe that this is something that would be common to the other 46 States? In other words, would this just be 40 percent of those four States and that is the worst, or how would you find it in the rest of the country? Let me ask it that way.

Mr. GROB. I would say that is probably the ballpark in the rest of the country. The rules of statistics do not allow us to use that same number for a universe that we did not look at in that particular sample, but as a matter of fact, we did other audits of home health agencies and the range was between 19 and 64 percent of payments that should not have been made.

Also, what we did, as we reported in one of our reports, is we tried to examine common characteristics of home health agencies throughout the country and compare them to these. So, for example, we found that the home health agencies in the five States that we looked at in this case for the second study, in terms of the number of patients, the average reimbursement per patient, the average number of services per patient, it was pretty much as it was in the rest of the country.

Also, the conditions that underlie this error, which is the certification system, the system for certifying the eligibility of the individual patient as well as the home health agency, are pretty much the same nationwide.

The CHAIRMAN. Thank you.

Senator Breaux.

Senator BREAUX. Thank you all very much for some very good work that you all have done and some very good recommendations that you have given this committee. It is now going to be our responsibility to do something with what you are recommending, but

I would suggest that this is not rocket science. To figure out what happened and why it happened, it is not rocket science.

If you look at your own report, and just put this in there for the record, spending for home health care has grown from $2.7 billion in 1989 to $12.7 billion in 1994 and projected to go to $21 billion. No. 1, we are spending a lot more money on it.

No. 2, a lot more people have gotten into it. The number of Medicare-certified home health agencies have grown from 5,692 agencies in 1989 to 7,864 at the end of 1994. That is an 83-percent increase. The latest numbers I have is that it is going to be almost 10,000 of these home health care agencies at the beginning of this year.

So we are spending one heck of a lot more money and we have a lot more agencies, but fiscal intermediaries in 1986 were conducting medical reviews on 62 percent of the home health claims that were being processed and now, due to the budget cuts, intermediaries are now required to conduct medical reviews on a target of only 3.2 percent of all claims, including home health claims.

This is not rocket science. We are spending a lot more money. There are a lot more people involved in it. Instead of increasing in a corresponding amount the amount of audits and supervision we do, we have dropped the number of audits from 62 percent to 3.2 percent because someone in Congress said we are going to save money. Look what has happened.

I do not have anything to ask you, really, other than to express congratulations for what you do. Again, it is very clear what the problem is. One of the answers has to be, when you have that much money being spent, we have to spend a corresponding amount to determine that it is being spent honestly.

We tried to talk about copayments, to try and connect the concept to the person that medical services cost something. We had $5 in the Senate bill. It would have taken 50 cents just to let people know that as when they go to a doctor or a hospital or a home health care visit, there is a cost connected with it. I am not sure that is going to survive. I doubt it very seriously.

With that, I have no other comments other than to congratulate you for your testimony. I yield back the balance of my time.

Senator ENZI [presiding]. Thank you, Senator Breaux.

Could you tell me what percentage of the home health care services are audited at the present time?

Mr. GROB. Are monitored at the current time?

Senator ENZI. Yes.

Mr. GROB. I think the 3 percent figure is approximately correct.

Senator ENZI. Is that 3 percent of the agencies, though, or 3 percent of the bills?

Mr. GROB. I guess it would be 3 percent of the agencies, but that would translate into 3 percent of the bills, roughly speaking. They are allowed to——

Ms. ARONOVITZ. Claims.

Mr. GROB. In claims. That is right. Three percent of claims are reviewed.

Ms. ARONOVITZ. Maybe I could even add something to that. Right now, there is a target for 3.2 percent of all claims on the part A

side. That would be all institutional providers—therapy companies, hospitals, home health agencies, and the like. That is the target of claims. The percentage of claims reviewed for home health agencies is a lot lower than that, perhaps around 1 percent at this point.

Senator ENZI. So you audited Ms. Garrison's every year, but on the average, a person could only be expected to be audited once every 97 years?

Ms. ARONOVITZ. It is interesting because I am not exactly sure what Ms. Garrison was referring to. There are quite a few different types of audits and maybe we could just clarify that for you.

One type of audit would involve survey and certification of an HHA. In other words, the HHA initially gets certified and is then recertified every 1 or 2 or 3 years to demonstrate that it is complying with the conditions of participation and therefore remains in the program. Now, those audits—and they are done by State surveyors—focus very, very strongly on quality of care issues. They really do not address reimbursement, payment, or coverage issues. Those are done more by the Inspector General and the intermediaries.

I think if she was referring to cost reports that were audited, that is where she was saying that very often, if cost reports are audited and there are disallowances, then the disallowances would just be subtracted from future payments. I think what we got into in her case eventually was an audit where there was an investigation of allegations of fraudulent or intentional inappropriate billings, and that gets to be a whole different story.

Senator ENZI. In Wyoming, we have a process with our Worker's Compensation where there are nurses that are hired to review absolutely every claim that comes through. They find errors in probably—when they first started, they found them in about 40 percent. Now they are down to about 20 percent, but it still saves millions. Do we have a similar process?

Ms. ARONOVITZ. We looked on the private side at some home health care agencies that provide services for the FEHBP—the Federal Employees Health Benefits Program—and examined what their practices were. We found that they keep a much tighter control over their home health claims. Again, it is a totally different type of population. The FEHBP population usually has acute care problems where as the Medicare population is composed of beneficiaries who often have chronic illnesses; the two populations are much different. But I believe the amount of oversight that is given to home health claims in the Medicare Program is substantially less than it is in the private side or in other types of insurance claims.

Senator ENZI. Has there ever been a look at using third party auditors to supplement that 3.2 percent that get audited at the present time?

Ms. ARONOVITZ. I am not sure it has, although, again, that is expensive to do, too, so there is a cost involved. I think it is something we could look into and find out. I do not know offhand that that has been looked at.

Senator ENZI. With an incentive program, that might not cost as much.

Mr. Hartwig, you did not answer the question before of how much the investigation cost, just roughly. We got $16.5 million back. What did it cost us to find that.

Mr. HARTWIG. I think in direct costs, which would be employee time and the logistical cost, it would probably be somewhere around $700,000, which is about what the ABC investigation cost, not including some of the overhead costs with the Government. The direct cost, if you add up the agent time, the auditors' time, and then the expenses with the investigation, travel costs incurred, they generally cost around $750,000.

Senator ENZI. Thank you. So that was very cost effective, then. Perhaps we do need more auditors.

Mr. Grob, you mentioned in your testimony that there should be a development of a data bank for owners, principals, and other agencies to identify the fraudulent practitioners. That ties in with that. It is my understanding that we have a 6-year project for a Medicare transaction system that is currently $65 million in the red. Are you recommending a new system or how would it tie in with what is being done?

Mr. GROB. The system we are recommending—actually, the Health Care Financing Administration has agreed and has already taken steps to develop that system. The system we are talking about relates much more to information about ownership of the different businesses and the previous records in doing business with the Government so that you can make checks back and forth on people who are applying to enter the Medicare Program, either as home health agencies, durable medical equipment companies, nurse registries, nursing homes, things of this nature, so you can look back and forth. That would not be part of that transaction system, which was primarily related to paying bills, but hopefully would be related to it.

Senator ENZI. Thank you. I yield back the balance of my time.

The CHAIRMAN. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman.

You all have done a thorough job and it seems to me it comes down to essentially a question of who gets into the program and then who is allowed to stay in. You all have essentially found deficiencies on both ends, and let me, if I might, just ask you a couple of questions.

Ms. Aronovitz, is it my understanding that you think that it is time for a Federal law that requires that somebody who goes into the home health field have some minimal basic training in health care?

Ms. ARONOVITZ. It certainly would not hurt. We found a case where a person started a home health care agency from the pantry of her husband's restaurant and they had to move the condiments over so that they could put the HCFA manuals down to read them. It really undermines the confidence one would have in serving Medicare beneficiaries when somebody has no knowledge of health care at all. So, we think it is a good idea.

Senator WYDEN. My concern is that in some high-growth areas, people who try to rip off this program are always looking at the next high-growth area. In other high-growth areas, say the HMO risk program, you do see these kinds of requirements for minimal

basic expertise and training. So, I think it is a good recommendation and one that I and, I think, colleagues on both sides of the aisle want to follow up.

My second question is, Would it not be a useful deterrent to kick a few people out of this program for flagrant, repeated, outrageous violations? We are not talking about kicking somebody out who puts paper A in box B. Everybody understands that there are scores of those kinds of situations. But for repeated violations, I do not see why, when you all bring these charts and talk about these repeat offenders, there is such squeamishness about kicking some of these people out.

Ms. ARONOVITZ. Unfortunately, in the home health program, there are no intermediate sanctions, so the only sanction available on the part of the Government is to terminate a home health agency and the law is very specific about when you can do that. It requires that a home health agency be in noncompliance with, at least, one condition of participation, that means one of those major conditions, and they still typically have 90 days to try to put together a corrective action plan and actually fix the problem. In other words, there is a whole set of due process rules that really help a home health agency get back into compliance.

Now, again, if there is a threat against the health or safety of an individual, the home health agency only has 23 days to get back into compliance and State surveyors must make a follow up visit to confirm that corrective action was taken. But you cannot just summarily decide that you do not like the way a particular home health agency is functioning and terminate them from the program without going through these various stages.

Senator WYDEN. Are you all advocating, then, establishing these intermediate kinds of sanctions. Because it seems to me that the taxpayers and seniors are getting fleeced twice. We do not have intermediate sanctions available for the many times when such sanctions would be appropriate. On the other hand, everybody says, well, do not boot them out because you are playing Rambo and that is not appropriate, either. So it seems to me the taxpayer ends up without any real deterrent.

Ms. ARONOVITZ. In 1991, HCFA proposed but never finalized intermediate sanctions, such as requiring an outside person to come in and manage the home health agency for a specified amount of time or civil monetary penalties, not approving payment or stopping payment for new admissions or for certain particular circumstances. Those have been discussed within HCFA; HCFA is very concerned about implementing intermediate sanctions before they finish revising the HHA conditions of participation, which have been out for review and will be finalized hopefully by the end of the year. They want to revise the conditions before they look at intermediate sanctions.

Also, there are intermediate sanctions now in the skilled nursing care arena and they are interested in looking at some of the experiences using those before they would proceed with the home health care sanctions.

Senator WYDEN. There was an op-ed piece I read in last week's USA Today where HCFA said they were on the right track in root-

ing out fraud. Based on your audits, are you convinced that they are on the right track in terms of dealing with it?

Ms. ARONOVITZ. We have been saying for quite a long time that we think there is a lot that HCFA could do with will and leadership and much better oversight of contractors and the different programs. We think, even within the budgetary constraints that exist right now, that there are a lot of things that HCFA could do better and should do better.

Senator WYDEN. I think you have made your case. Let me ask you just one other question, if I might. With respect to families and the consumer and how we could empower them to better help ferret out some of this, do you have any ideas and suggestions? It seems to me the documents people get, particularly with respect to cost-based reimbursement, which in most parts of the country dominates this field, really do not give the family or the consumer much in the way of information to root out these abuses. Could more be done here?

Ms. ARONOVITZ. There is a recent requirement now for Medicare beneficiaries receiving home health services to receive a notice of utilization even though they do not pay a copayment. In other words, they will, at least, know what services are being billed on their behalf. To my understanding, that notification does not include the actual costs that are being billed on their behalf but it does indicate the number of visits.

HCFA has been looking at the benefits of sending out the notices of utilization. We certainly think it is a good thing to do, but HCFA, to be honest, has not had much experience in using that information to identify home health agencies that may be billing for too many services or committing fraud.

Mr. GROB. Senator, on this matter, I think there are some things that should be on the record in regard to your question, though, because the Congress just last year did enact into law two new provisions which go exactly in the direction that you are talking about.

One of them is a beneficiary incentive program which will provide a financial reward to beneficiaries or others who report fraud to the program that results in the prosecution of an individual who has committed it. That program is being developed for implementation right now by the Health Care Financing Administration.

Another one was that the Congress appropriated $2 million last year to the Administration on Aging to develop a demonstration program across the Nation to help the elderly and their families to understand their bills and to understand these notices that Ms. Aronovitz just alluded to. So that program is also being developed.

If I could say, we have just expanded nationwide our hotline for reporting fraud. The number is 1-800-HHS-TIPS, and anyplace you are in the country right now, you can call up and you can talk to a hotline representative who will listen to your complaint and take action on it. This went into effect nationwide just a couple weeks ago.

Senator WYDEN. You all have made a good presentation. Mr. Chairman, I would only say, and my time is up, that if HCFA feels that they are on the right track at this point with the kind of abuses that you all have found, I suspect there are a fair number

of taxpayers in this country that would be inclined to disagree with them.

The CHAIRMAN. It is a topic of discussion at every town meeting that we have about waste, fraud, and abuse in Medicare and whether or not we are really doing anything about it, even whether or not we are taking it very seriously, speaking for my State, at least.

Senator Hagel.

Senator HAGEL. Mr. Chairman, thank you, and to the panel, thank you for your testimony.

Ms. Aronovitz, I wanted to ask you in line a little bit of the questioning that Senator Wyden began and some of the other comments that were made today. Could you give this panel analysis of what you believe is the state of quality competition out there in the home health industry? Is there quality competition?

Ms. ARONOVITZ. I am sorry, quality competition?

Senator HAGEL. Yes.

Ms. ARONOVITZ. Are you asking if we think that there are——

Senator HAGEL. Is there? I come at this for a lot of reasons and a lot of different directions. One, especially from where Senator Wyden is coming around, I come at it a little differently. There seems to be some reluctance on the part of some, as he said, why do we not get tough? Why do we not terminate? I notice in your prepared statements, your quote here is, "The threat of termination has little, if any, deterrent value." So, I would like you to respond to that and go back to my first question, What do you believe is the state of quality competition in this country today in the home health care business?

Ms. ARONOVITZ. I think the reason why home health agencies are not worried about the threat of termination is that it so rarely happens that the chances of it happening in that particular case are very minimal. There is very often the opportunity to provide a corrective action plan or to talk to the State surveyors and show them your plans and timeframes for correcting standards and conditions of participation that are out of compliance. You will be able to get recertified by having come back into compliance even for a little while. You could string along the surveyors for a very long time.

So, I think that is really the reason why termination is not really a deterrent, because it hardly ever happens. As a matter of fact, I think last year, home health agencies that were involuntarily terminated were less than 1 percent in a particular year nationwide and that was based greatly on the——

Senator HAGEL. My question is, If that hardly ever happens, is it not happening because there is not enough competition, not enough quality care out there? Is that one of the reasons it is not happening?

Ms. ARONOVITZ. No. I think that in some ways, there is not enough oversight. There is not enough will in some cases to go after people and hold them to the line. I think the surveyors are under a lot of pressure to do a lot of surveys and recertifications and they do not have the ability to go in and do a thorough look at a home health agency to assure that the quality is there.

Senator HAGEL. How do we fix that?

Ms. ARONOVITZ. Well, one way is to try to be much more careful about who you target in terms of doing an indepth recertification survey. Also, a home health agency could currently get certified to start billing Medicare if they are serving one patient and providing only two services. You do not have to be in business for a certain amount of time. There is no history of an operational performance you have to meet. There are no national standards other than that the HHA be treating at least one patient. As long as you meet the conditions of participation, you say you are going to comply with the civil rights law and one other minor standard, then you can probably get your Medicare certification.

We think that if there was a way that you could ask home health agencies to perform at a certain level before they could get certified, maybe have a minimum of 10 patients or show a history of all the services that they are ultimately going to provide, that there will be a better sense of whether this agency is capable of providing quality services.

One concern that HCFA has is that if we ask for these types of minimal requirements some home health agencies, which only serve patients in rural areas, might only serve a few patients the whole year. Consequently, they would not have enough patients to prove that they could provide quality care and would lose their ability to be Medicare certified. We can make exceptions in those cases where there is a valid reason for rural access. But on the whole, home health agencies probably should do a much better job demonstrating their proficiency before they get certified and before they could start billing.

Senator HAGEL. Mr. Grob, would you like to comment?

Mr. GROB. Yes.

Senator HAGEL. Thank you, Ms. Aronovitz.

Mr. GROB. I think there needs to be a better established basis of financial and management standards, as well, both to determine who is suitable to be brought into the program and to examine the behavior of home health agencies after they have been in for a while.

The truth of the matter is that it is possible that you may not be able to legally keep people out. For example, if someone were to declare bankruptcy on one day and show up and request participation in the home health program the next day, we would not have a legal basis for stopping them. If they committed a crime that was not a home health crime, we could not stop them for that reason. They could owe Medicare money and still come back in and want to be a home health agency and we would not have the basis for stopping them. I think we need to take a closer look at the standards of financial and management behavior that are acceptable in this program.

Senator HAGEL. I am going to ask you and the other panel the same question I asked Ms. Garrison. Could some of that be done more efficiently and more effectively at the State level, give them more responsibility for that than they now have?

Mr. GROB. Right now, there is a screen, if you will, about home health agencies in the sense that they are certified by the States in which they operate first and to the extent that States have conditions that they require home health agencies to pass before they

can be considered, that would certainly be a big help. But I do have to say that this is a Medicare Program. There is home health under Medicaid, as well, but what we have been talking about is primarily the Medicare Program, which is reviewed by the fiscal intermediaries.

Senator HAGEL. I realize that, but I think this is so severe and I think we are going to get into even more severe problems. We have major severe problems not just in this business but all this $200 billion program. It is going to get worse. We are going to have to be bold and open up all kinds of thinking here, being very creative and figure out how we do it better. I mean, that is what you are talking about. That is your lives. That is what you do every day. I do not think we should be boxed in with just small thinking here.

Thank you very much.

The CHAIRMAN. Senator Landrieu.

Senator LANDRIEU. Thank you, Mr. Chairman. I appreciate your courtesies to let me just make a few brief remarks. I came to hear our very able Secretary, Bobby Jindal, who will testify in a moment about some of the solutions that he has found to this problem as the Secretary for Health and Human Services in our State.

But let me just say from being here for a few minutes that the taxpayers of this country should be outraged by what they hear about what has happened and I think a couple of points that are worth making. To reiterate a point of Senator Breaux, that cutting budgets does not always save money is a good lesson. In this particular example, we have to be careful about where we cut because in the long run, it could cost us more. Perhaps this is an example of that.

Second, as Senator Wyden said, HCFA may be on the right track or they may not but they had better be on a fast track to solve this problem because I do not think people should tolerate this. I do not think taxpayers in any State, not Louisiana, not Texas, not Illinois, should have to put up with this. There are so few dollars, Mr. Chairman, in this country for good quality health care, children who go without, parents who work hard that want and need health care, to have us waste money in this way is literally beyond comprehension.

Let me make another point. Whoever is responsible needs to be fired, punished, or put in prison. I do not want to be a part of a system that says, well, this happened. We lost $100 million or $1 billion and we cannot find out who is responsible. Let us, Mr. Chairman, find out who is responsible. Let us put the proper punishment. Let us do it as quickly as we can. Let us find solutions as fast as we can and perhaps learn some lessons from this so that it does not happen again.

I want to tell my senior Senator from Louisiana who is ranking, I am happy to help him in any way that I can to work with you, Mr. Chairman, and look forward to hearing from Louisiana as an example of what can be corrected and how it has been corrected so we can get a handle on this as quickly as possible. Thank you.

The CHAIRMAN. Thank you.

I want to ask a couple more questions. It would be to both witnesses. You each made some recommendations to Congress. What

recommendations that you have made are not pending before Congress or have not been introduced in some way or, at least from your point of view, maybe have been ignored that you want to call our attention to?

Mr. GROB. I would pick three. One would be the establishment of the financial and management standards that I alluded to earlier.

The second one would be the resources to back up the enforcement of those. We have advocated the idea of an application fee for people who want to be in the program to help finance the reviews that are necessary to ensure that the home health agencies operate according to the standards.

Although it is unrelated to the purpose of this hearing, there is another problem with the physician supervision of the patients in this program and so we would want to see that to be strengthened, perhaps by rules that require that the physicians actually examine the patients before they certify the need for home health.

The CHAIRMAN. Ms. Aronovitz.

Ms. ARONOVITZ. I would like to take the opportunity to talk about how you can strengthen the survey and certification process, since that is what our study really focuses on, even though there are a lot of other things you can do in the home health program generally.

We found that the surveyors do a wonderful job under the terribly tight time constraints that they have. They are being paid by Medicare to do a certain number and they have to follow certain rules. But we still think it would be very beneficial to expand the recertification process so that you would look at all conditions of participation at least periodically, include branch offices, not just the parent office, in recertifying a home health agency, and visit patients being served by branch offices. On the later point, sometimes the branches serve more patients than even the parent does, and they are not really being overseen very well.

We think that at some point, maybe 6 months following initial certification or a year, that all conditions of participation should be looked at because a lot is missed when you only look at five conditions plus one standard when initially certifying an HHA.

Also, we think that it would be very important to train surveyors to look at reimbursement and coverage issues so that they could help the intermediary identify such problems. For example, surveyors currently concentrate on quality of care issues. That is what the conditions cover and that is their job. However, if they are conducting a patient visit and they notice that somebody is not homebound, that is a reimbursement issue. That person is not eligible for the program and the home health agency should not be reimbursed. But the surveyors should be able to identify that and tell the intermediary so that they could immediately stop payment for that person.

Finally, we think that as Ms. Garrison demonstrated, companies that are rapidly growing, that are billing at huge increases each year, are very, very vulnerable to the complexities of the system and it becomes much more difficult for them often to meet all the conditions of participation. So we think that rapid growth should

be a criteria in deciding how often a home health agency should be reviewed.

The CHAIRMAN. Thank you.

Senator Breaux.

Senator BREAUX. I thank the panel. I just want to emphasize, Mr. Chairman, that while we are concentrating on the bad actors in the home health care industry Congress must recognize that there are literally thousands of home health agencies that are doing a very fine job in providing a very valuable service within the Medicare and Medicaid Programs as well as with private insurance for some very needy senior citizens and others who are ill in our Nation.

So while it is necessary that we focus in on the bad actors, it is not to say that we do not at the same time recognize the thousands that do very good work. It is in those that do the very good work's prime interest to get the bad actors out so that their reputation will not be soiled by those who have tried to scam the system. I thank you.

The CHAIRMAN. I have no more questions. We thank you very much. We always rely upon your agencies to help us get to the bottom of things and thank you for being good inspectors and auditors.

I am going to ask Senator Landrieu and Senator Breaux to introduce their witness and then I will introduce mine. Would you start out, please?

Senator BREAUX. Very briefly, we are delighted, Senator Landrieu and I both—I know Senator Landrieu wants to make a comment or two—with the fact that the committee has seen fit once again to invite Bobby Jindal, our Commissioner of the State Department of Health and Hospitals in Louisiana to be with us. Bobby, we are delighted to have you. It is a very large department with 13,000 employees. We used to have a budget of about $4 billion under his leadership. It is providing more services at about $3 billion in savings and have produced a surplus for the last 2 years in a row.

This is a man who comes to our State with outstanding credentials, attending Brown University and graduating in biology and public policy with a perfect 4.0 average and was accepted to both Harvard and Yale Medical Schools and Harvard and Yale Law Schools and for their loss, our gain. He rejected both and came to Louisiana, where he has been leading the department with great distinction and we are delighted to have you back again, Bobby.

Mr. JINDAL. Thank you, Senator.

The CHAIRMAN. Senator Landrieu.

Senator LANDRIEU. That was a very complete introduction. I would only say, you have to sort of wonder. The Secretary turned down many, Mr. Chairman, excellent job offers in the private sector, but we are happy to have him do a wonderful service for the people of our State and Nation, so thank you for being here, Bobby, and we appreciate you participating.

Mr. JINDAL. Thank you, Senator.

The CHAIRMAN. I am happy to introduce somebody who has also been an outstanding public servant for my State of Iowa. A few years ago, Mary Ellis was head of our Department of Health. She is now the Vice President of Wellmark, Inc., and that is the succes-

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sor name for Blue Cross/Blue Shield of Iowa and other States. As a fiscal intermediary, she will discuss, among other things, examples of home health fraud and abuses and the intermediary antifraud activity.

Would you start, Mary, please?

STATEMENT OF MARY L. ELLIS, VICE PRESIDENT FOR MEDICARE, WELLMARK, INC., DES MOINES, IA

Ms. ELLIS. I should note that my testimony that I submitted is pretty long and inclusive, so I am only going to summarize those remarks.

The CHAIRMAN. I would suggest, a little bit late, but for everybody's testimony that is summarized, the entire testimony will be put in the record as submitted, even though not delivered. It is the same for both of these witnesses.

Go ahead, Mary.

Ms. ELLIS. Thank you. As Senator Grassley said, we are the Medicare contractor. We have responsibility for Part B in Iowa, for Part A in Iowa and South Dakota, and we are the regional home health administrator for a number of States, right now about 15 States where we are the primary contractor, plus the District of Columbia.

The regional home health intermediaries, of which there are six—if you look at the colored map, the blue area is where we have responsibility and the other colors, there are five others where other intermediaries have primary responsibility. We are in a unique position. Wellmark some years ago, in the 1980's, was named the alternate for the country. What this means is that if a home health agency or hospice agency is wishing to make a change in their fiscal intermediary for some reason and petitions HCFA to do this, if HCFA agrees, then the new fiscal intermediary is almost always us.

Because of that, we have collected a great number of problem providers over the last several years. One of the reasons that a home health agency might ask for a change in fiscal intermediary is because they are having their claims denied, perhaps some problems with their fiscal intermediary. They are looking for maybe somebody else who might not be as tough on them, is their thought, and if that occurs, again, it is always us.

Because of this, we have now, if you look at the second map, we have responsibilities besides the blue area, which is our primary area, we have responsibilities in all 50 States. We have roughly a third of all the home health agencies that we administer claims for plus we monitor their activities in regard to costs and fraud and abuse.

The CHAIRMAN. I missed the point. You have the blue area there. How does that differ from what you just said, that you had responsibility in every State for home health care?

Ms. ELLIS. We are primary in the blue area. We have all of the agencies there.

The CHAIRMAN. OK.

Ms. ELLIS. The others are reassigned to us, and we now have a great number in some States, which might tell you something about the activities there. In California, we are administering over

200 home health agencies and we have around 60 in Texas and 60 in Florida. These are 1996 figures, so the numbers are actually higher right now.

Would you put up the two next posters, please?

As other speakers before me today have mentioned, many of the causes for fraud and abuse in home health, it really is a very sad story, I think. This should be a very good thing, helping those who are unable to help themselves. However, this has been a very lucrative business for many and a business that has attracted many opportunists of the worst kind, whose owners have little or no affiliation with health care. Some have grown swiftly and are paid several million dollars a year.

Because there are no national standards or norms regarding the quantity of home health services, there are great inconsistencies across the country regarding average payments and numbers of visits. Although you cannot see them very clearly here, the two blue colored maps depict in one the average cost per beneficiary receiving home health services. The average cost throughout the country is now $4,400 per beneficiary receiving home health services per year, $4,400. The range here is a low in Iowa of $2,325 a year to a high in Louisiana of $8,579 per year per beneficiary that is receiving home health services.

The other map shows the average number of visits per year per beneficiary receiving services. The average per year nationwide is 70, with a low of 33 visits per beneficiary per year in the State of Washington. The high is in Louisiana, with a high of 152 visits per beneficiary per year.

Because our Medicare Program has collected such a large proportion of problem providers, we have become extremely active in the fraud and abuse activities. We have two primary ways that Medicare contractors do prevent or recover excessive and inappropriate payments to home health agencies. One is through medical review of claims and the other is through audit of facility cost reports.

As has been mentioned earlier today, medical review of claims is grossly inadequate in order to prevent payment of inappropriate costs. Our cost-benefit ratio for reviewing medical claims today is about 1 to 13. For every dollar that is invested in administration of medical review activities, we bring back to the Medicare Trust Fund about $13.

Unfortunately, as has been said, we have only been able to review a little less than 3 percent of the medical claims. These claims show so many disturbing and costly activities and the primary problem that we find with most of them is that the patients are not homebound. This is really the biggest problem that we see when these claims are reviewed. The patients are not homebound overall.

We also find that services are not medically necessary, they are not documented. Some are not even provided or ordered by a physician. Again, because there are no limits on the number of home health services, it is easy to provide many more services than are medically needed.

A second way of recovering payment is through audit of facility cost reports and it is quite amazing to see the kind of costs that some providers would like the Medicare Program to pay for. It is

true, as you have heard, they do buy personal property, gifts, pay themselves and their relatives exorbitant salaries, profit from related businesses, make personal loans to themselves, buy real estate.

I would like to defend our auditors today. I believe that the auditors that are employed through the Medicare Programs, at least speaking personally for ours, are extremely highly qualified, well educated, sophisticated, and do know their business.

We have returned to the Federal Government on an annual basis a 1 to 26 ratio. For every dollar invested in the administrative costs of auditors, we have returned $26 to the Medicare Trust Fund. Last year, we returned somewhere between $50 and $100 million in recoveries to the Medicare Trust Fund. In addition, last year, we also had one very, very large case that was mentioned earlier here today, the other big case in Georgia of ABC or First American that we assisted in and that returned $235 million to the Medicare Trust Fund.

Recently, we have found a great deal of frightening criminal activity, frankly, causing me some concern about sending our auditors onsite at some of these locations. There are examples of firearms onsite, laundering of drug money, and international intrigue using home health agencies as fronts for criminal activities.

If we had more administrative money for audits of fraudulent providers, we could readily recover much, much more. We presently only are able to do onsite audits of the very top tier, of the very worst problem providers. We cannot even get down to the next layer of very bad which we know are there.

This whole system is dependent upon coordination and corroboration among Government agencies. If you look at the other colored poster there, it does show partnerships amongst our State and Federal agencies. We work daily with the Office of Inspector General, the FBI, and the U.S. attorneys in various States as well as the State certification surveyors. These relationships are very productive. Great progress has recently been made in their effectiveness.

We are finding that many more cases are now being investigated and a few have been prosecuted, but we have a very long way to go. The many years of low funding for these activities have taken its toll and the backlogs are great. We spend way too much time at our facility monitoring problem providers that we must continue to pay as we wait for their cases to be addressed or settled.

We do greatly appreciate the additional funding and the purpose of the Health Insurance Affordability and Accountability Act of 1996 and we look forward to seeing the results of that law. However, we are still concerned that in many of the States where fraudulent activity is greatest, the investigative agencies have their hands full with other kinds of criminal activities and are not anxious to take on home health cases. We hope there will be improvement in this area in the future.

I also want to mention that I think there is a misconception that we do not know where fraud and abuse exists and that we need to continue to identify more and more and more. The truth is that we have so much fraud identified that we cannot even begin to close out a small percentage of these cases and stop paying these agencies. It is very, very difficult to get rid of bad providers.

There has currently been a high public interest in asking beneficiaries to help identify fraud and abuse, and if I could—I see my time is really up—if I could just speak to that for a second, I will stop, if that is OK.

The CHAIRMAN. Go ahead.

Ms. ELLIS. I think it is certainly a good idea for Medicare beneficiaries to know more about their Medicare services and to be aware of potential problems with home health services, but it is not very realistic to expect Medicare beneficiaries to be a major source of identification of fraud.

We have recently been instructed by Congress to send beneficiaries explanation of their Medicare benefits for all Medicare services. We are spending millions on this new activity. We receive no funding for this purpose, and so far, we have recovered less than $2,000 that might be called fraud. We have answered thousands of phone calls from beneficiaries who mainly want to tell us that they like their providers and to please not stop paying for their services. If we could have used the additional $1 million we spent on sending out these notices and answering the phone calls, we potentially could have recovered another $26 million from onsite audits using that 26 to 1 ratio.

The CHAIRMAN. So you are saying that Congress and/or HCFA required you to send some notices out that is costing millions and you have only recovered $1,100?

Ms. ELLIS. That is correct. This is part of the, under the Health Insurance Accountability and Affordability Act of 1996 that has a section that says, notices must be sent, an explanation of Medicare benefits, to all beneficiaries for all of their services whether Medicare paid for them or not, and again, an OK kind of thing to do, but we have begun sending out this year for all home health services notices of utilization, to begin there. In the future, HCFA has plans for us to send out then explanation of benefits in a summary for all other services. We do send some for other kinds of services now, too, but this is the first year we have sent them out for home health. It has just been bringing in so many, many phone calls, but they really have very little to do with fraud and it is a very, very expensive kind of activity.

The CHAIRMAN. Is that your testimony?

Ms. ELLIS. Yes, sir.

[The prepared statement of Ms. Ellis follows:]

TESTIMONY TO THE SPECIAL COMMITTEE ON AGING UNITED STATES SENATE on HOME HEALTH FRAUD AND ABUSE IN THE MEDICARE PROGRAM

Presented by Mary L. Ellis, Vice President for Medicare
Wellmark, Inc.
Des Moines, Iowa
July 28, 1997

Mr. Chairman and Members of the Committee:

I am Mary Ellis. Vice President for Medicare at Wellmark. Inc.. headquartered in Des Moines, Iowa. Wellmark also does business as Blue Cross and Blue Shield of Iowa and South Dakota. My responsibilities include administration of the Medicare operations under contract to the Health Care Financing Administration (HCFA). We administer a Part B contract in Iowa, and a Part A contract for Iowa and South Dakota. In addition, we are the primary Regional Home Health Intermediary (RHHI) for the 10 states in HCFA Regions VII and VIII, and, as of August 4, 1997, we will add the five states plus the District of Columbia in HCFA Region III. We are also the alternate home health and hospice fiscal intermediary for the remainder of the United States and. as a result, have an administrative presence in all states.

The Home Health Fiscal Intermediary Structure

There are currently eight RHHIs in the United States, although two of them will exit this business over the next few weeks. The remaining six RHHIs are headquartered in South Carolina, Wisconsin, California, Maine, Illinois, and Iowa. In FY96, there were nearly 270 million home health visits nationally and $16.9 billion paid to home health providers.

Because Wellmark is the alternate RHHI for the US, we are in a unique position of being the only RHHI that deals with home health agencies throughout the country. If a home health provider requests a change in fiscal intermediary and receives approval from HCFA, the new fiscal intermediary, in most cases, is Wellmark. Although many very large home health companies have transferred to Wellmark for appropriate reasons, such as consolidation of multistate business under one fiscal intermediary, there are many others who have requested a change in fiscal intermediaries because a large percentage of their claims are being denied or repayments requested. These providers hope that they may be treated differently under a new fiscal intermediary. As a result, we provide oversight for a large number of potentially fraudulent agencies.

RHHI Responsibilities

Under the home health benefit. Medicare pays for skilled health care related to the treatment of an illness or injury. To receive home health care, a beneficiary must be under the care of a physician who has determined that medical care in the home is appropriate and has prepared a plan of care. Furthermore, the beneficiary must be confined to the home and must be in a need of intermittent skilled nursing care, physical therapy, or speech pathology services. The care must be provided by a Medicare-certified home health agency. Home health aide services also may be provided to the eligible beneficiary to assist with personal care and required services of daily living. Medical social services and occupational therapy, as well as associated medical supplies also may be covered.

The responsibilities of the RHHIs include processing and paying home health and hospice claims, responding to inquiries from providers and beneficiaries, beneficiary outreach, provider education, reviewing claims for medical necessity, developing and implementing policies for prepayment review or denial of claims, identifying and investigating agencies with care practices and patterns outside of the standard practice norms, setting payment rates and monitoring reimbursements, settling cost reports and investigating questionable expenditures and billing practices, and developing and referring potentially fraudulent cases for further investigation and prosecution.

Growth in Expenditures and Utilization

Expenditures in home health services are one of the fastest growing components of Medicare. There are many reasons for this.

The Medicare population is growing in number. According to a recent report by the US Census, the over 65 population doubled in the 25 years prior to 1995 and the over 85 population increased by 274% in that time period.

The length of stay in hospitals has declined dramatically over the last decade. Many older people utilize home health services upon discharge. The number of home health providers has more than doubled over the past ten years to approximately 10,000 home health agencies, with 100 newly certified agencies now being added each month. Of the 38 million Medicare beneficiaries, approximately 9% now utilize the home health benefit.

Although these facts sound like a reasonable supply and demand situation, there is much more to the story.

Between 1988 and 1995, there was a 167 per cent increase in home health visits and a 38% annual increase in home health expenditures. Proprietary home health agencies comprise about half of all Medicare certified agencies and provide, on the average, more visits and have higher costs than the nonprofit agencies.

The average number of home health visits nationwide in 1996 was 70 visits per year per beneficiary served. There is a wide variation among states ranging from a low of 33 visits per beneficiary per year in the state of Washington to a high of 152 visits per beneficiary per year in Louisiana. The expenditures per visit also vary across the United States with a range in cost per beneficiary per state from $2,325 in Iowa to $8,579 in Louisiana and a nationwide average of $4,426.

I might add that the quality of care does not appear to be compromised by the lower home health expenditures in Iowa. For several years Iowa has led the nation with the highest proportion of people over the age of 85 and last year a major publishing company named Iowa the country's healthiest state. In fact, the top five states having the highest proportion of population over the age of 65 (North Dakota, South Dakota, Nebraska, Kansas, and Iowa), all are well below the national average in number of home health visits and related costs per beneficiary. High costs and excessive numbers of home health visits do not appear to correlate with a long and healthy life.

Examples of Home Health Fraud and Abuse

Home health is an area of expenditure and growth that has had few constraints and offers few incentives for cost-conscious behavior. The norms of professional practice in home care are less well established than for more traditional health care. Work still needs to be done to establish standards for cost and utilization.

We are seeing a high volume of claims submitted by home health agencies that are for care that is not medically necessary, or was not provided at all, or for services that were never ordered by a physician, or where physicians orders were forged. Other claims are for beneficiaries who are not homebound and, therefore, are not eligible for this service. At times, we find that the care provided was not of high quality or not appropriate for the beneficiaries' needs.

Our financial auditors are finding significant amounts of unallowable expenses submitted in many providers' end-of-year cost reports. Examples are purchase of items for personal use, entertainment and gifts, personal loans, purchase of personal real estate, costs for operating non-related businesses, "phantom" employees, exorbitant salaries for the owner, family members on the payroll who may have other full-time jobs, and management employees who also collect social security disability checks. More serious situations have been found recently involving organized crime and the laundering of illegal drug money.

Identification of fraud and abuse

RHHIs receive fraud referrals from a variety of sources. Many complaints originate from Medicare beneficiaries and their families by phone or letter, or they are routed first through another agency such as a Congressional office or Social Security Administration. However, most of the beneficiary inquiries typically result in findings of billing errors,

not fraud. It is also necessary to identify a pattern of questionable practices or aberrance before an investigation is initiated: it would be highly unusual for a case to be developed from one beneficiary complaint.

Other sources of fraud referrals include:

- Employees of health care providers

Recently, RHHIs are seeing more cases that originate from a "Qui Tam" situation, brought forth by an insider or "whistle-blower" which entitles them to share a percentage of any civil recovery that the federal government collects from a fraudulent provider. Employees or ex-employees are often excellent leads for identifying Medicare fraud and developing a successful case against the guilty party.

- Other agencies such as state survey and certification agencies, Medicaid, or law enforcement

- Local health care fraud task forces composed of law enforcement agencies and other health care insurers

- RHHI departments such as Medical Review and Provider Cost Report Auditing

Large scale identification of home health fraud or abuse is usually identified by the RHHI through provider audit and reimbursement methodology or through the medical review of claims. When patterns of fraud and abuse emerge from either or both of these sources, the case is turned over to the RHHI's Anti-fraud Unit for further investigation and/or development for referral to external investigative or prosecuting agencies.

Activities of these RHHI departments are described below:

1. RHHI Medical Review activities

There are many edits programmed into the electronic claims processing system that cause claims to be suspended or denied prior to payment for lack of information, duplication, or other reasons. Data is collected and analyzed from this system in search of trends and patterns of inappropriate Medicare billings by specific providers and for specific topics. Results of this analysis combined with review of referrals from outside sources are the basis for ongoing prevention efforts to reduce inappropriate payments.

Denial of claims and education of the provider who has a history of inappropriate billing practices next occurs. If no positive improvement is noted, then a comprehensive medical review is performed. This comprehensive review includes beneficiary interviews to validate the provider's billings.

If the comprehensive review and intense education of the agency staff still does not result in improvement of billing practices, the provider is referred to the RHHI Anti-Fraud Unit.

Unfortunately, the process of reviewing home health claims is limited by the lack of detailed information available on the home health bills. In addition, RHHI financial resources only allow for approximately 3% of home health claims to undergo a regular prepay medical review plus we were only able to conduct 50 onsite medical reviews in FY96. These 50 onsite reviews only enabled us to investigate the providers with the most obviously aberrant practice patterns.

2. RHHI Provider Audit and Reimbursement activities

Home health agencies are paid at cost for the services they provide to Medicare beneficiaries. When a home health agency submits a claim for payment, they are paid for each claim based on an established interim rate (usually an amount per visit). This interim rate is based on prior audit history and an estimate of the correct year-end total payment to the agency. At the end of each year, home health providers are required to submit a report of their costs related to services to Medicare beneficiaries.

Although all Medicare cost reports are audited, onsite audits are conducted for only a small number of these cost reports, depending on available funding from HCFA. Unfortunately, because of the large number of potentially corrupt agencies for which we bear responsibility, the low level of funds available in recent years has allowed us to audit only the "worst of the worst" agencies. We often find that providers report many costs that are not reimbursable by the Medicare program or they have not allocated the proper share of their total costs to Medicare. Audit adjustments are then proposed in order to remove any improper amounts included in the Medicare cost report. Adjustments are negotiated with the provider, a final settlement amount is determined, and an amount due and a repayment schedule to Medicare is established or, on occasion, an additional payment is made to the provider.

In FY96, our provider audit staff returned $26 to the Medicare program for every $1 of audit administrative expenditure. This amounted to $50,000,000 from annual home health audits. In addition, an audit of a large home health chain (who had collected $500 million a year from Medicare) recovered $235,000,000 over four cost report periods. The owner of this chain was convicted and is now serving a jail sentence.

Although the provider audit department regularly refers fraud and abuse situations to our Anti-Fraud Unit for further investigation, these situations often are not resolved externally as criminal cases. The providers are frequently allowed to continue operating and the unresolved issues of fraud or abuse still exist. If the cases are accepted by external investigative agencies, it also takes a very long time to bring them to resolution. In the meantime, we are still responsible for recovering the multimillions of dollars due to Medicare from the inaccurate cost reports. In these situations, because there is no penalty for the provider, the agency can continue to abuse the Medicare system and it

requires substantial audit resources to monitor and ensure a proper payment. Sometimes the debt owed to Medicare is very large, the provider files bankruptcy, and there is little money remaining for Medicare to recover. The current environment provides many options of administrative relief for the provider, but few options for the Medicare contractor to recover the funds.

3. RHHI Anti-Fraud Unit activities

The RHHI's medical review and provider audit departments described above refer potential fraud cases to the RHHI Anti-Fraud Unit.

Each RHHI has an anti-fraud unit whose duties include receiving and screening referrals or complaints concerning alleged Medicare fraud and abuse; investigating fraud referrals; referring suspected fraud cases to federal law enforcement agencies and supporting their investigations; providing education regarding Medicare fraud to beneficiaries, RHHI employees, health care providers, and law enforcement agents; and helping maintain a nation-wide database of fraud investigation.

The first step in developing a fraud case is to screen each fraud referral to determine whether the issue involves a Medicare violation. Many referrals can be resolved at this stage as a misunderstanding, billing or processing error, or it may be forwarded to an external entity. For example, a complaint concerning the quality of medical care would be forwarded to the state's Board of Medical Examiners, or to the state's department for facility surveys and certifications.

A review is made of the provider's history with the RHHI to see if the current referral is a continuation of improper activity that has already been addressed with the provider, if the provider's billing data indicates an aberrant trend as compared to their peers, if it is an isolated incident, and to assess the amount of Medicare's financial exposure.

A determination is made whether the case should be referred to law enforcement for possible criminal and/or civil remedies. In some cases immediate referral is made to law enforcement, such as complaints made by a provider's employee, or allegations that kickbacks are being paid. RHHIs are required to first consult with the Department of Health and Human Services' Office of Inspector General (OIG). If the OIG declines the case, it may be referred to another law enforcement agency such as the FBI or US Postal Inspections. If the fraud case is accepted by a law enforcement agency, then the RHHI supports law enforcement and prosecuting agencies by providing supporting documentation, claims data analysis, and expert assistance with issues such as Medicare guidelines and policy, medical necessity, and Medicare cost reports.

If a case is determined to not involve fraud and is declined by law enforcement, then the RHHI will attempt to collect any overpayment that was identified and provide formal notice to the health care provider of the Medicare guideline and policy violations that

occurred. The activities of these providers are then closely monitored for a period of time.

Funding Source for Anti-Fraud Activities

Medicare contractors have learned to become extremely efficient with limited funds. The total contractor administrative budgets have been reduced by 5 to 7% each year for the past several years while workloads increased. Electronic billing systems and other efficiencies have enabled basic claims processing operations to continue most activities. but monitoring of claims and provider activities have declined dramatically due to the lack of funds. For example. prepayment review of only 3% of beneficiary bills paid is not nearly adequate. nor is the reliance on review of paper claims submitted. The lack of onsite audits allows abuse to run rampant. Fraudulent providers are willing to take the fairly safe risk of not being subjected to intense scrutiny as they continue inappropriate practices.

The Health Insurance Portability and Accountability Act of 1996 will provide much needed funding initiatives to assist in anti fraud efforts. It will provide a permanent mandatory source of funding from the Medicare Trust Fund for Medicare contractor anti-fraud efforts for Medical Review. provider audit functions, and other anti-fraud activities. Unfortunately. the funding reductions for Medicare contractors in this and past years have greatly decreased anti-fraud and monitoring of provider activities. A huge backlog of problems has been allowed to mount.

National Projects and New Initiatives

Operation Restore Trust is a two year pilot program initiated in 1995 to focus on fraud and abuse in the five states where 1/3 of all beneficiaries reside. Agencies with extraordinarily high utilization. inappropriate billing practices, or numerous allegations of questionable activities were targeted for intensive scrutiny. Increased sharing of information between state surveyors and RHHIs, as well as among all investigative agencies, was encouraged. This project has been very successful in uncovering substantial fraudulent activities and recovery of Medicare funds, and is now being expanded to an additional twelve states.

HCFA is considering several new activities to strengthen the Medicare program administratively. Among these are an outcome assessment process for evaluation of results of home health care to beneficiaries; new conditions of participation that hold the agency accountable for better coordination of care, establish limits on subcontracting for caregivers, establish criteria for the agency management, require more information to patients regarding expectations about their care, and encourage more physician involvement in patient care; encouraging more involvement between RHHIs and state surveyors for certification: addressing the need for more consistency and strength in states' certification; and a new prospective payment system.

Remaining Problems

Problems that have an urgent need to be addressed are:

Lack of resources

Each year's regular reduction in administrative funding to Medicare contractors has severely limited our ability to combat fraud and abuse effectively and to carry out basic claims processing and related activities. As the workload increases, the operational resources decline. Many contractors are now expecting to exit the Medicare fee for service business because their private business parent is finding it necessary to subsidize their fee for service operations. Obviously, that can not continue.

Although the more stable funding source provided by the Health Insurance Portability and Accountability Act of 1996 will greatly assist fraud and abuse efforts, adequate and stable funding levels are also essential to accomplish the tasks involved in basic administration of the Medicare program operations in order to maintain quality service to beneficiaries and providers.

Lack of administrative tools to prevent payment

While the court system attempts to deal with its backlogs of cases to prosecute, we are concerned that many of these cases will be disposed of by settlements at far lower amounts than the actual provider liability. For example, the RHHI may have determined that a clever, corrupt provider has been paid $10 million dollars incorrectly, but the case may be settled for $5 million because that is all the money the provider has left. Then it has been very worthwhile for that provider to defraud the government and he has gained much from the experience. He did not go to jail and is then able to plan his next criminal venture.

Please note that this is not a criticism of the investigative or prosecuting arms of government, but only a statement of situational reality due to the high volume of cases and their complexity.

Explanation of Medicare Benefits (EOMB)

The Health Insurance Portability and Accountability Act of 1996 included direction to Medicare contractors to send an Explanation of Medicare Benefits (EOMB) for all services rendered as part of a Medicare benefit. If the primary purpose of this activity is for the beneficiary to maintain a medical record of their Medicare services and to enhance customer service, then this may be an appropriate expenditure of funds. However, if this activity is meant to be a first line strategy to assist Medicare contractors in identifying fraud and abuse, then it is a very expensive strategy with a very low return.

EOMBs have primarily been sent only when the beneficiary had a liability for payment of a portion of the services. Due to the high cost of administration. EOMBs have not traditionally been sent for services paid solely by the Medicare program. In FY97. RHHIs were instructed to mail Notices of Utilization (NOUs) to beneficiaries receiving home health services. The costs of printing. mailing, and responding to inquiries to the NOUs has cost Wellmark approximately $1.2 million with actual recovery of only $1100 attributed to this source. The other RHHIs report similar experiences.

After receiving the NOUs. many beneficiaries call or write to report a billing error or to tell us that they appreciate home health service and fear that we will stop paying for it. Very few calls are actually fraud referrals. The thousands of additional calls and correspondence severely tax limited administrative resources and have required hundreds of hours of overtime pay and reduction of staff in other departments this year. There have been no additional funds made available for this activity and. in fact. it has occurred within a reduced administrative budget. Again. it is not unlikely that the private insurance company parent is actually subsidizing these government efforts for some of the Medicare contractors.

In addition. the undeliverable mail returned for the NOUs is approximately 10% of all NOUs sent. Our offices alone have now collected at least 50.000 returned envelopes in the past 6 months.

Pilot projects are in process in several locations to test sending EOMBs for all other types of services paid by Medicare. When this activity occurs nationwide for over 900 million claims over the next years. the expenditures for mailing and follow-up will consume an enormous amount of money. It will be unfortunate if these funds compete with expenditures for preventing and recovering the multimillions of dollars now leaving the Medicare program due to fraud and abuse by clever criminals, or with expenditures necessary for accurate processing of Medicare claims.

If the EOMBs must continue to be sent. then there also should be an aggressive educational process to encourage beneficiaries and their families to take a more active role in their health care. to ask questions of their providers about that care, and to keep a log of home health visits.

Inability to bring fraud cases to resolution

The legal system is bogged down with too many cases of all types to expeditiously handle the backlog of home health cases. There is also a lack of resources or inability to deal with home health fraud cases, of which many are complicated.

We estimate is that it takes four years from first identification of fraud through the RHHI until resolution of the case. Continuing to monitor these potentially fraudulent agencies while they await further investigation or prosecution stretches limited RHHI resources. The problem also is perpetuated as the providers continue to operate and we continue to

pay them. There are no sound mechanisms for stopping payment prior to prosecution or other resolution.

Againk this is not a criticism of our investigative partners. but only an acknowledgement of an overloaded system.

Need for increased knowledge about the Medicare program

The recent emphasis on home health fraud has caused investigative agencies to seek more knowledge about the Medicare program. Our anti-fraud staff are now in great demand as trainers and presenters regarding Medicare policies and procedures at seminars for the FBI and U.S. Attorneys.

In addition. administrative law judges (of the Social Security Administration) overturn many RHHI decisions on appeal. We believe that this also occurs due to a need for better understanding of the complexities of the Medicare program and the health care system.

Manipulation of the system by corrupt providers

Some providers have learned to manipulate the complex system in their own best interest. In some cases. they have even persuaded elected officials to write us letters requesting approval for questionable practices (e.g. allowing high salaries for agency management. longer repayment schedules. or other costly and aberrant practices).

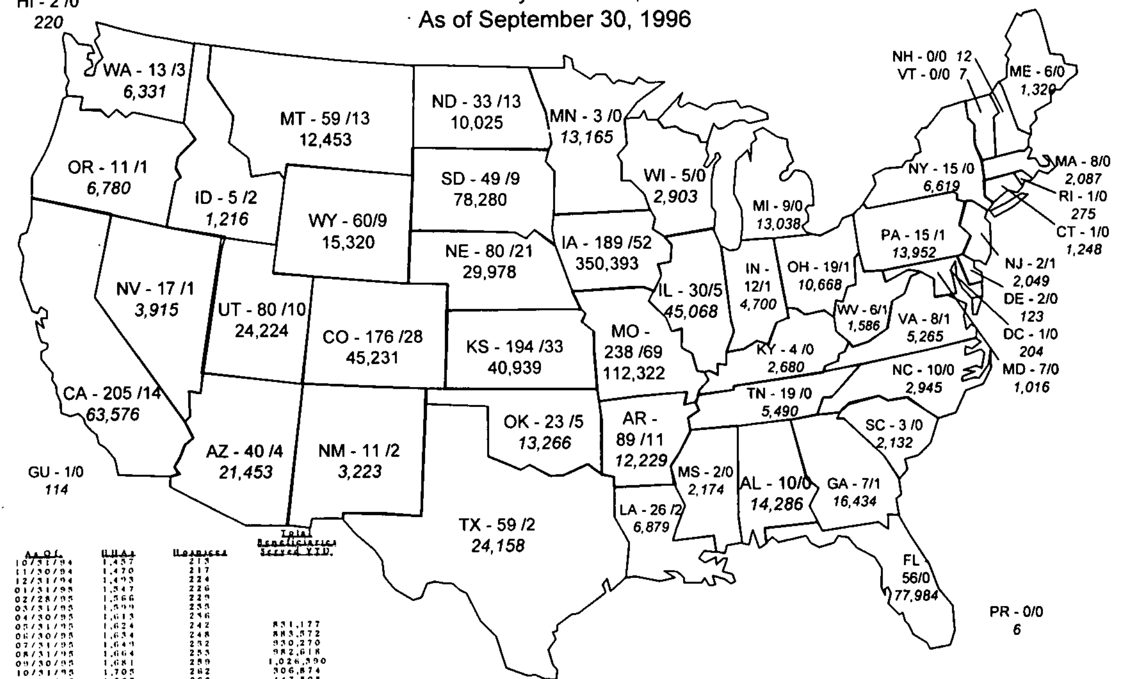
Auditor site visits to certain locations has also become a great concern. There have been instances of firearms on the premises and other potentially dangerous situations.

Conclusion

It is important to note that most home health providers are honest and do not attempt to defraud or abuse the Medicare system. Only a small percent of home health agencies are currently found to exhibit fraudulent practices. But it is a system highly vulnerable to exploitation.

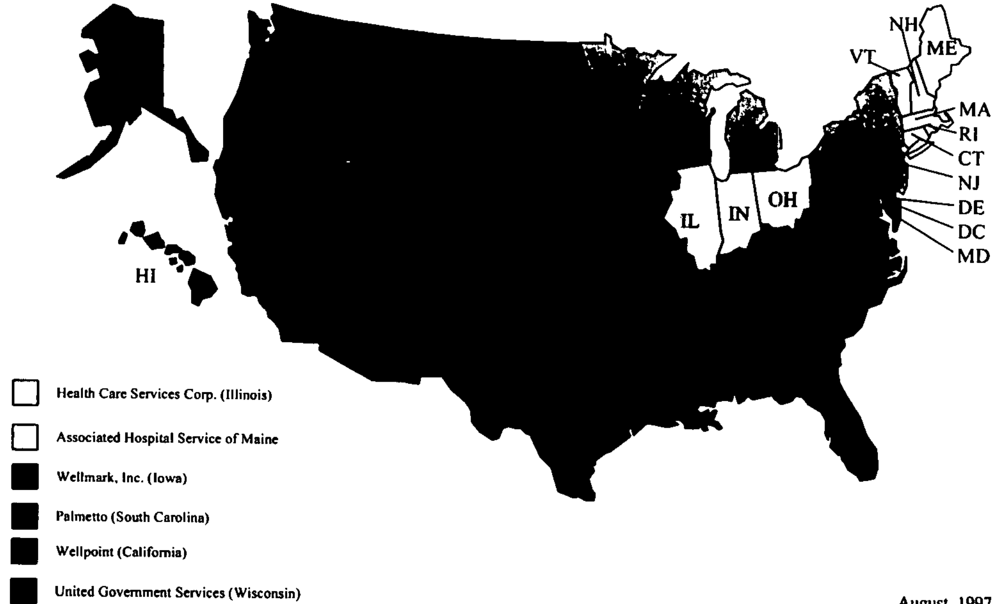
The Medicare system and its related parts are enormously complex. It is, however, a critical and essential program to our citizens and it is necessary to attempt to understand and maintain it. Your continued attention to improving its operation is appreciated.

Thank you for the opportunity to testify today.

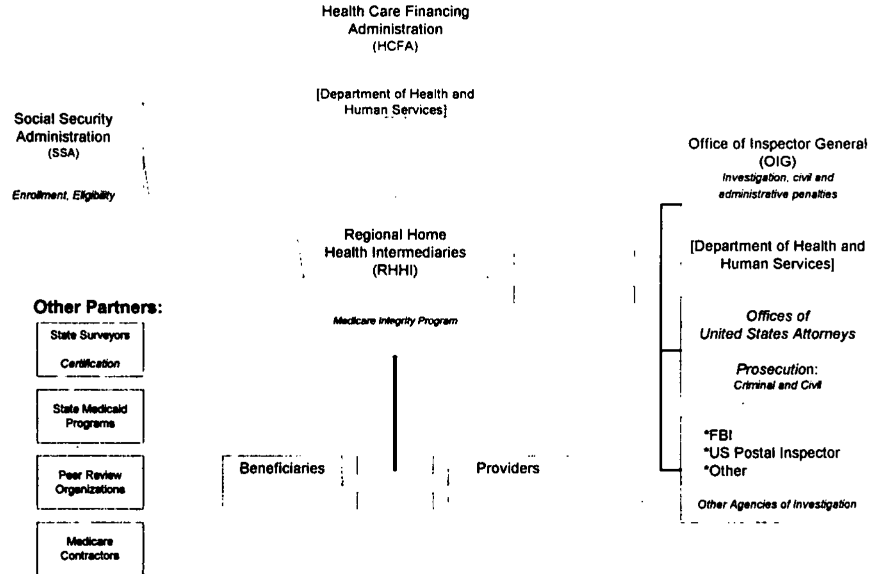


As Of	HHAs	Hospices	Total Beneficiaries Served YTD
10/31/94	1,457	213	
11/30/94	1,470	217	
12/31/94	1,493	224	
01/31/95	1,547	226	
02/28/95	1,566	229	
03/31/95	1,599	233	
04/30/95	1,613	236	
05/31/95	1,624	242	831,177
06/30/95	1,634	248	883,572
07/31/95	1,649	252	930,270
08/31/95	1,664	253	982,618
09/30/95	1,681	259	1,026,590
10/31/95	1,705	262	306,874
11/30/95	1,727	263	447,505
12/31/95	1,755	272	551,362
01/31/96	1,774	272	644,390
02/29/96	1,790	277	716,056
03/31/96	1,819	291	790,328
04/30/96	1,850	301	857,346
05/31/96	1,856	305	925,132
06/30/96	1,875	309	974,742
07/31/96	1,886	309	1,030,170
08/31/96	1,909	314	1,085,598
09/30/96	1,923	316	1,132,000

Medicare
Regional Home Health Intermediaries (RHHIs)
Primary Service Areas



PARTNERSHIPS IN PROTECTING MEDICARE HOME HEALTH BENEFIT DOLLARS



Prepared by Wellmark, Inc. June, 1997

The CHAIRMAN. Mr. Jindal, thank you very much.

STATEMENT OF BOBBY P. JINDAL, SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS, BATON ROUGE, LA

Mr. JINDAL. Thank you, Mr. Chairman. Thank you, Senator Breaux. Thank you, Senator Landrieu. I do appreciate the committee's allowing us to come and actually speak to this problem from a State's perspective. I know we have heard a lot about home health care fraud. We have heard a lot about Medicare fraud. We would like to speak to you a little bit about the Medicaid Program and what the State of Louisiana has done. I think you will see many of the insights will be relevant to Medicare.

Like many speakers before me, I am not here to criticize a home health agency or the industry. I am actually very proud that we have got representatives from Louisiana from that industry that have come here to support what the Department and what the State have done.

We have submitted comprehensive testimony that talks to some of the specific instances of fraud and specific solutions. I am not going to detail those for you because I think the previous speakers have done a good job of that and I do know we have limited time. Rather, I would like to make some unique points about Louisiana's experience and what has worked there.

Let us start with the differences between Medicare and Medicaid. I know you are very aware of the difference in recipients and the way that those two programs are funded. I want to talk to you a little bit about how those two programs are managed.

You have heard a lot about the certification process. You have heard a lot about the surveying process. I want to tell you a little bit about how that process differs between Medicare and Medicaid and what that difference has meant in Louisiana.

In the Medicare Program, HCFA subcontracts with Louisiana to do the quality of care reviews and that is all we do with the Medicare Program. We literally go into the agencies annually and ensure that they are meeting their quality of care standards. It is a very important function, but that is really the scope of our interaction with the Medicare Program.

In Medicaid, the State is much more involved. We actually administer that program, so in addition to doing the quality of care reviews, we also do the fraud reviews and much of the rest of the certification and review process.

Now, I point to that distinction because I want to show you a couple of charts that show some of the things that have been happening in home health care in Louisiana, the differences between the Medicare and Medicaid Program, and I am going to conclude in a few minutes by pointing out how the difference in certification has really driven some of these changes. We have included all three of these charts in the booklets in front of you, but I am going to refer to these charts rather than the booklets.

If you look to that first chart on the extreme left of the wall, the furthest away from you, on the top, you see what is going on in Medicaid in Louisiana. The top two charts show you what has happened in Medicaid over the past few years. We have gone from hav-

ing about a $1 billion program in 1990 to a peak in 1994 of $4.6 billion. In 4 years, the program grew almost fivefold, and if you look to the right of that, the top upper corner, you see on a per capita basis, the program got much, much more expensive by hundreds of dollars per recipient, almost doubling over that same timeframe. We went from being one of the most cost-effective States in the South to one of the most expensive States in the South in Medicaid.

But if you look at the last 3 years, from 1994 to 1997, that trend has been reversed. In Medicaid, our expenditures have gone down by a third to a quarter. We have saved over $1 billion in Louisiana annually. Even while the minimum wage was going up, even while the number of recipients was going up, even with medical inflation, we are actually spending less money in aggregate terms and per recipient. We have gone from being the most expensive State in 2 years in the South to being below the Southern average.

Now, if you contrast the Medicaid numbers, the program the State is running from pretty much start to end, below with the Medicare numbers over that exact same time period, the exact same State, sometimes similar types of recipients, you see a much more normal trend, what you would expect in health care. The numbers have been steadily growing with medical inflation and other costs. Over that same time period, even as Medicaid went up and then down dramatically, Medicare has steadily been increasing, and I would bet that if we came back here a year from now or 3 years from now, you would see Medicaid continue to decline and the cost getting cheaper and cheaper whereas Medicare would continue to get more and more expensive.

Let me link that to home health care. Home health care is an example of what is going on in Medicaid and Medicare in Louisiana across the entire programs. I could easily give you anecdote after anecdote of all the abuses we have seen in home health care in Louisiana in both Medicare and Medicaid, and that is in the testimony. But rather than repeating all the horror stories and all the different types of problems, I do want to spend more time talking about solutions.

So if you look at the second chart, this shows what is happening with Louisiana's home health care expenditures in Medicaid. If you look at that little bar graph at the bottom, what you will see, in the last 2 years, we have cut home health care expenditures by 25 percent. We are spending one-quarter less on home health care expenditures this year than we were 2 years ago.

If you look at the top half of that chart, what you will see is Louisiana's Medicare Program as you just heard, is the most expensive State in this country when it comes to home health care services on a per capita basis. You can look at this any way you want, numbers of visits, number of visits per recipient, total spending, dollars per recipient. We are No. 1 in the country and we spend over $8,500 per home health care recipient. You switch that from Medicare to Medicaid, and we are one of the cheapest States in the country. Out of all 16 Southern States, we are 15 out of 16 and we spend less than a quarter of what Medicare spends per recipient.

Hopefully, between those two charts, what you have seen is even though in Medicare we have growing expenditures, in Medicaid, in

the State program, things are actually turning around. What I would like to do is tell you about some of the laws that we have passed, some of the policies we have adopted that have led to these savings, and hopefully you will hear some consistencies from previous testimony. It is everything from stronger certification standards to prior authorization. Many, many people came up here and told you that the Federal certification process is not strong enough. We in Louisiana enacted a stronger State licensing law to fill in those gaps.

I see my time is running out. I do want to point your attention to——

The CHAIRMAN. No, go ahead. We will give you the time you need.

Mr. JINDAL. Thank you, Mr. Chairman.

Let me call your attention, then, to that third chart as an introduction to some of the laws we have enacted and policies that we have enacted, because these solutions I am about to describe to you have worked not only in home health care but across the entire health care system in Louisiana. We have enacted everything from qui tam to triple damages to financial rewards for those people that do come forward with cases of abuse and fraud in the State.

If you look at the last chart in your books, the very last page in your books, we have picked out four different industries and shown you their experience in Louisiana where we have applied these policies. I am going to really focus your attention on the last 2 years.

We have already talked about home health care, how we have decreased costs by a quarter.

If you look in the upper right quadrant, inpatient mental health, we have saved over $200 million annually in the Medicaid Program simply through prior authorization. We went from providing half a million inpatient days to mental health patients 2 years ago to providing only 84,000 days of care for the first 6 months of this calendar year.

We did it without denying one patient the health care services they need. We did it simply by hiring full-time child psychologists to go in and review patient cases to see when care was actually required. We went in and said, providers simply cannot provide care until benefits are exhausted and then simply kick patients out. Patients only need to remain in institutions for as long as they have diseases that can be treated. They simply should not be held for a provider to make money.

The same policies and the same lessons are applied to the next two types of services. If you look at the bottom left corner, psychiatric rehabilitation, this is another program where in the last 2 years, we have decreased expenditures by over 80 percent. We are saving tens of millions of dollars, and those of you familiar with Louisiana's program may remember the headlines from 2 years ago. You may remember bus loads of patients being shipped to providers while the State and the Federal Government were paying for those services. That is no longer happening.

Psychiatric rehabilitation is another service where we have cut expenditures by over 80 percent simply by doing clinically the right thing. We did not start new copayments. We did not put a cap on

services. We did not tell people, you cannot get the care you need. We simply said, we are only paying for services when they are truly, genuinely, objectively needed.

Finally, the last example, perhaps one of the most well-publicized and worst examples of fraud in Louisiana, nonemergency transportation. We at one point had over 2,000 vans, station wagons, and buses driving around the State of Louisiana with little placards saying they were nonemergency transportation vehicles. We spent over $70 million in our State, a relatively small State, just 2 or 3 years ago providing these transportation services.

Part of the joke was that many of these providers were billing the State for patients long dead, patients that did not exist. Many of these providers simply did not have the medical equipment to truly provide any services. It would have been cheaper at one point to give everybody free tokens to take taxi rides in the State rather than paying for this program, and we have been able to control that program. We have gone from $70 million to a low of about $11 million, once again through the same kinds of policies, same kinds of procedures and laws that we believe you can enact with home health care.

Let me quickly, because the documentation in front of you does spell out in great detail what we have done, let me hit the highlights of what we have done and what we think could work with home health care.

We enacted one of the region's if not the country's toughest antifraud bills, containing everything from triple damages to qui tam provisions to financial rewards for those that come forward. We also enacted automatic liens to make sure that providers do not dispose of their property when they are under investigation, to make sure they simply do not dispose of their assets and then flee the State, as often happens.

We actually also enacted a bonding law. We have heard over and over that we have got fly-by-night providers, people that come into the State, make a lot of money, and then leave and are not there when the auditors finally catch up with them. We now have the power to stop such abuse. We now have a law that requires every provider in the Medicaid Program to put up a $50,000 bond or a letter of credit so that at least not only do we have leverage should they try to flee the State but we also keep the overnight companies out. It is also a very effective tool at keeping out those that are simply interested in gaming the system.

We have a qui tam provision, once again, that lets private individuals seek recoveries. There has often been the case not only at the Federal level but at the State level, the perception that the Government simply is not interested or does not have the resources to pursue every one of these cases. The qui tam law empowers every single taxpayer, those that are actually paying for these services, to become the overseer. It empowers every single citizen in Louisiana to say, this simply is not right. If you see something that is illegal or immoral or a waste of your taxpayer dollars, you can go to court, but it also punishes those who bring frivolous suits. It also punishes those who simply try to tie up our court system.

We have a moratorium on the number of new home health care agencies. We went from 150 to over 500 home health agencies in

the span of the last 3 or 4 years. We have got twice as many home health care agencies as we do McDonald's in the State. They are everywhere, on every corner, and when you get that kind of number of agencies, not only does it overwhelm the regulatory system but it impedes their ability to deliver high-quality care. They are simply not getting the stable patient base they need to deliver high-quality care and to respond to State regulations and State requirements.

Since we put in that moratorium, we have kicked out between 15 and 20 agencies from the Medicaid Program in the last 10 months alone. That rate is ten times—10 times—the Federal rate, the national rate that you heard about from the GAO report. We expect that rate to be even higher next year. If you were to ask us to come back in a year, we think that rate would be much higher than the 3 percent that it is now.

We have done many other things. Quickly, every month we mail 4,000 recipients a copy of their bill with a stamped self-addressed envelope saying, did you get these services? Tell us whether there was fraud. Tell us whether you really did see the doctor. Tell us whether you really did receive 50 home health visits during this past month.

We have set up 1–800 numbers. We have set up Web site pages. We have made it as easy as possible for individual recipients, individual employees, individual taxpayers to give to us their insights, their tips, their information so that we can prosecute these crimes, so that we can get these dollars back for the State. We have done everything from introducing one of the first in the country PC-based antifraud systems to hiring new auditors.

Let me close just by talking about two of the most successful things we have done and two of the things that have resulted in the most recoveries and the most dollars saved for the system.

I began by telling you in the Medicare system, the State's responsibility was limited to only ensuring quality of care. All we did in terms of Medicare was to go in with our reviewers and say, yes, they have got nurses, yes, they have got doctors, yes, they are meeting health standards.

We did a pilot project where we said, if we are going to be in these agencies anyway, why do we not go in the front door and also look at their billings. Why do we not also at the same time that we are there also make sure that they are actually obeying the laws of the State and the Federal Government, make sure they are not cheating the system. So at the same time we do that quality review, we also did a program integrity review.

We started out in 1995. In the first year, we recovered close to $400,000. In the second year, in reviewing 25 of the largest agencies in the Southern part of our State, we did find, consistent with the national standard, that 40 percent—40 percent—of the bills were recoupable. Forty percent of the revenue they had collected was actually owed back to the Federal and State Governments. We returned $2 million in 1996 alone just from these 25 agencies to Medicare and Medicaid.

This year, in 1997, we are expanding the program. We are doing 33 agencies, and this has been such a successful pilot project, it is actually being applied in other States across the entire Southern

region. We do think that when we are going to do certification anyway, if we are going to go into the front door anyway to look at records and look at quality of care, let us go ahead and do a comprehensive survey.

Now, it did cost us in terms of administrative dollars. We are spending 50 percent more man hours per agency in terms of that review, but we do think that is money well spent. It is a dose of preventive medicine. When you look at these charts, especially if you look at that third chart, if we can prevent home health care from becoming another nonemergency transportation in Louisiana, if we can prevent it from becoming another inpatient health, we would much rather spend that money up front.

Finally, in terms of effective State policies, we have talked a little bit about prior authorization. We have talked a little bit about our tougher licensing standards. We have also come up with intermediate sanctions. You have heard one of the criticisms at the national level is it all or nothing. We either kick you out or you are in the system.

In Louisiana, we do have financial penalties. We do levy financial penalties, we do have temporary licenses, and we do require the agencies to pay for the costs of the survey so that it is a self-sustaining program. It is not something we ask the taxpayers to pay for. It is something we say, if you want the right to be in this business, we are going to ask you to pay for it.

I know I have exceeded my time. The last page in our testimony is a grocery list of items that we believe that could be done at the national level in terms of addressing the Medicare issues and the issues that we came to talk about today.

I thank you for this opportunity. I do think it is important to hear from the State's perspective and to see how at least one State is responding to some of these challenges and some of these problems. Thank you, Mr. Chairman.

[The prepared statement of Mr. Jindal follows:]

TESTIMONY OF
Bobby P. Jindal, Secretary
Louisiana Department of Health and Hospitals
TO THE
UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING
Senator Chuck Grassley, Iowa, Chairman
Senator John Breaux, Louisiana, Ranking Member
July 28, 1997

FIGHTING HOME HEALTH CARE FRAUD

LOUISIANA'S EXPERIENCE AND SOLUTIONS

State and Federal Involvement in Medicaid and Medicare

	MEDICAID	MEDICARE
Description	A program of medical assistance, funded by the federal government and by states, for impoverished individuals who are aged, blind, or disabled, or members of families with dependent children Each state determines who and what services will be covered, how much providers will be paid and how its own program will be administered within federal guidelines	A federal program to fund the growing health care costs of the nation's aging population The program consists of two components: Part A, which covers institutional services, including inpatient hospitals, skilled nursing facility, home health services and hospice services; Part B, which provides optional supplementary medical benefits for primarily outpatient and physician care costs
Eligibility	Covers categories of persons in financial need	Covers aged or disabled individuals without regard to need
Management	Administered by the states and varies widely among them	Administered by the federal government and is uniform throughout the states
Administration	At the federal level, the Secretary of Health and Human Services is responsible for administration of federal grants-in-aid for the state programs. Immediate responsibility at the federal level has been assigned to the Health Care Financing Administration (HCFA), Department of Health and Hospitals Each state is required to have a Medical Assistance Unit within its state agency to provide direction & leadership as well as a Medical Care Advisory Committee to advise the state agency on matters of policy	The Medicare program is directed by the Secretary of Health and Human Services (HHS), but most of the program's administrative functions are delegated to the Administrator of HCFA; HCFA sets policy and oversees the program's operation from its central office in Maryland and from its 10 regional offices Part A is administered by intermediaries who process claims submitted by health service providers. They also determine the reasonable cost for provider services under both Parts A and B. Part B is largely administered by the private sector because private insurers, group health plans and voluntary medical insurance plans have experience in reimbursing physicians
	The state's role is to run the program, regulate the finances, and manage and set conditions subject to HCFA approval	**The state's role is limited to that of an agent monitoring the program's compliance with federal quality of care guidelines**

NOTE: A "buy-in" provision in the Social Security Act allows states to enroll Medicare-eligible individuals who are also eligible for Medicaid in the Medicare Part B program, which covers physicians' services. A state that enters a Part B buy-in agreement with HHS agrees to pay the Part B premiums.

Home Health Problems

Note: Between 1988 and 1996 Medicare spending for home health grew from $2.1 billion to $18 billion and by the year 2000 is projected to exceed $21 billion. Along with increasing expenditures, the number of home health agencies has also increased from about 5,800 to over 9,000 (GAO/HEHS-97-108).

BILLING

- **BENEFICIARIES ARE NOT HOMEBOUND**

  Patients do not meet the eligibility requirement of being homebound to receive the home health services

- **SERVICES ARE NOT RENDERED**

  Providers erroneously bill for home health visits that never took place

- **INAPPROPRIATE BILLING FOR SUPPLIES/EQUIPMENT**

  Providers erroneously bill for home health supplies that were never received or were not necessary for the patient's improvement or care

MANAGEMENT

- **UNNECESSARY OR OVERUTILIZED SERVICES**

  Agencies provide more visits to patients than necessary to meet the patient's needs. This is a result of the agency poorly or inappropriately assessing the patient, or the agency's disregard of proper utilization of services

- **PATIENT DOES NOT KNOW ORDERING PHYSICIAN**

  Home health agencies solicit patients in their homes to coax them into using their services. Frequently, an agency will bring a patient to a physician with which the agency has an alliance for the sole purpose of having the physician order home health services, regardless of whether the patient needs the services or meets the eligibility requirements

- **SAME PHYSICIAN SIGNING LARGE NUMBERS OF PLANS OF CARE**

  This may be an indication that the physician has a relationship with or a financial interest in the agency to admit and sign home health treatment plans for patients that the physician does not have a history of treating

Home Health Problems

MEDICAL

- **CANNED PLAN OF CARE (POC)**

  Plans of care for patients' treatment are not individualized to meet the needs of each patient or remain unchanged despite changes in the patient's health status

- **SERVICES NOT FURNISHED ACCORDING TO POC**

  The plan of care for the patient is ordered by the physician and includes specific treatment services including the frequency and duration of the services. Home health agencies fail to follow the plan of care as ordered (either by missing visits or not giving treatment services as ordered)

- **ALTERATIONS TO MEDICAL RECORDS**

  There are many variations of this practice: patient records have forged patients' signatures; documentation of visits are done before actual visits are made to the patients; information is entered on documented visits in different handwritings; discrepancies are noted in the times that visits are done; some records contain documented visits to a patient by different nurses or home health aides on the same date at the same time and with different findings annotated

- **PROVIDER NOT HELD ACCOUNTABLE FOR PATIENT OUTCOMES**

  There is no requirement for an agency to inform the patient of an expected outcome of services to be delivered, and the agency is not held accountable if they fail to meet or exceed the patient goals

- **INCONSISTENCY BETWEEN POC/RECORDS & PATIENT'S CONDITION**

  Documentation in patient records reflects a different picture of the patients and their limitations than what is observed during the home visits by surveyors

Examples of Medicare Home Health Problems in Louisiana

- Homebound patient drove over 600 miles to Mexico for his honeymoon
- Four home health agencies were owned by the same family and share the same parking lot
- Home health patient rode his bike 10 miles each day on a busy highway
- Home health agency had no administrator, no director of nursing and no nurses on staff
- Home health director bragged that she was buying $700 worth of jewelry with Medicaid money
- Nurse delivered home health services (17 visits weekly) to her parents while living with them
- Home health patient attended Head Start Program 5 days a week

Louisiana's Improvement Tools

ANTI-FRAUD LAW	**Civil monetary penalties** - provides for the imposition of civil monetary penalties of up to $10,000 and judicial interest **Anti-kickback provisions** - describes illegal remuneration which includes kickbacks, bribes or unauthorized rebates; provides for establishment of "safe harbors" **Rewards for fraud & abuse** - allows rewards of up to $2,000 for tips which lead to successful actions **Whistle blower protection** - protects Qui Tam plaintiffs & tipsters from adverse actions and allows them to bring suit if an adverse action occurs; this provision allows whistle blowers to receive exemplary damages **Forfeiture of property for payment of recovery** - the court may order forfeiture of property to satisfy a judgment **Injunctive relief/property disposal restrictions during investigations** -allows for injunctive relief against the transfer of a provider's property or to preserve the provider's business during an action taken against the provider; if an injunction is issued, a receiver may be appointed by the court to run the provider's property during this period; a pendency of action may be placed on the provider's property during this period **Assumption of liability/continuing liability** - provides for continuing responsibility for payment recovery when a provider's business is sold, consolidated or merged

BONDING LAW	gives DHH the discretion to require $50,000 surety bonds or letters of credit before certain health care providers could enroll in the Medicaid program

Louisiana's Improvement Tools

QUI TAM	empowers a private citizen to bring action for illegal remuneration, false claim or misrepresentations or illegal acts on behalf of the Medical Assistance Program; the Qui Tam plaintiff may receive up to 30% of the total recovery; the Qui Tam may also receive an award for costs, expenses, fees, and attorney fees; no adverse action may be taken by defendant against the Qui Tam plaintiff unless the court finds that the Qui Tam actions were meritless or brought for the purpose of harassment
MORATORIUM LAW	extends existing moratorium through 2001 to stop the expansion of new home health providers. Since 1990, the number of agencies increased from 165 to 550; since October 1995, 15 agencies have been excluded
BILL MAILING	conducts monthly random samplings of about 4,000 recipients; sends actual bills to the home health patients asking them to verify the services billed
HOTLINE/WEBSITE	enables 4 million Louisiana citizens to report suspected fraud and abuse; approximately 100 calls a month are received
SURS (Surveillance & Utilization Review) SUBSYSTEM	conducts on-site reviews of providers selected through a computer control file and by complaint for adherence to rules, regulations and policies. The unit investigates providers and applies administrative sanctions including recovery of money and suspension from the Medicaid program when appropriate
NEW AUDITORS	added staff to increase annual reviews from 2.5% to 5% of providers enrolled; 20 new positions were approved to increase audit and program services to prevent waste, abuse, and fraud

Louisiana's Improvement Tools

PILOT PROJECT	
1995 PILOT PROJECT (PHASE 1)	▶ Incorporated data exchange between the fiscal intermediary and state agency ▶ Payment denials increased / program integrity increased ▶ 2 sequential surveys conducted - Quality of Care / Program Integrity reviews ▶ Training of surveyors provided by the fiscal intermediary ▶ 31 agencies reviewed; overpayments totaled $365,716
1996 PILOT PROJECT (PHASE II)	▶ Survey protocol developed to integrate two sequential surveys ▶ 375 claims reviewed; 159 denied; for a 42.4% denial rate ▶ Average survey hours increased from 43 to 64 after implementation of project ▶ Overpayment for one provider reviewed in the pilot program totaled$188,450 ▶ Twenty-five agencies reviewed; overpayments totaled $2,114,420
1997 PILOT PROJECT (PHASE III)	▶ Pilot program expanded to other states ▶ Refinement / adjustment to the survey process ▶ Continue reduction in fraud and abuse ▶ Projections: 33 agency reviews

ONGOING ACTIVITIES

PRIOR AUTHORIZATION	allows recipients to receive only those services needed and reduce the number of providers gaming the system; for example, the number of non-emergency transportation vehicles has fallen from 2,223 in January 1994 to only 437 in January 1997; in psychiatric hospitals, the number of days patients were hospitalized dropped from 449,000 in 1995 to 230,000 in 1996 to 84,000 for the first six months of 1997; the average length of stay for mental health patients decreased from 22 to 9 days
SERVICE DELIVERY TRACKING TOOL	an electronic system that works through the patient's home telephone and logs the provider's time in and time out and verifies that the call was made from the patient's home
HOMEBOUND DEFINITION	clarifies the definition of homebound to prevent (or reduce the amount of) different interpretations rendered by home health providers, physicians, etc.

Home Health Problems

Summary of Problems

BILLING

- Billing Medicaid for services not rendered
- Billing for unnecessary services
  - Unnecessary patient assistance
  - Services the patient already performed for himself
  - Services for patients who were not homebound
  - Visits which were not medically necessary
  - Unneeded skilled nurse or aide visits
  - Services provided that the patient could have performed
- Billing for inappropriate services
  - Shopping
  - Cleaning
  - Cooking

MANAGEMENT

- Business/Financial/Management problems
  - Staff not paid
  - Under-qualified staff
  - Appointments not kept by home health aides

MEDICAL

- Recruiting/soliciting Medicaid patients by bringing persons to doctors who approve or prescribe home health services, instead of the process originating with the doctor
- Changing the doctor's orders
- Inappropriate clinical interventions

"unnecessary services to ineligible recipients by unqualified staff"

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Suggestions for Change

BILLING

- Continue to require fiscal intermediaries to send reports to beneficiaries and physicians regarding the number of visits billed by the home health agencies
- Look at technological ways to identify patients receiving duplicated services paid by both Medicare and Medicaid; many dually eligible patients are receiving similar services paid by both payer sources
- Require a public notice of survey results or billing information of each provider
- Require the fiscal intermediary to make a telephone contact with the patient/caregiver prior to beginning payment for submitted home health claims
- Initiate prior authorization of all further home health services after a certain cap is met on each patient
- Develop a cap for Medicare home health services; when a patient reaches the maximum allowed, the physician should be required to conduct a comprehensive assessment and medical review of the patient's condition and needs before any further home health services are authorized

MANAGEMENT

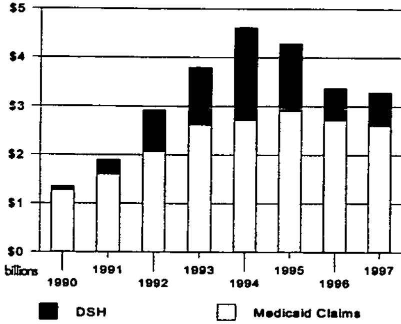
- Clearly define the guidelines for homeboundness to facilitate the physician or agency in making the determination of who meets this eligibility requirement
- Require all home health agencies to provide to all patients,upon admission, the criteria to qualify for Medicare/Medicaid home health services, and to have a signed receipt of these criteria; also, launch a federal and state education effort to inform all beneficiaries of eligibility requirements to receive home health services
- Require all physicians to receive education regarding the requirements a patient must meet to be eligible to receive home health services
- Require all providers to sign waivers allowing federal, state or local agencies to disclose to the regulatory state agency serious incidents of accrued tax debt; this would allow the state agency to take steps to impose licensing sanctions for not being in compliance with federal/state tax laws, i.e., provisional or revocation of license

MEDICAL

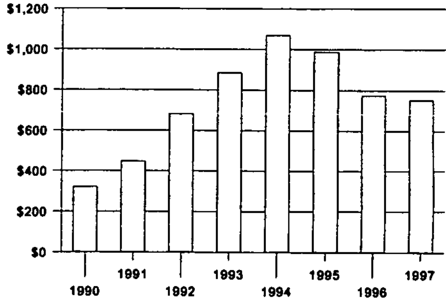
- Change Medicare requirement that skilled nurses must be needed to receive other home health services; many patients are receiving skilled nurse services for the sole purpose of making them eligible to receive home health aid
- Require all patients to be seen on a regular basis by their physicians
- Require all physicians to provide to the fiscal intermediary periodic attestation statements that the patients continue to be under their care

Louisiana Medicaid/Medicare

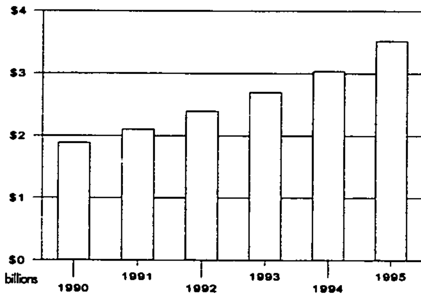
Medicaid Expenditures



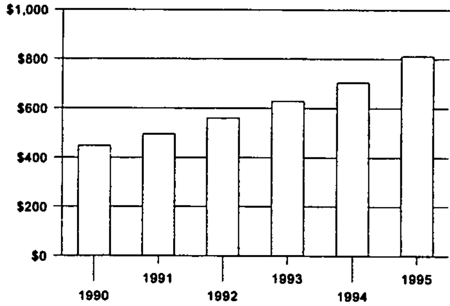
Medicaid per capita Expenditures



Medicare Expenditures



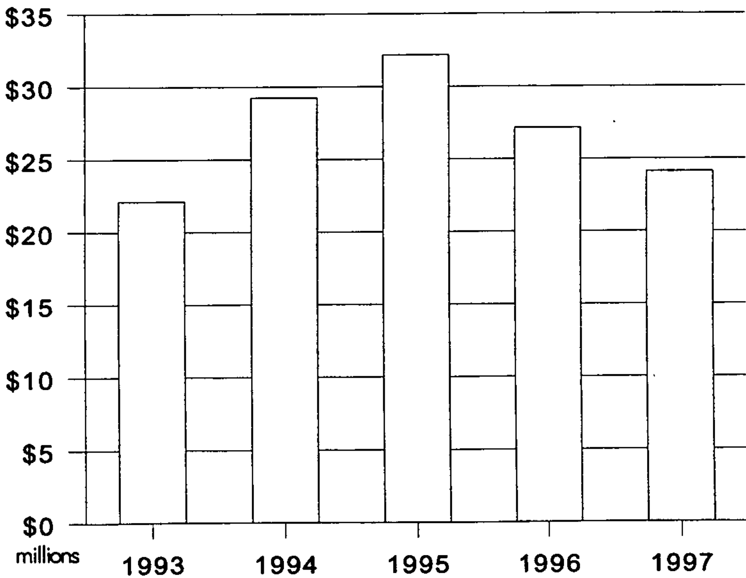
Medicare per capita Expenditures



Louisiana / National Comparison

	MEDICARE	MEDICAID
COST PER HOME HEALTH RECIPIENT	$8,570	$1,698
RELATIVE RANKING (1 = most expensive)	1/50	15/16 Out of southern states

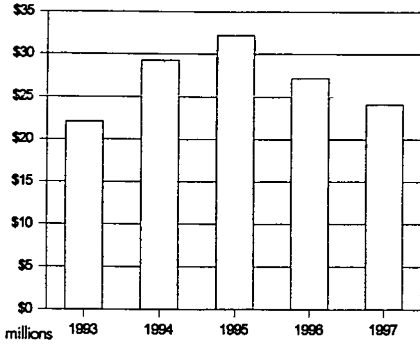
Louisiana Medicaid Home Health Expenditures



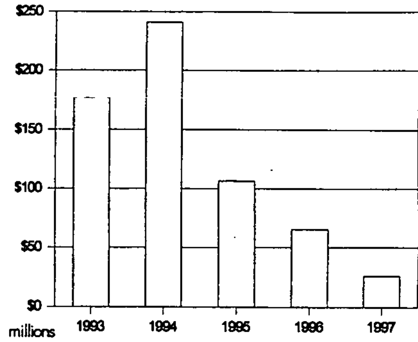
JINDAL TESTIMONY - ADDENDUM 2

Louisiana's Medicaid Expenditures

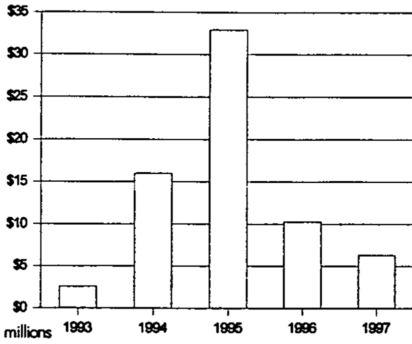
Home Health



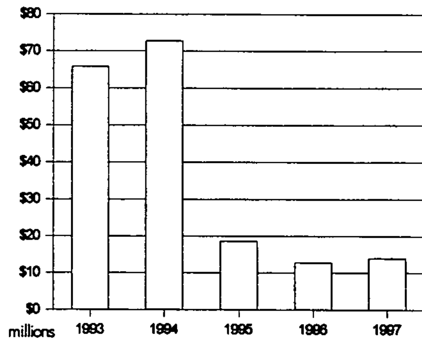
Inpatient Mental Health



Psychiatric Rehabilitation



Non-Emergency Transportation



The CHAIRMAN. Thank you, Secretary Jindal. I appreciate it very much.

Mary, I would like to start out with asking you questions. What is the most common reason for the denial of claims during a medical review?

Ms. ELLIS. The most common reason is not being homebound. I believe that the definition of homebound, and I think most people believe the definition of homebound is very open to interpretation. One of the problems we have, not only just with medical review and finding that they are not homebound, these providers and beneficiaries can have their denials appealed and when they are appealed, it is often overturned in favor of them because the definition of homebound is so weak and so vague and so open to interpretation that they are declared to be homebound and they are reinstated. So homebound is a major issue for us.

The CHAIRMAN. I would like to have some examples of kind of what you might call the worst case providers that are being audited and whether or not you would classify these as criminal acts.

Ms. ELLIS. Worst case providers are true criminal acts and we have encountered many, many of them, many illegal operations where they have just been using home health as a front. There have been situations where there is laundering of drug money, money being taken out of the country. Those are the very, very worst cases and we are finding more and more and more of them. The lesser types of crime are not nearly as frightening, where they may not be carrying guns, but there are guns in the worst cases. The next level are some that are being prosecuted today, much like the one that we heard from earlier, and we have also many of those on the list. Our problem is we cannot get them prosecuted. The courts are clogged with these cases. There is a backlog and even the lesser ones are not getting settled. We continue to pay them and monitor them and we cannot seem to get rid of them.

The CHAIRMAN. You have seen drug money in the home health care business?

Ms. ELLIS. Yes, sir.

The CHAIRMAN. Could you quantify that?

Ms. ELLIS. Those are all turned over to investigative agencies after they have been identified and we do not continue to work on them other than to provide information from our records. But there are a number of them that I believe the investigative agencies would verify.

The CHAIRMAN. It is apparent from your testimony that you find yourself kind of in a catch-22 position when it comes to monitoring the agencies that you know are abusing the system but you have to keep paying them the money anyway. It is a terrible position to be in, I am sure you agree.

Ms. ELLIS. Yes.

The CHAIRMAN. I would like to have you share some of your ideas about how we could overcome that dilemma.

Ms. ELLIS. Again, as you heard before today, it is very difficult to get rid of these providers because there are not good remedies for doing so. There are very few administrative remedies. There are few penalties and sanctions against them and not being able to get

the cases prosecuted or settled leaves us in a position of just having to continue to pay.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you very much, Ms. Ellis and Bobby, for your presentation. I am tremendously impressed, Bobby, with what you have done in our State of Louisiana. I was looking at the chart. We were first in reimbursements for home health care and the average amount per patient and we were first in the average visits per patient. Iowa, I think you were last in both. We were first in both.

But I think the thing that strikes out of all these charts is that when you were able to do something about the Medicaid Program and, it really made a difference. You do not have the authority to fix Medicare. I wish you did because the results, if it would be anything like what you did with Medicaid, would be terrific.

Your cost for a home health care recipient under Medicaid is $1,698. The average cost for a home health care recipient under Medicare is $8,570. Now, every time I have heard anything about costs, they generally say that poor people generally, because of their conditions, are generally sicker than wealthy people who get sick, and yet under the Medicaid Program for poor people in Louisiana, you have cut the cost substantially. Are not the same home health care agencies providing the home health care services for both Medicare and Medicaid patients?

Mr. JINDAL. They are in most cases, Senator.

Senator BREAUX. You do not have "Home Health Care of Louisiana Medicaid" and a whole group of different providers that are "Home Health Care Medicare," do we?

Mr. JINDAL. No. It really is a lot of the same providers. If anything, you may have some that only do Medicare, but the vast majority do both.

Senator BREAUX. So why the difference? I guess my question is answered by everything that you have done to ensure that you do not make the mistakes that are being made under Medicare.

Mr. JINDAL. Sure. I think there are two big reasons, and there are obviously many reasons about the difference between Medicaid and Medicare, but these are two big regulatory differences. First you have heard a lot about the reimbursement methodologies. Medicare continues to be a cost-based reimbursement methodology so that if you have home health agency A versus B, if A is more expensive, they get a higher rate. In the Medicaid Program, that is not the case. We take the cost reports for the entire industry and every few years rebase it, but——

Senator BREAUX. So you are doing prospective payment.

Mr. JINDAL. Exactly, and that has had tremendous efficiencies. As anybody that is familiar with the private market knows, if you set the capitation rate and you allow the industry to find more efficient ways to deliver those services, they will do that.

Senator BREAUX. That is encouraging, because hopefully one of the reforms that will survive under Medicare is prospective payments for home health care and you are saying that that is one of the things that has helped you tremendously.

Mr. JINDAL. If I would only recommend one thing, that would be the first thing we would recommend.

The second thing, very closely after that, is we actually review each case after a patient hits a threshold, a certain number of visits. We actually go in and do a manual review of that patient to determine whether they need to continue receiving the home health care services. We do believe there needs to be some kind of Federal trigger—for example, in Louisiana, the threshold is 50 visits. After a patient gets to 50 visits over the course of a year, we do a manual review. We would recommend that some threshold be activated at the Federal level.

When you have done those two policies, you decrease the cost per service. You have also decreased the numbers of services. These are not tremendously expensive services per unit.

Senator BREAUX. The average visits per patient in Louisiana is 143 home health care visits a year.

Mr. JINDAL. That is exactly it. It is volume. You asked about worst examples. We have had some agencies that can make their payroll off of one or two patients alone, literally cover their costs.

Senator BREAUX. What is the average number of visits under the Medicaid Program?

Mr. JINDAL. I have those numbers. I think we pay on average between $50 and $60. I know the number is lower than 50 visits. I do not have it right in front of me.

Senator BREAUX. Lower than 50, but if it is the same home health care agency treating a Medicare patient, the average is 143 visits.

Mr. JINDAL. That is right, and the costs are much higher per visit, as well.

Senator BREAUX. The average reimbursement for a patient, this chart says, you have $8,507 per patient.

There is one other thing I wanted to ask you. You heard the testimony earlier about the percentage of claims that are being audited. I think it was about 3 percent. Do you have an estimate of about what percentage is being audited in Louisiana under the Medicaid Program?

Mr. JINDAL. Sure. The way the Medicaid Program operates is actually every single provider is put through a fairly sophisticated computer system—we have worked on this with HCFA—and the outliers are kicked out. So in some sense, 100 percent of the providers are actually reviewed in terms of their bills. If we see a provider that doubles their billings in a week, let us say, or if we see a provider that is unusual compared to their peer groups—we try to rank all the providers with their peers so we compare apples to apples—we will do a manual audit.

If we see a provider that catches our attention, then we say, wait a minute. What is going on here? That triggers a manual review. That triggers actual auditors doing surprise visits, actual auditors looking at their paper trails. So in reality, 100 percent of providers are reviewed. The number of providers that get that actual paper audit has doubled since we have come into office. We have hired 20 new auditors. It is closer to 5 percent. But we are fairly confident between those two systems that we are catching the worst abusers in terms of dollars wasted and clinical harm.

What I would argue in conclusion to that question, though, is that it is really not just about hiring additional auditors. That is

the easy solution. Really, the real answer is restructuring the program so that it is not a cost-based system, so that it is not an open-ended system on the number of visits.

Prior authorization is what saved hundreds of millions of dollars across the State of Louisiana. It is by going before the service is delivered, not after the fact. It is always harder after the dollars have already been spent to get those dollars back. You heard from the agents. They spend three-quarters of a million dollars on every case. If we put that money into prior authorization up front, I guarantee you would save tens of millions of dollars easily.

Senator BREAUX. You heard Ms. Garrison's testimony about all of these suppliers where she said they were really making their money from and that they really were not looked at. Can you comment on that? Should they be looked at? Do you do that in Louisiana?

Mr. JINDAL. Sure. What we try to do is we try to look at industries as a whole. For example, when we did the 4,000 bills to each recipient per month, what we actually did was we targeted an industry at a time because we do not find it is very effective when you simply send out bills across the board. We actually picked those industries that were causing us troubles.

The woman that testified before mentioned DME's, durable medical equipment for example. This is a program that is causing tremendous problems. It is causing tremendous problems across the country in Medicare and Medicaid and we see that in Louisiana. In Louisiana, if we had to pick the three industries that we were looking at, if we were looking at our crystal balls and saying, these are the industries that we need to look at in the future, after home health, the first would be DME's.

The second would be substance abuse. That is another program that is growing. It is a small program. We put in some tough rules just last week, but we caught it before it becomes even a $10 million program.

A third program would be rural health clinics. Once again, those are clinics that are cost reimbursed due to Federal policy. Senator, I know you are familiar with the geography of the State of Louisiana. In Hammond alone, we have three or four of these clinics and you and I both know Hammond is not a rural or underserved city or town. But yet again, here we have rural health clinics in that city and services receiving compensation at the rate of $500 to $600 for a simple doctor's visit because they get reimbursed based on cost.

Another industry that we would look at would be long-term hospitals. We think we are cleaning up that program in the Medicaid part of the program. We know they are going into Medicare. We literally have providers come to us and say, we know we cannot get the dollars out of Medicaid. We just want to be licensed for Medicare. When we got some of our tougher licensing laws through the State legislature, we had many people come to the table and say, we do not care if you do that in Medicaid. We know we cannot get in that program anymore. Leave the door open for Medicare. Just let us follow the Federal standards. We do not want to follow these tougher State standards.

But anyway, those are the programs that certainly we are looking at very carefully, DME, substance abuse, and long-term hospitals and rural health clinics.

Senator BREAUX. Little programs today become very large programs tomorrow if unchecked and unaccountable.

Mr. Chairman I took Mr. Jindal's suggestions and I put on top of them "S. 1234," Grassley-Breaux legislation. I suggest that we just introduce it as a bill, because, indeed, the suggestions, I think, are right on point and we thank Mr. Jindal for his work.

I would only again conclude that while this committee has focused in on the bad actors and the bad problems, it is always important to continue to say that home health care has literally thousands and thousands of companies that do a very good job, provide a needed service that is a very special type of service that can save money with regard to people who are at home getting treatment that they otherwise would have to get in an institution. The good should not have to suffer for the bad and we are trying to get rid of the bad. Thank you very much.

The CHAIRMAN. Mary, I would like to ask you a question that Senator Breaux asked Mr. Jindal, and that is if you had one piece of legislation, he mentioned prospective reimbursement, if you recall, that would reduce home health care fraud, waste, and abuse, what would you suggest?

Ms. ELLIS. I do not think I could limit it to one. I certainly would agree with the limits on home health services. I would agree with the prospective payment. I think that is an excellent idea.

I would add a couple of things. In regard to the home health claims that we receive, they should have coding so that we can discern what kind of activities really are going on there. It is very, very difficult to know what is really happening.

I also, as far as the beneficiaries are concerned, I think it would be most helpful if, and they would pay much more attention to the services that they are getting if they had a small copay that they were required to pay. I think that if there were just a few dollars each time the home health agency came into their home that they had to come up with, they would be much, much more careful about allowing them to come in so readily.

The CHAIRMAN. Also, you mentioned in your State qui tam legislation. You mentioned that it is working. I am the author of the False Claims Act of 1986, which is similar type legislation. I got it passed for my war on defense fraud, waste, and abuse, but it is being used now more in health care. How is it working and would you suggest any changes in it at the Federal level?

Mr. JINDAL. It is actually just a very recently passed law. We got it done during the last session, and I applaud you for doing it at the Federal level. It is a very important piece of legislation.

We very largely modeled our law after the Federal statute. Let me tell you about some of the key differences, and these may or may not make sense to you. We obviously limited ours to health care. This was a piece of legislation initiated by the health department. When we drafted our law we did it as purely a civil, not a criminal, act, and not only to lower the burden of proof but also because you have heard over and over about the courts being clogged.

We found that by making it a civil procedure and still leaving intact the AG Office's ability to pursue criminal charges, we are going to get many, many more referrals and many dollars back, especially when you combine that civil burden of proof with triple damages. Given those twin powers, we see that many agencies are much more willing and much more wanting to come forward and settle and compromise with the State.

A second key difference, in addition to making it civil, not necessarily a criminal statute, is that we have taken the extra dollars that are recovered by the State after the State and the Federal Government have been made whole, after Medicare and Medicaid have been made whole, we have taken those extra dollars and reinvested those into anti-fraud efforts. The thinking is that if for every dollar we spend in Louisiana in anti-fraud efforts, we save at least $6 to $10, there it makes sense to reinvest those dollars back where they can do the most good.

Another provision that we added that was not in the Federal statute is that we have actually protected providers from frivolous qui tam provisions. One of the concerns of the provider community, who, by the way, unanimously endorsed the statute when it did come up in front of the legislature, was how do I make sure my competitors do not simply use this as a nuisance? How do I make sure a disgruntled employee does not simply tie me up in court and tie me up in legal costs for frivolous lawsuits?

What we have done is build in certain protections so that if they do that, if the courts determine that these are frivolous lawsuits, there can be sanctions against the people that initiate the lawsuits.

Finally, we have expanded the scope. You heard about the related businesses. The first witness testified about how related businesses sometimes contribute to this fraud. We expanded the qui tam provisions to apply to contractors, suppliers, and other indirectly related businesses.

There are many other technical differences which we will make available to you, things like, for example, making State employees ineligible, making sure that if somebody benefited from the abuse that there is a cap on what they can recover to make sure somebody does not simply turn around and try to make money off of their own illegal acts.

We also enacted other stiff provisions, for example, caps on what individuals can make off a qui tam provision to make sure that people are not just out there filing bounty lawsuits. But for the most part, it is very similar to the Federal statute.

As a hint of the successes to come, we had one man who actually came to my office and said, thank you for this law. I do not need the State to do anything else. He estimated he could generate millions of dollars in savings not only for the Government but also in terms of compensation to him. He already felt like he had the facts on enough cases.

To give you a second example, in our first year of office, we identified 15 psychiatric hospitals that had been overpaid and whose debts had been sitting on the books. These debts had been sitting on the books for 4 or 5 years. We have collected in 1 year alone over $20 million simply by bringing actions against them. If Louisiana had had its own State qui tam provision, those are cases that

could have been pursued in the last 5 years but simply had not been.

So in summary, we think the law will be very successful and those are the key differences in terms of the Federal statute.

The CHAIRMAN. Senator Breaux, I have a short summation. Do you have anything you wanted to say in closing?

Senator BREAUX. I will echo what you say.

The CHAIRMAN. You do not know until I say it. [Laughter.]

First of all, I owe you a special thank you, both of you for your participation in the third panel, but I need to repeat again, we would not be here if it was not for some very good witnesses from all three panels. I suppose a special word of thanks to Ms. Garrison is called for. Without her insightful candid and personal testimony, we would not be as informed as we are now regarding home health care fraud.

In addition, I need to give a thank you to people that you have not heard about yet, but we have Helen Albert of the Health and Human Services Office of Inspector General and Wayne Oaks of the FBI because these folks worked tirelessly to ensure that we could put a face on the home health care fraud, waste, and abuse when it came to our access to Ms. Garrison.

We have heard a great deal of testimony here today on one end of the spectrum. One could say that it is pretty scary, how much fraud there is there and how easy it is to commit the fraud. The OIG advised us that 40 percent of the total services provided by home health care agencies should not have been paid. The GAO noted that Medicare's survey and certification process is pretty ineffective.

But I do believe that there is light at the end of the tunnel. As I am sure many would agree, we are a lot better off with this information than without it and hopefully we will be able to use the testimony of this hearing to bring about needed change.

Thanks to the incredible testimony that I have heard today, the committee is better equipped to legislate, and as we all know, legislation for the sake of legislation is pointless. However, legislation that is carefully targeted and crafted to address a problem can make a positive difference.

Today, we have heard a number of proposals regarding how to contain home health care costs and how to increase accountability and how to decrease fraud, waste, and abuse. We heard ideas ranging from increasing the number of signators on a cost report, to imposing a moratorium on new home health care agency certifications, to requiring that each home health agency principal have prior health care experience. These proposals, among others, will be carefully examined and refined to capture desired results.

I am committed to producing legislation that is the right fix and not a fast fix as we look at what is a tremendous problem.

As a result, I am going to instruct the committee staff to call together the Office of Inspector General, the General Accounting Office, the FBI, HCFA, others, like the authorizing committees of the Congress, to work and identify the right combination of proposals that I hope will make hamburger out of this economic jackpot that we call health care fraud.

During the roundtables that we would have here in discussing this matter, I would like serious thought given to a strike force to go after home health care offenders. I would be remiss if I did not emphasize, though, also, something that Senator Wyden pointed out each time he spoke today, the importance of consumer empowerment. I think that every speaker has alluded to this, as well.

The points that need to be made, and I have a chart on this, to select a reputable known home health care agency, be aware and understand the coverage to which you are entitled, read everything very carefully—it seems to me that that is an admonition that has come out of every one of our hearings that we have had on almost any subject before this committee this year, become familiar with rights and responsibilities, protect your health care insurance information and numbers just like you would your Social Security number, do not give in to pressure to accept unneeded items and services and keep relevant records, review statements sent by insurance companies and if you find an error make it a matter of public record, and then following up on what Mr. Jindal and I just talked about, utilize False Claims Act, the qui tam legal process that empowers private citizens to bring action for illegal acts and in return the qui tam plaintiff can receive a portion of any money recovered.

With these thoughts in mind, I again say thank you to everybody, including the audience who has been here for 3 hours and 15 minutes on a very important issue. We thank you for your participation.

Before adjourning, I would like to include in the record prepared testimony provided by the National Association for Home Care.

[The prepared statement of the National Association for Home Care follows:]

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TESTIMONY FOR THE RECORD

SUBMITTED TO THE SENATE SPECIAL
COMMITTEE ON AGING

U.S. SENATE

JULY 28, 1997

ON BEHALF OF THE

NATIONAL ASSOCIATION FOR HOME CARE

Representing the Nation's Home Health Agencies, Home Care Aide Organizations and Hospices

The National Association for Home Care (NAHC) is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's members are every type of home care agency, including nonprofit agencies like the Visiting Nurse Associations, for-profit chains, hospital-based agencies and freestanding agencies.

The National Association for Home Care does not deny that there is fraud in the home care industry. For every dollar of fraud affecting home care, there is a dollar less to be spent on delivering care to needy beneficiaries. For that reason, NAHC has a zero tolerance policy on fraud.

Congress has expressed concerns about the growth of the home health benefit. The significant growth in the benefit has raised questions about fraud and abuse in the industry. Recent provisions in the fiscal year (FY) 1998 budget and other anti-fraud initiatives were designed to limit utilization of home health services and curb the growth of the benefit. Yet, there are a number of legitimate factors that contribute to the growth of the Medicare home health benefit.

I. GROWTH IN HOME CARE

The Medicare home health benefit has been an evolving benefit for most, if not all, of its existence. In Medicare's earliest years, home health expenditures amounted to only about 1% of the total. Today, home health comprises close to 10% of total Medicare payments. Therefore, while the benefit has increased each year, it still represents a small proportion of Medicare spending.

In 1996, nearly 4 million Americans received Medicare home health services, representing an estimated $18 billion in Medicare spending. Much of the increase over time can be attributed to one-time expansions or clarifications that were specifically designed to allow more individuals access to additional in-home services.

Even without pending legislative changes to the benefit, home health growth is projected to moderate and fall to more modest levels in the next few years. The Health Care Financing Administration (HCFA) Office of the Actuary expects annual growth in the volume of visits to steadily decrease to around 6% through the year 2000.

Reductions in Hospital Lengths of Stay. Growth in the home health benefit must not be looked at in isolation. There is a direct connection between the implementation of the prospective payment system (PPS) for hospitals and the growth in the home care benefit. PPS has made it in the hospitals' best interest to move patients out of hospitals as soon as possible, and to collect the full diagnosis related group (DRG) payment for fewer days of care. In fact, over the last six years, lengths of stays in hospitals fell 31% in the DRGs most associated with post-acute care use. Much of the growth in the home health benefit has resulted from quicker discharges of more acutely ill patients from hospitals to home care or elimination of hospital-based treatment altogether.

Coverage Clarification. In the mid-1980s, Medicare adopted documentation and claims processing practices that created general uncertainty among agencies about what services would or would not be covered. The result was a "chilling effect" under which some Medicare covered claims were diverted to Medicaid and some patients went without care. This "denials crisis" led in 1987 to a lawsuit (*Duggan v. Bowen*) brought by a coalition led by Representative Harley Staggers and Representative Claude Pepper, consumer groups and NAHC.

The successful conclusion of this suit led to a rewrite of the Medicare home health payment policies. Just as lack of clarity and arbitrariness had depressed growth rates in the preceding years, the policy clarifications that resulted from the court case allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended.

The correlation between the policy clarifications and the increase in visits is clear. The first upturn in visits (25%) came in 1989 when the clarifications were announced; and an even larger increase took place (50%) in 1990, the first full year the new policies were in effect.

Cost Effectiveness. Home health has evolved beyond its traditional boundaries, making it possible for patients to prevent, reduce or eliminate altogether their need for costly inpatient treatment. It is also important to note that while home care has experienced growth in the number of visits provided per patient, home care's costs have remained steady over the last decade, making home care still one of the best health care buys.

An Aging Population. The aging of the U.S. population will continue to influence future need for home health services. Older individuals are more likely to need home care and they are likely to use more home care services than younger home health patients. For example, the National Medical Expenditures Survey found that individuals over age 85 are three times more likely to use home care than the general elderly population, and their resource consumption is also significantly higher. Individuals over age 65 used an average of 65 visits whereas individuals over age 85 used an average of 75 visits.

Improved Access. Throughout much of the 1980s, the home care industry, along with the rest of health care, was experiencing a personnel shortage. Although there are still acute shortages of certain disciplines, conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to 9,923 in 1996. Although access varies somewhat from state to state, for the most part enrollees who need home health care now have access to it.

Public Awareness and Preference. The past decade has seen dramatic increases in awareness among physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery of health care services. For example, a 1985 survey found that only 38% of Americans knew about home care; by 1988, over 90% of the public understood home care to be an appropriate method of delivering health care, and supported its expansion to cover long-term care services as well. A 1992 poll found that the American public supports home care by a margin of nine to one over institutional care. Nearly 82% of all accredited medical schools now offer home health care training in their curricula.

Technological Advances. Over the years, sophisticated technological advances have made possible a level of care in the home that previously was only available in hospitals and other institutions. The most significant of these advances has been the introduction of home infusion therapy and radical improvements in ventilator equipment.

II. CONCERNS ABOUT AND EFFORTS TO ADDRESS FRAUD AND ABUSE

A. NAHC's Policy

As in any area, growth brings with it the potential for unethical or illegal behavior. NAHC strongly believes it is the responsibility of all parties involved -- patients, payors, and providers -- to act aggressively to uncover, report, and act against fraudulent or abusive home care providers.

NAHC has taken a leadership role in combatting fraud and abuse. It has been engaged in a longstanding effort to maintain the highest degree of ethics and values in the health care industry through a combination of member education, cooperation with and assistance to enforcement agencies, and consistent support of federal legislative proposals designed to combat abuses in health care programs.

In addition, NAHC has initiated an outreach effort to educate consumers and policy makers on fraud issues, including development of "Consumer Tips for Recognizing, Preventing, and Reporting Fraud and Abuse" (Attachment 1). This pamphlet is a guide for educating patients about the need to protect their health benefits and to help beneficiaries recognize and report suspected fraud in home care. Another information paper entitled "Home Care and Hospice Fraud: Fiction versus Fact," (Attachment 2) seeks to debunk some of the myths set forth in some recent media reports which have suggested that the home care and hospice benefits are fraught with fraud.

In January 1994, NAHC implemented a broad new policy governing member conduct. (See Attachment 3, National Association for Home Care, Code of Ethics). While America has embraced home care as the site of choice for meeting its health care needs, the growth of the industry has unfortunately been accompanied by a few unscrupulous providers of care who seek only to profit illegally at public expense. The incidence of established fraud in home care services is low. However, even a single occurrence of fraud or abuse is not acceptable and must be eliminated.

B. NAHC's Efforts to Combat Fraud

Legislation alone cannot control fraud and abuse. Health care providers must have a comprehensive understanding of acceptable standards of conduct. Internal self-audit and self-enforcement must be performed to minimize the risk of illegal activities. Over the past several years NAHC has provided extensive education on the issues involved in health care fraud. National workshops have been held at our regional conferences, annual meetings, and annual law symposiums. State home care associations have joined in this effort to make this education as widely available as possible.

NAHC believes that increased public awareness is a valuable means of oversight and that the public must be fully involved in the process of fighting fraud. It is the health care consumer and the taxpayer who are ultimately the injured parties. While the government should increase the information it provides to the public about known schemes and scams, the health care industry must also do its part. In accordance with the NAHC fraud and abuse policy, the home care industry has not only cooperated with media investigations but has worked to engage the attention of the media to focus on important areas of concern.

One of the most important roles that the home care industry plays in eliminating fraud and abuse is to lend its knowledge and expertise to enforcement authorities. Over the years, NAHC has acted as an extension of the investigatory arm of federal and state enforcement authorities. On the simplest of levels, NAHC has put individuals and providers of services who have evidence of fraudulent conduct in touch with the Department of Health and Human Services (HHS) Office of Inspector General (OIG). On a deeper level, NAHC has provided guidance to enforcement authorities on areas in which resources might be targeted in their home care efforts.

Historically, fraud and abuse in health care has taken the form of false claims in Medicare cost reports, billings for services never rendered, and kickbacks for referrals. These types of fraud are now being joined by an entirely different form of abuse found in managed care. In the traditional fee-for-service system incentives exist for overutilization and overcharging. Managed care may create financial incentives to improperly underutilize care. The health care consumer is harmed doubly in these circumstances: financially, care is prepurchased but not delivered; and healthwise, necessary care is lost. NAHC strongly recommends that Congress and the enforcement authorities take a long hard look into the abuses in managed care. New strategies must be developed to address this new type of abuse. Clinicians, rather than accountants, will need to operate at the heart of this effort. Good managed care can help bring about economy and efficiency in health care. Bad managed care, controlled by financial greed, can mean the death of the patient.

C. Operation Restore Trust and Its Impact on Home Care

Home care has come under increased scrutiny through the Administration's anti-fraud initiative, Operation Restore Trust (ORT). While well-intended, this is reminiscent of the "denials crisis" of the 1980s where allegations of overutilization, allegations of noncovered services and allegations of waste, fraud and abuse severely affected availability of necessary home care and hospice services to Medicare beneficiaries.

Congress confronted the "denials crisis" by appointing a Commission to study the impact of arbitrary denials on Medicare home health beneficiaries. The Report to Congress and the Health Care Financing Administration from the Advisory Committee on Medicare Home Health (July 1, 1989), found that poorly designed budget-savings initiatives, inconsistent interpretation and reinterpretation of Medicare criteria, and increased fiscal intermediary review of home health claims were just some of the factors that created a "chilling effect" causing home health agencies to discontinue services and deny care in order to avoid arbitrary denials.

Similarly, as a result of ORT practices, some home care agencies are currently being terminated based on unwritten and arbitrary standards for participation. These standards are inconsistent with long-standing written interpretations. Moreover, agencies are unable to protect themselves because their rights to appeal and a hearing only manifest after an agency has been terminated. By then, it's too late.

While the anti-fraud initiatives of ORT certainly have merit, the OIG and other enforcement agencies must ensure that necessary and desirable utilization should not be curtailed in the name of eliminating fraud and abuse.

D. FY98 Budget

It is important to note that the Administration and the Congress have already taken significant steps to discourage fraudulent and abusive practices. A number of home care provisions have been included in the budget package currently under consideration by Congress:

Homebound: The budget would require the Secretary of HHS to report to Congress by October 1, 1998, a proposal for determining the criteria and methods for determining if an individual is homebound.

Payment Based on Location Where Home Health Service Is Furnished: Home health agencies would be required to submit claims on the basis of the location where a service is actually furnished, rather than the location of the agency billing office.

Intermittent Care: The budget would codify current regulations by defining "intermittent" skilled nursing care as skilled nursing care that is either provided or needed on fewer than seven days each week, or combined skilled nursing and home health services for less than eight hours each day, for periods of 21 days or less, with certain exceptions.

The budget also codifies current regulations relating to the definition of "intermittent" for purposes of determining whether an individual qualifies for Medicare coverage.

Prospective Payment System (PPS): The budget calls for the implementation of PPS for home care by October 1, 1999. The current cost-based payment method has inherent incentives for home care agencies to provide a higher volume of services. PPS will encourage providers to be more efficient.

Surety Bonds and Disclosure of Ownership Interest: This provision would require home health agencies to post a $50,000 bond to participate in the Medicare program. The provision also mandates that home health agencies disclose identification of all officers, directors, physicians, and principal partners owning five percent or more of the agency. Durable medical equipment (DME) suppliers would also be subject to the disclosure and surety bond requirements.

Normative Standards for Home Health Claims Denials: This provision would authorize the Secretary of HHS to establish through regulation normative guidelines for the frequency and duration of home health services. Additionally, the Secretary is authorized to establish a process for notifying physicians in cases in which the number of home health service visits provided under the physician's plan of care exceed these thresholds.

Venipuncture: A provision included in the House package would revise the definition of skilled home health services to specifically exclude venipuncture (blood drawing) from the eligibility criteria for intermittent skilled nursing services.

NAHC has a number of concerns with some of these budget provisions. For example, NAHC supports efforts to strengthen the admissions requirements for participation in the Medicare program. Yet, NAHC believes that an accreditation program, which predicates Medicare participation on broad

based competency, would be a more effective bar to entry than a surety bond requirement which allows access to Medicare based solely on financial capital.

NAHC also agrees that Medicare payments should more closely reflect the costs of care in the places where those tasks are performed. The budget provision calling for payment based on the location where the home health service is furnished, however, only recognizes the varying labor costs that occur specific to the site of care. Billing, clerk functions, and other activities that are carried out in an agency office should also be reflected in an agency's reimbursement levels.

NAHC also has concerns about the use of normative standards. These will guarantee that many individuals who need home care services would be denied Medicare coverage. The use of norms implies an average amount of care for patients with specific criteria. Averages, however, cannot be used to deny coverage to individuals since the averages are made up of a range of care needs of specific patients. To determine what is a reasonable and necessary level of care requires an individualized review of that patient's circumstances.

Excluding venipuncture from the eligibility criteria for intermittent skilled nursing services would also have a profound effect on some of the most frail and vulnerable homebound Medicare beneficiaries. Receipt of additional services beyond venipuncture by eligible individuals does not constitute "abuse" and allows thousands of beneficiaries the option of care at home as opposed to long-term care facilities. Eligibility for venipuncture coverage does not automatically result in additional services being provided to the patient; an individual must meet all of the criteria for receipt of care and these services must be prescribed by a physician. NAHC is hopeful that the budget conferees will accept the Senate recommendation and drop the venipuncture provision from the final budget package.

E. Overstatement of Home Health Fraud

NAHC and the vast majority of the home care community applaud efforts to root out fraud and abuse and prevent their occurrence. However neither home care beneficiaries nor providers are served well by efforts to exaggerate the incidence of fraud. In a statement reported in the **New York Times**, Secretary of HHS Donna Shalala was quoted as saying that, "Our recent investigations in several states show that 25 percent to 40 percent of home health visits paid for by Medicare were for services that were either never delivered or were provided to people who did not qualify for those services." This quote, rather than being interpreted as applying to a few unscrupulous providers, is being used to characterize the entire home care industry.

Industry research indicate that Secretary Shalala's figures are based on reports issued by the HHS OIG that are, at best, of limited use. One report issued by the OIG related to a single agency in southern Florida for which 50% of claims were noncovered. Out of this study the OIG conducted a further survey of home care claims within the state of Florida. That report, issued in June 1995, concluded that 26% of claims in Florida do not meet Medicare coverage requirements. Clearly, the results of the single-agency study are not applicable to the broader population of home care agencies nationwide.

However, there are also some serious problems with the broader study of Florida agencies that bring into question its applicability to home care generally. HCFA's own data indicate that in 1995, out of more than 300 million visits rendered, a mere 0.2% of home health care visits were denied on the

basis that they were deemed not necessary. This is in sharp contrast to the broader Florida survey, which involved review of only 200 claims out of more than 50,000 claims submitted for February 1993. This is a sample of less than 0.25, nowhere near representative of the industry as a whole.

Second, a large number (12) of the claims deemed "noncovered" by the OIG involved patients receiving home health aide visits while residing in adult congregate living facilities (ACLF). The OIG concluded the facilities had the responsibility to provide personal care services to residents. However, requirements for ACLFs to provide personal care vary considerably from location to location. In fact, HCFA has not yet determined the appropriate way to handle the delivery of personal care to Medicare-eligible residents in ACLFs.

When developing legislative solutions to combat fraud, efforts should be made to make distinctions between intentional fraudulent activity and technical noncompliance with the vast array of Medicare regulations. There is a tendency by both government agencies and the media to characterize as fraudulent instances of miscoding, lack of documentation, and other technical violations that lack the requisite criminal intent that constitutes fraud. NAHC recommends that while Congress addresses noncompliance issues firmly, it makes the distinction between noncompliance and true fraud.

F. NAHC's Recommendations to Combat Fraud and Abuse

During the 104th Congress, NAHC played an active role in helping shape an anti-fraud health care package. Ultimately, these proposals were incorporated into the Health Insurance Portability and Accountability Act (HIPAA), P.L. 104-191, that was enacted into law.

Passage of HIPAA marks a good first step in eliminating waste, fraud and abuse in our health care system. There are, however, some specific issues within home care that need to be addressed by anti-fraud legislation.

Congress should pass a home care specific anti-fraud package that:

* **Mandates Freedom of Choice Information.** Hospitals, physicians, and other health care providers, should be required to give patients full information about the availability of Medicare certified home health agencies serving the areas in which the patients reside, and should be prohibited from steering patients to certain agencies.

* **Prohibits Home Health Agencies from Assisting Physicians in Care Billing.** Home health agencies should be prohibited from providing record keeping and bill preparation services to physicians for their role in home care.

* **Requires Home Health Care Administrators to Meet Certification and Accreditation Standards.** The last several years have seen an unbridled growth in the number of Medicare certified home health agencies. Home care agency administrators should be required to meet high and rigorous standards for all aspects of running an agency, including knowledge of issues that affect quality of care.

* **Strengthens Worker Screening Requirements to Include Federally Funded Criminal Background Checks for all Home Visiting Staff.** An organized system for criminal background checks should be developed which is reasonable in cost and will provide up-to-date information in a timely manner. Some states have required criminal background checks for home care aides only. NAHC recommends that criminal background check laws should cover all home visiting staff; there is currently no uniform mechanism through which other staff (such as nurses and therapists) are checked.

CONCLUSION

NAHC urges the Congress to consider preventive measures to combat fraud and abuse along with the anti-fraud laws they have strengthened in recent times. Preventive measures directed at the systemic problems that allow fraud and abuse to occur will gain more for the Medicare program than efforts which merely increase sanctions against offending parties.

While NAHC regrets the fact that we could not review the government reports released by the Committee today, we look forward to working with members of the Committee in developing sound anti-fraud legislation that effectively targets unscrupulous providers while ensuring that Medicare beneficiaries receive the proper level of high-quality home health services they need.

ATTACHMENT 1

HOMECARE

Consumer Tips for Recognizing, Preventing, and Reporting Fraud and Abuse

National Association for Home Care, May 1997

According to a March 1997 survey conducted for the American Association for Retired Persons by the International Communications Research Survey Research Group, the public perceives a clear self-interest in reducing health care fraud. People view fraud as costing them money, and the reduction of fraud as improving their own health care. According to the survey, 85% of the respondents say they stand ready to assist in the fight against fraud and abuse, if they only knew how.

The National Association for Home Care (NAHC) has responded to this request by providing consumers with tips for recognizing, preventing, and reporting fraud and abuse in the home care and hospice industry. Although rare, fraud and abuse does exist. NAHC believes that educating patients about the need to protect their health benefits contributes a valuable service that will assist in ensuring availability of funds for medically necessary patient care in the future.

How can consumers recognize health care fraud?

Fraud can be defined as knowingly and willfully making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. Some examples of fraud include:

- submitting bills for services that were not furnished or supplies that were not provided;
- altering claims forms or receipts to receive higher payments;
- submitting duplicate bills to a payor or submitting a bill to multiple payors for the same service;
- falsifying patient or physician signatures; and
- misrepresenting noncovered services, intending to bill as services covered.

How can consumers recognize health care abuse?

Abuse consists of practices that result in unnecessary costs to health care because services and supplies were not medically necessary or did not conform to professional standards of practice or because they were not provided at a fair price. Some examples of abuse include charging in excess for services or supplies; providing services or supplies that were not medically necessary; and failing to fulfill the requirements of the formal agreement the provider has with the government or insurance company.

How can consumers protect themselves from potential fraud and abuse?

For individuals who require home care or hospice services, the first step to avoid fraud and abuse is to select a reputable agency. They should determine how long a provider has been serving their community and whether that provider is licensed, accredited, and/or certified by Medicare. In addition, consumers should request and review providers' written materials describing services, eligibility requirements, fees, funding resources, and patient-rights statements. NAHC recommends ongoing monitoring and vigilance. To help consumers in selecting a home care or hospice agency, NAHC distributes free of charge the publication *How to Choose a Home Care Provider: A Consumer's Guide*. Interested consumers should write to NAHC, *Consumer Guide*, 228 Seventh Street, SE, Washington, DC 20003.

How can consumers participate in preventing health care fraud and abuse?

Consumers who are informed of what constitutes fraud and abuse can take measures to protect themselves and their health insurance benefits. These measures include:

- requesting and reading benefit brochures from their insurance companies or Medicare offices to understand the coverage to which they are entitled;
- working with their doctors, hospital discharge planners, or community agencies

to find home care and hospice providers that have good reputations and are able to deliver services to meet their needs;

- knowing their rights and responsibilities when arranging for home care and hospice services and supplies;
- giving health care insurance information or numbers only to service providers whose identity they can verify as providers of necessary health care services;
- refraining from signing any papers unless they have read them thoroughly;
- requesting information in writing that spells out how a provider will bill for all services and supplies and any personal liability for payment;
- taking an active part in planning for home care and hospice services, including the type and amount of services and supplies to be provided;
- refusing to give in to pressure to accept unneeded items and services;
- checking with doctors if agencies provide services or supplies not requested;
- keeping a record of services or supplies provided on a calendar or log if the provider does not give copies of receipts or written records; and
- reviewing statements sent by health insurance companies to verify that payments accurately reflect services and supplies received.

Where can consumers report instances of fraud and abuse?

If consumers suspect questionable practices by any health care provider, their first step is to contact the provider to have the questions and concerns resolved. If the provider does not supply satisfactory answers, consumers should take additional action:

- Make the complaint a matter of public record. Contact the appropriate agencies, such as the city, county, or state consumer affairs or protection offices, or get in touch with the state attorney general.
- If the community has a Better Business Bureau, register the dissatisfaction there.
- If the workers or agencies at fault are licensed or certified, or if an agency is accredited, notify the accrediting organization.
- Report any suspicion of fraud, even on the slightest scale, to the state department of health. If a case involves the delivery of Medicare home care or hospice services, contact the Office of the Inspector General hot line at 800/HHS-TIPS.

HOMECARE

ATTACHMENT 2

Home Health & Hospice Fraud: Fiction Versus Fact

National Association for Home Care, May 1997

***FICTION:** Home care and hospice are, for the most part, highly unregulated industries. As a result, fraud and patient abuse are widespread and unchecked.*

FACT: Nearly half (9,120) of all identified home care entities and approximately 90% (2,090) of all hospice agencies are Medicare certified, which means that they must meet rigorous standards set by the federal Department of Health and Human Services (HHS). Many noncertified agencies also are subject to rigorous standards through private accreditation or state legislative requirements. Additionally, many states have certificate-of-need laws that limit the number of new home care agencies and hospices when need cannot be established.

***FICTION:** Forty percent of home care visits paid for by Medicare were for services that either were never delivered (fraudulently billed) or were delivered to individuals not eligible for those services.*

FACT: The 25%–40% figure that HHS Secretary Donna Shalala recently cited is based on a 1995 HHS Office of the Inspector General (OIG) study of a small sampling of agencies in Florida. The results of this study, however, cannot be applied to the broader population of home care agencies nationwide. The Health Care Financing Administration's (HCFA) own data indicate that in 1995, out of more than 300 million visits rendered, a mere 0.2% of home health visits were denied on the basis that they were deemed not necessary. In addition, recent data indicate that Medicare intermediaries reverse 40% of claims during rereview of their own denials, and administrative law judges reverse 80% on appeal.

There is no discernible way to quantify the amount of fraud in the home health industry or in our federal health programs in general. Most estimates place the amount of fraud in the Medicare and Medicaid programs at less than 10%.

***FICTION:** Sixty-five percent of the patients under hospice care for longer than 210 days did not qualify for the hospice benefit because it was determined that they were not terminally ill at the time of admission.*

FACT: That 65% figure, which an OIG representative recently cited, is based on an ORT audit of nursing home patients—not all patients—in just four hospices. The OIG has since clarified this statement, saying "In certain selected hospices, 65% of the nursing home Medicare beneficiaries that were on hospice care more than 210 days were not eligible for the hospice program at the time of admission to the hospice." It is also clear that this audit is not applicable to the broader population of hospices nationwide because of its limited sample size.

Furthermore, a growing body of knowledge supports the fact that predicting a six-month prognosis is far from an exact science. Recent studies have shown that no reliable definition of terminal illness exists and any statistical criteria for differentiating between terminally ill patients and seriously ill patients will prove "unavoidably arbitrary." There is also growing evidence that the overall national average length of stay is decreasing, both in terms of HCFA statistics as well as the numbers emerging from individual hospices.

***FICTION:** Unexplained regional variation in home health care utilization rates is the result of fraudulent providers and weak oversight in these locales.*

FACT: At a recent Congressional hearing HCFA Administrator Bruce C. Vladeck said that the variation in regional utilization could be related to the lack of other public health care programs in those areas. Vladeck noted that areas of high home health utilization, concentrated mostly in southeast states, have high utilization for all Medicare benefits. He suspects that because these areas have tougher eligibility standards for Medicaid

and other public health services, higher levels of home care exists to serve the unmet medical needs in that region.

FICTION: *Blood monitoring is the "gateway" that home care agencies use to provide more lucrative home health services.*

FACT: Receipt of additional services beyond venipuncture by eligible individuals does not constitute "abuse." Eligibility for venipuncture coverage does not automatically result in additional services being provided; an individual must meet all the criteria and these services must be prescribed by a physician. Eligibility requirements for venipuncture in HIM-11 (Medicare's Home Health Agency Manual) are quite specific. Additionally, other home health care (such as home care aide services) play an important role in maintaining stable functioning of these patients. Without such services, many of these individuals would wind up in long-term nursing facilities or could experience a series of acute-care episodes that move them in and out of emergency room hospital care.

FICTION: *Medicare home health and hospice expenditures continue to grow primarily because of fraudulent activities.*

FACT: The Medicare home care and hospice programs have grown dramatically in recent years, and many factors have contributed to that growth. Demographics show that the number of elderly and disabled is increasing. Hospitals are discharging acutely ill patients more quickly, moving them to a less intensive care setting. Nursing home use is declining. More patients and physicians are aware of home care and hospice. Technological advances are permitting more services to be delivered at home. Legislative changes and judicial rulings have made home care and hospice more broadly and readily available. Finally, for most people, home is the preferred setting for health and supportive services.

FICTION: *Home health care and hospice expenditures comprise a large portion of total Medicare spending.*

FACT: Home health care expenditures are less than 10% of the total Medicare budget, less than 4% of total national health care expenditures. Hospice expenditures are less than 2% of the Medicare budget.

FICTION: *Home health care services paid for by Medicare are mostly personal care services and have no relationship to medical need.*

FACT: Less than half (48.7%) of home health care services are delivered by home care aides (HCAs). Home care aides help patients with activities of daily living such as getting in and out of bed, walking, bathing, toileting, and dressing. This hands-on care helps patients live with dignity and a sense of independence in their own homes. HCAs make it possible for families to remain together. They help keep people at home, where they are happier and healthier than in institutions. In addition, these services help to avoid emergency hospitalization and short-term or long-term nursing home placement. This care is only available to individuals who have a skilled-care need (skilled nursing or therapy), are confined to the home and meet other stringent criteria, and for whom a physician has prescribed such care.

FICTION: *Home health care was originally intended for individuals who had an acute care hospitalization. Most home health care covered by Medicare is currently provided without a prior hospitalization and is therefore either not necessary or is long-term care and should not be charged to Medicare.*

FACT: The United States health care system has undergone considerable change in the last 15 years. Incentives have shifted away from hospitalization, and technological advances allow many procedures to be performed outside of the hospital. Additionally, home care can help to stabilize infirm patients so that hospitalization

may be delayed or avoided altogether. Patterns of home care use reflect these trends and indicate that, in fact, home care has been responsive to changing patterns of health care in the United States.

FICTION: *The public believes that fraud in the home care industry is widespread.*

FACT: According to a March 1997 survey conducted for the American Association of Retired Persons, the American public believes a "great deal" of health care fraud is committed by pharmaceutical companies (33%), insurance companies (29%), medical equipment companies (28%), and hospitals (28%). These are followed by doctors (22%) and patients/consumers (21%). Interestingly, home health care companies were not high on the respondents' list (18%), while government officials see this area as "particularly susceptible to fraud."

FICTION: *The best way to combat home care overutilization is to impose a copayment on home care beneficiaries.*

FACT: Copayments fall most heavily on the poorest and oldest Medicare beneficiaries and would create strong barriers for those who most need home care. Many poor elderly who need care would go without, leading to possible hospitalization or nursing home admission. Home health care was exempted from the Part B coinsurance in 1972 to encourage use of less-costly, noninstitutional services. Reimposing a copayment would dramatically undermine that effort.

In recent testimony before the House of Representatives Commerce Committee, HCFA Administrator Bruce Vladeck stated his opposition to home care copayments. He states that they would have "a disproportionate effect on low-income beneficiaries" and would "discourage needed utilization as well as needed services." In addition, Vladeck expressed concern "with the federalism aspect" of the proposal because the cost of the copayment would shift to the states for low-income, qualified Medicare beneficiaries. He also stated opposition to a means-tested copayment that would only be assessed on high-income home health care beneficiaries. Additionally, home care copayments would be difficult and costly for agencies to administer.

FICTION: *The home care industry is unwilling to consider changes to Medicare that would increase efficiencies in the home health care benefit.*

FACT: The home health care industry has developed and endorsed a prospective payment system (PPS) as an alternative to copayments and bundling and as a mechanism to control costs within the Medicare benefit. PPS, by providing desirable, market-like incentives that encourage the efficient and effective provision of care, would avoid the administrative complexity and the potential for overutilization present in the current cost-based reimbursement system.

The revised unified PPS plan, which the National Association for Home Care (NAHC) and a majority of the home health care industry supports, promotes efficiency and preserves access to quality home care services.

ATTACHMENT 3

HOMECARE

National Association for Home Care
CODE OF ETHICS

PREAMBLE

The National Association for Home Care (NAHC) was founded with the intention of encouraging the development and the delivery of the highest quality of medical, social and supportive services to the aged, infirm and disabled.

In the process of bringing these essential services to the needy, the Association and its members seek to establish and retain the highest possible level of public confidence.

This Code of Ethics, adopted by the NAHC Board of Directors in September 1982, serves as a statement to the general public that the Association and its individual members stand for integrity and the highest ethical standards.

This Code of Ethics serves to inform members and the general public as to what are acceptable guidelines for ethical conduct for home care agencies and their employees.

It is inherent in the promulgation of this Code of Ethics that the Association and its members convenant to protect and preserve the basic rights of their patients and to deal with them in an honest and ethical manner.

Finally, the Code of Ethics serves as notice to government officials that the Association expects its members to abide by all applicable laws and regulations. It is a precondition of membership in the Association that they do so and that failure to comply will result in expulsion from membership in the Association in addition to other penalties prescribed by law.

The Code of Ethics is intended to serve as a guideline to agencies in the following areas:

A. Patient Rights and Responsibilities

B. Relationships to Other Provider Agencies

C. Responsibility to the National Association for Home Care

D. Fiscal Responsibilities

E. Marketing and Public Relations

F. Personnel

G. Legislative

H. Hearing Process

A. PATIENT RIGHTS AND RESPONSIBILITIES

It is anticipated that observance of these rights and responsibilities will contribute to more effective patient care and greater satisfaction for the patient as well as the agency. The rights will be respected by all Agency personnel and integrated into all Home Care Agency programs. A copy of these rights will be prominently displayed within the agency and made available to patients upon request.

1. The patient is fully informed of all his rights and responsibilities.
2. The patient has the right to appropriate and professional care relating to physician orders.
3. The patient has the right of choice of care providers.
4. The patient has the right to receive information necessary to give informed consent prior to the start of any procedure or treatment.
5. The patient has the right to refuse treatment within the confines of the law and to be informed of the consequences of his action.
6. The patient has the right to privacy.
7. The patient has the right to receive a timely response from the agency to his request for service.
8. A patient will be admitted for service only if the agency has the ability to provide safe professional care at the level of intensity needed. The patient has the right to reasonable continuity of care.
9. The patient has the right to be informed within reasonable time of anticipated termination of service or plans for transfer to another agency.
10. The patient has the right to voice grievances and suggest changes in service or staff without fear of restraint or discrimination.

    A fair hearing shall be available to any individual to whom service has been denied or reduced or terminated or who is otherwise aggrieved by agency action. The fair hearing procedure shall be set forth by each agency as appropriate to the unique patient situation (e.g., funding source, level of care, diagnosis).
11. The patient has the right to be fully informed of agency policies and charges for services, including eligibility for third party reimbursements.
12. A patient denied service solely on his inability to pay shall have the right of referral.
13. The patient and the public have the right to honest, accurate forthright information regarding the home care industry in general and his chosen agency in particular, e.g., cost visit, employee qualifications, etc.

B. RELATIONSHIP TO OTHER PROVIDER AGENCIES

1. The principle objective of Home Care Agencies is to provide the best possible service to patients. gencies shall honestly and conscientiously coop- erate in providing information about referrals and shall work together to assure comprehensive services to patients and their families.
2. Members shall engage in ethical conduct of their affairs so that maximum fair trade occurs.

C. RESPONSIBILITY TO NAHC

1. The Bylaws and policies of NAHC reflect mutual cooperation among members in attaining goals that assure quality care for the patient and family. The members of NAHC shall abide by those Bylaws and policies. Adjudication or arbitration procedures of the Association shall be used to resolve ethical complaints between members as provided in Section "H" of this document.
2. Members shall promptly pay all dues owed for membership, and shall participate and contribute talent to foster a dynamic, progressive organization from which all members can benefit professionally.

D. FISCAL RESPONSIBILITIES

1. The amount of service billed is consistent with amount and type of service provided.
2. The cost per visit includes only legitimate expenses.
3. The medical equipment sold or rented to patient is provided at the lowest possible cost consistent with quality, quantity, and timeliness.
4. The salaries and benefits of the provider and administrative staff shall be consistent with the size of the agency, responsibility and geographical location.
5. The provider shall not engage in "kick-backs" and "pay-offs."
6. The provider shall submit dues to NAHC based on the actual revenues received from all Home Care activities for the previous year.

E. MARKETING AND PUBLIC RELATIONS

1. Oral and written statements will fairly represent service, benefits, cost and agency capability.
2. Agencies which promote their service in the public media shall include information descriptive of home care in general, as well as agency specific information.

F. PERSONNEL

1. The agency shall be an equal opportunity employer and comply with all applicable laws, rules and regulations.
2. The agency shall have written personnel policies available to all employees and uniformly applied to all employees.
3. The agency shall provide an on-going evaluation process for all employees.
4. The agency shall hire qualified employees and utilize them at the level of their competency.
5. The agency shall provide supervision to all employees.
6. The agency shall provide continuing education and in-service training for all employees to update knowledge and skills needed to give competent patient care.
7. The agency shall hire adequate staffing to meet the needs of the patients to whom they render care.
8. The agency shall have a pay scale that is consistent with the area and pay only for those expenses for travel and business that are within a reasonable norm.

G. VIOLATIONS

Members who have been determined under the provisions of Section "H" to have violated this Code shall be subject to disciplinary action, suspension and/or expulsion from the National Association for Home Care.

H. HEARING PROCESS

In the event of an apparent breach of conduct reflected in this Code or any dispute arising out of allegations of misconduct, redress will be provided in the form of a hearing before an Ethics Committee composed of at least three disinterested parties.

The Committee shall be appointed by the Chairman of the Board and approved by the Board of Directors to hear specific disputes. The Committee shall be non-continuous, dissolving at the conclusion of its appointed task. Service on the Committee shall be restricted to representatives of agency members of NAHC in good standing.

The Committee by majority vote may suspend or expel a member from the National Association for Home Care or fashion other forms of disciplinary action which are less severe if justified by the Committee's finding of fact.

Judgments of the Committee shall be final and binding with respect to the provisions of this Code. The Committee shall be bound by all the common requirements of due process including but not limited to giving the accused a statement of the charges against him or her, an opportunity to appear on his/her own behalf, proper notice of the time and place for any hearing to be conducted by the Committee, the right to suggest witnesses to be heard by the Committee and the right to representation by counsel with the understanding that counsel may appear to advise his/her client but may not actually testify on behalf of his/her client.

The Committee may require the testimony of individuals under oath administered by a duly qualified notary public. However, if the Committee elects to proceed in this manner, the entire proceeding must be transcribed and retained in the files of the Association.

An accused faced with disciplinary action may appeal the Committee's ruling to the full NAHC Board of Directors. The Committee's decision will be sustained unless two-thirds of the members of the Board, a quorum being present, vote to overturn the decision.

The CHAIRMAN. With that, I will adjourn the hearing.
[Whereupon at 4:15 p.m., the committee was adjourned.]

APPENDIX

OFFICE OF INSPECTOR GENERAL RESPONSES TO SENATOR COLLINS QUESTIONS

Question. Our witness on the first panel did not really answer my question about the relationship between the Federal auditors and her company. You mentioned that the indictment against Healthmaster charged the company with "obstruction" of a Federal audit. Could you elaborate a bit more on the circumstances behind those charges?

Answer. The indictment charges that one of the Healthmaster company officials made the services of prostitutes available to three auditors representing Aetna, the Medicare contractor. The prostitutes approached the auditors at an Augusta motel during the May, 1991 audit of Healthmaster, Inc. The company official hired the prostitutes to attempt to influence, obstruct, and impede the Aetna auditors in the performance of their official duties relating to Healthmaster.

Question. Our first witness told us how her home health agency billed Medicare for—among other things—pleasure trips to Las Vegas and New York and a luxury automobile for her son. Can you explain how Medicare's current method for reimbursing home health agencies makes it possible for unscrupulous providers to take advantage of the system in this way?

Answer. Home health agencies are reimbursed on the basis of information supplied in the form of a cost report. This cost report requests specific financial information, summarized in a prescribed format. The support for the information summarized in the cost report is required to be kept on file by the provider. These summary figures can hide a multitude of unallowable costs that any unscrupulous provider is willing to include. Until an audit of the supporting files is conducted, none of these costs are visible to a HCFA contractor administering the program.

Question. How often are cost reports audited? Are they audited routinely or only when a problem is suspected?

Answer. Cost reports for home health agencies are reviewed routinely. However, there are many types of reviews that may be performed. It all depends upon the level of documentation requested. These routine reviews are sometimes called "desk" audits. The person conducting the review, merely reads the submitted cost report to make sure that all of the information is provided and that, as submitted, the information appears correct and there are no obvious errors or inappropriate items included. The intermediaries vary with respect to the frequency with which the routine desk audits are conducted. Many intermediaries do the audits annually but it can be as infrequent as once every three years. Depending upon the results of these desk audits, a more detailed review can be required, including visits to home health agency offices. But even if these schedules were adhered to, there is ample opportunity for unscrupulous providers to take advantage of the system. For instance, in the case of field visits, only the headquarters is usually visited, not the branch or field offices where the detailed data is kept. Even if caught with unallowable submitted costs, most providers are assessed an overpayment, provided information on proper cost report preparation, and allowed to continue billing. Only the most egregious are prosecuted either administratively or criminally.

Question. As you know, home health visits are currently not subject to copayments or deductibles. The Senate recently included a $5 per visit beneficiary copayment for home health services in its version of the budget reconciliation bill. Like a number of my colleagues, I opposed this copayment because I was concerned that it would have a disproportionate affect on our most vulnerable Medicare beneficiaries. I was also concerned that it would only serve to discourage appropriate use of the benefit and would do nothing to address the systemic problems we have heard about today. Do you think that the imposition of a beneficiary copayment would do much to address the problems the IG and GAO have identified with the Medicare home health program?

Answer. Reasonable people disagree about the effectiveness of copayments to control costs. For instance, one of the main problems with home health agencies is over utilization due to unnecessary services and billing for services not rendered. In the current system, the beneficiary will be notified of services being billed on their behalf, but will not be aware of the amount of billing. Thus, the imposition of a copayment might alert the beneficiary to the cost as well as the level of services and could cause them to question the validity of any billing for non-rendered or unnecessary services. It is illegal for a provider to routinely waive copayments, thus providing some assurance the beneficiary will be notified. On the other hand, we are not aware of any hard evidence that shows copayments to be an effective deterrent to unnecessary services, at least as currently implemented. Use of Medigap insurance policies, purchased by beneficiaries to cover copayments and deductibles, is an example of how a copayment's effectiveness can be eroded. In any event, during budget reconciliation negotiations, we wanted to provide policy makers with all options available to reduce waste and abuse in the home health care program, and copayments was one option which was put forth for discussion and debate.

GAO RESPONSES TO SENATOR COLLINS QUESTIONS

Question. It is estimated that 83 percent of the overall growth in home health agencies in recent years is due to new, for-profit home health agencies. Is there any evidence that proprietary agencies are more likely to be "problem" providers?

Answer. We reviewed ownership information for home health agencies targeted under three Operation Restore Trust (ORT) studies that focused on HHAs with aberrant billing practices or utilization patterns. HCFA's Dallas regional office conducted two of the studies while its San Francisco regional office conducted the third study. We found that proprietary HHAs comprised a disproportionate share of all the HHAs targeted in each study, but not always by a great amount. We based our calculations on the percentage of proprietary HHAs in 1994 in each State included in the studies—the latest information we had available regarding the type of ownership of HHAs within a State. Also, HCFA and Medicare contractors that process and pay home health claims used 1994 claims data to help identify potential HHAs for inclusion in each study.

In both Dallas studies HCFA targeted HHAs that had aberrant billing practices or other problems compared to their peers. In the first study, involving a total of 74 HHAs located in Louisiana and Texas, 81 percent (60) were proprietary, or slightly more than the 76 percent of all HHAs in the two States in 1994 that were proprietary. In the second study covering HHAs located in Louisiana, Tennessee, and Texas, 90 percent of the 62 targeted HHAs were proprietary versus the 75 percent of all HHAs in the three States that were proprietary in 1994. Similarly, proprietary HHAs included in the San Francisco ORT study comprised a disproportionate share of the targeted HHAs. About 84 percent (37 of 44) of the targeted HHAs in California were proprietary compared to 63 percent of all California HHAs in 1994. This ORT study targeted HHAs with apparent aberrant utilization patterns and primarily focused on quality of care issues. Of the 21 HHAs terminated from the Medicare Program as a result of this ORT study, all but one was a proprietary agency.

Question. Are there any quality of care issues raised by your investigations? For instance, in your written testimony you indicate that your audit found that 6 percent of services for which Medicare billed did not have valid physician orders. I would think that this would have tremendous implications for patient care.

Answer. Our review showed that the survey and certification process does not ensure that only those health agencies that provide quality care in accordance with Medicare's conditions of participation remain certified. Medicare initially certifies home health agencies before they have demonstrated a sustained capability to provide quality care to patients. It is not uncommon for Medicare to initially certify an agency when that agency only has one patient, has been in operation for a short period of time, and has not delivered all of the services that it seeks to be certified to deliver.

Further, certified agencies that provide substandard care year after year may remain in the program because they have supposedly taken action to correct their deficiencies in meeting Medicare's conditions of participation. Yet, when surveyors return to these agencies to conduct the next recertification survey, they often find that the agency is again deficient. As we noted in our testimony, agency that repeatedly had difficulties meeting the conditions of participation was not terminated until one of its patient's died from inadequate care provided by the agency.

Question. In your testimony, you state that HCFA's standard survey addresses a home health agency's compliance with 5 of the 12 conditions of participation, plus one of the standards associated with a sixth condition that HCFA believes best evaluates patient care. Are the same 5 conditions of participation always included in the standard survey? How often do surveyors review the remaining seven conditions of participation? Isn't this a little like the professor who gains a reputation for always asking the same question on the final exam? Students know that they will only be held accountable for those questions and can ignore everything else.

Answer. Yes, the standard survey always consists of reviewing an agency's compliance with the following five conditions of participation: (1) Patient rights; (2) Compliance with Federal, State, and local laws; (3) Acceptance of patients, plan of care and medical supervision; (4) Home health aide services, and (5) Clinical records. Additionally, one standard—coordination of patient services—under the Organization, services and administration condition is also reviewed during a standard survey.

Surveyors rarely review an agency's compliance with the remaining conditions of participation. If surveyors find that an agency is out of compliance with one or more conditions when conducting a standard survey they are supposed to expand the survey and examine the agency's compliance with the remaining conditions. However, each year only about 3 percent of all agencies are cited for being out of compliance with Medicare's conditions of participation and thus may have been reviewed for compliance with all 12 conditions.

While HCFA has the authority to review an agency's compliance with all conditions of participation at any time, this is rarely done. As a result, home health agencies know what areas of their operations will be reviewed when undergoing a recertification survey and can concentrate on ensuring that these areas are in compliance with Medicare's participation requirements.

Question. Based upon the results of the Operation Restore Trust project in California, would you say that fewer home health agencies would be certified if all 12 conditions of participation were included in the standard survey?

Answer. We believe that fewer agencies would likely be initially certified if held accountable to more than the five conditions and one standard associated with a sixth condition that are reviewed in a standard survey. The actual decision to certify an agency as a Medicare provider is based on very limited information. Although HHAs are required by law to meet all 12 conditions, Medicare's initial certification process occurs too early in the life of an agency, does not encompass a complete review of an agency's operations, and covers less than half of Medicare's conditions of participation. It should be recognized, however, that some conditions which specifically address quality of care issues simply cannot be reviewed until after the agency has been operational over a period of time.[1]

The California ORT study found that almost half of the targeted agencies failed to comply with one or more of the conditions excluded from review in a standard survey and almost half were terminated from the program. If similar targeting approaches were employed, it would not be unreasonable to expect that fewer agencies would remain certified if they were assessed against all 12 conditions of participation rather than just those covered in a standard survey.

Question. Do you think that the California HHAs would have done a better job if they had known that they could be held accountable for all twelve conditions of participation?

Answer. It would seem reasonable to expect that any organization would pay more attention to complying with the conditions of participation it knows it will be assessed against.

Question. Do home health intermediaries routinely communicate with state surveyors? For instance, do they routinely identify potential "at risk" providers—providers with particularly high utilization rates for instance so—that state surveyors can better target their resources? Do state surveyors routinely share information about problems they have identified with the intermediaries' anti-fraud units? Would better communication between surveyors and intermediaries enhance our efforts to combat fraud and abuse in the home health program?

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[1] For example, one of these conditions requires a group of professional personnel to establish and annually review agency policies and operations. This group is also to meet frequently to advise the HHA on professional issues, program evaluation, and liaison with other health care providers. Another condition requires an overall evaluation of the agency's total program at least once per year by the group of professional personnel, HHA staff, and a consumer representative. This evaluation must assess the extent to which the agency's program is appropriate, adequate, effective, and efficient. Also, health professionals must review a sample of active and closed clinical records at least quarterly to determine whether established policies are followed.

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Answer. We reported in 1989 that the regional home health intermediaries (RHHIs) developed information which would be useful to state survey agencies in assessing compliance with the conditions of participation and had recommended that HCFA establish a procedure to give that information to state surveyors.[2] Until the advent in 1995 of ORT activities in several States, however, RHHIs did not routinely provide surveyors with information that indicated potential quality of care deficiencies nor did state survey agencies routinely share the results of their surveys with the RHHIs.

Improved coordination between state survey agencies and RHHIs would benefit the Medicare Program. State survey agencies routinely conduct on-site reviews of HHA operations. While reviewing an agency's compliance with the conditions of participation, surveyors may also identify claims payment issues not associated with certification, such as beneficiaries who are not homebound and who therefore do not qualify for services, or beneficiaries receiving supplies that are not used or needed, or agencies providing services that were not ordered by a physician. Such information would be useful to RHHIs who process and pay home health claims for Medicare: Conversely, RHHIs develop information under their program integrity efforts that are indicators of potential quality of care problems at an agency. For example, through their claims analyses, RHHIs deny payment because agencies are providing unnecessary services to beneficiaries. If the services are unnecessary, agencies may not be appropriately assessing the beneficiary's care needs which is a certification issue. Recent ORT studies in California and Texas demonstrated the effectiveness of increased communication sharing between state survey agencies and RHHIs.

HCFA regional office staff in San Francisco targeted 44 agencies for inclusion in an ORT study based to a significant extent on information supplied by the 2 RHHIs serving agencies in the State. Specifically, the RHHIs developed a rank-order list of agencies with the highest per patient charges and visits per patient and also supplied information about potential fraud and abuse issues at specific agencies. Surveyors found most of the 44 targeted agencies out of compliance with multiple conditions of participation and almost half are no longer in the program. HCFA's Dallas Regional Office conducted two studies that were intended to promote increased communication and cooperation between the state surveyors and the RHHI. As in California, the RHHI targeted agencies based on high utilization patterns and other factors and provided billing information to the surveyors before they conducted surveys at these agencies. Unlike California, the primary focus of these studies was on whether claims were appropriately supported rather than the survey and certification process itself. Surveyors through their on-site reviews at the targeted HHAs, provided information to the RHHI of potential coverage problems and other indicators of fraud and abuse. From these 2 studies the RHHI denied a significant number of claims with estimated savings totalling several million dollars.

MEDICARE RESPONSES TO SENATOR COLLINS QUESTIONS

Question. As you know, we have reduced the number of home health intermediaries in recent years. Have we perhaps gone a bit too far? Do these intermediaries have sufficient resources and personnel to adequately monitor the increasing numbers of home health providers and home health claims?

Answer. The reduction in the number of regional home health intermediaries (RHHIs) is not the problem. The problem has been the annual reductions and instability in funding to all Medicare contractors. In the case of RHHIs, these reductions have prevented all of us from staffing up to do more onsite audits and other important functions that could have helped to lessen the backlog of problems now existing. We have felt hand-cuffed in our overall ability to monitor provider activities and payments in recent years.

With fewer and larger RHHIs, economies of scale now allow us to keep administrative costs lower. It is very difficult for a small Medicare contractor to carry out all of the varied responsibilities within their limited budgets. It is not likely that smaller contractors, unless performing some very specialized functions under different budget methodology, will be able to survive if HCFA's budget targets go any lower.

There just isn't enough money to do all that is needed. The number of providers and the fraud and abuse problems have increased while intermediaries' budgets have decreased.

[2] *Medicare: Assuring the Quality of Home Health Services*, (GAO/HRD–90–7, Oct. 10, 1989.

I don't believe that throwing money at a problem is usually a good solution; but not having had enough money to do an adequate job is a major reason for the problems we now experience.

Question. Do home health intermediaries give as much priority to anti-fraud efforts as they do to the paying of claims?

Answer. Obviously, claims must be paid. And it is a priority to see that they are paid accurately and timely. It is preferable to pay "right" rather than to "pay and chase".

There is funding designated for Program Management functions (including claims processing) that is separate from funding for Medicare Integrity functions. The amount to be spent in each area is determined as part of the annual budgeting process.

It is somewhat easier to determine the amount of money needed for the claims processing function than it is for the more open-ended anti-fraud efforts. However, reductions have occurred annually in both areas. Both have historically been underfunded, staffing has had to be reduced, and intermediaries are constantly challenged to be more efficient to accomplish the workload.

Intermediaries place a high priority on both areas and do as much as can be done within the money allotted for each of the functions.

Question. What kind of threshold do you use to determine when an investigation into a pattern of questionable practices is warranted? What criteria do you use in determining whether a case should be turned over to the OIG?

Answer. *Thresholds for Investigation.* Various thresholds may be used for determining when an investigation of questionable practices is warranted. One that is given the most weight is the known or estimated monetary impact to the Medicare Program. Obviously, an aberrant pattern that is unique to one provider and does not represent a lot of money would be given a lower priority than an issue that involves a number of providers and higher potential overpayments. The amount of the monetary threshold will vary depending on the type of provider, the geographic location, the type of service, and the amount of resources available by the contractor for audit and review work.

If an issue involves a national investigation of a particular provider or issue, it will be given a higher priority.

Health risks to Medicare beneficiaries are also taken into account. An issue that involves unnecessary invasive surgery would be given a higher priority than issues that involve only upcoding.

A provider that has been previously audited or investigated and received either administrative, civil, or criminal penalties, would be given a higher priority.

Referring Cases to the OIG. HCFA has established criteria for Medicare contractors to use in determining if the OIG should be contacted *immediately* whenever certain allegations or situations arise. These are:

- Contractor employee fraud
- Informants who are employees of former employees of the provider
- Providers who have prior convictions or are currently under investigation by law enforcement
- Schemes by a provider that affect more than one contractor
- Kickbacks, bribes, or crimes by Federal employees
- Involvement by organized crime
- Sensitive issues and those likely to get widespread publicity

Otherwise, we contact the OIG about cases where there may be intent to commit fraud. For instance, personal or other expenses that are obviously not related to serving Medicare patients, but are claimed on the Medicare cost report; continuing or recurring claims coding problems, such as upcoding or misclassifying the service or diagnosis, when the contractor has previously noted similar problems with the provider through formal audits of, and reports to, the provider.

The nature of the problem is also taken into account. An issue that involves medical necessity is less likely to be referred to and accepted by the OIG, than cases that involve services that were billed to Medicare but never performed.

The dollar amount of the cases is a factor. A case that involves tens of thousands of dollars would most likely not be referred to and accepted by law enforcement in Los Angeles. However, the same cases would be referred to law enforcement in South Dakota.

Question. You mentioned that your resources were sufficient to conduct only 50 onsite medical reviews in fiscal year 1996. Do you routinely communicate with the state survey and certification agencies? Would better communication help you to make better use of your resources?

Answer. Communication and coordination with state surveyors has greatly improved since the occurrence of the Operation Restore Trust (ORT) and the Wedge projects in selected States. Fiscal intermediaries have been training state surveyors in those States to carry out medical review audits and the surveyors now make recommendations back to the Fiscal Intermediaries based on those reviews. Trained surveyors also are now able to even identify some reimbursement issues in addition to quality issues as they make routine visits. We look forward to the expansion of ORT to conduct additional reviews in more locations.

BOBBY JINDAL RESPONSES TO SENATOR COLLINS QUESTIONS

Question. How can beneficiaries and their families do a better job of helping you to identify fraud and abuse in the home health program? What should they look for?

Answer. Beneficiaries and families can be a tremendous source of information in combating fraud and abuse.

a. Beneficiaries need to remember they are consumers and have every right to know what home health services they are to receive, the frequency, who is to deliver the service and what they should expect as an outcome of this service. They should ask these questions at the start of home health services and anytime they feel a change has taken place in some aspect of care or services.

b. Beneficiaries should request, from the agency, copies of the plans of care sent to their physicians. This enables the patients or caregivers to see if the patients have been represented correctly to the physicians and/or the payor source(s), while also allowing them to verify the frequency and types of services they should be receiving.

c. The patient or family should periodically request from the agency a summary of the billing sent to the payor source. If the fiscal intermediary reviewing the home health claims sends a billing summary to the patient for review, the patient or family should carefully review this for any discrepancies in services rendered or billed.

d. The patient or family member should be required to validate each visit to the home by a nurse or other discipline. This is done in our State by a requirement that agencies obtain the signatures of the patients or responsible parties at each visit. The families should keep their own logs of the dates of visits by the home health staffs.

Question. Is Louisiana seeing the same kinds of fraud and abuse in its Medicaid home health program that we have seen in Medicare?

Answer. During the on-site survey visits made to home health agencies we see the same scenarios continuously occurring whether the service is paid for by Medicaid or Medicare: patients not homebound, services rendered and not needed, patient not being assessed properly, and patients being either over-served or under-served. However, the State has created many safeguards within the Medicaid Program so that approximately one-half of our providers get little or no revenue from the State. We are seeing more abuse in the Medicare Program, even as Medicaid regulations have gotten tougher and more effective.

Question. Do problem providers tend to be problems for both programs?

Answer. Definitely! A problem provider will be non-compliant regardless of payor source. A provider that does not oversee the services they provide or their business operations will continue to do so whether the patients they are servicing are Medicaid or Medicare beneficiaries. Additionally, if the agency has problems remaining compliant with regulations, this will affect both their Medicare and Medicaid provider agreements.

Question. How do you coordinate your anti-fraud and abuse efforts at the State level with Medicare?

Answer. Our state survey agency (Health Standards Section) has been very involved for three years now in fraud and abuse efforts involving the Medicare regional home health intermediary for this state and HCFA. (Reference: Pilot Initiatives) It has become a routine procedure for our state agency surveyors to make referrals on any suspected instance of fraud or abusive billing practice that is found during our on-site visits to home health agencies. This referral is made to the Medicaid or Medicare unit as determined by the payor source for the services that are suspect.

Since mid-1995, this State has had a task force that meets quarterly to share and discuss current trends and findings of Medicaid/Medicare fraud and abuse. This task force is made up of many different agencies: Medicaid Program Integrity, A/G, OIG, DHH, Medicare and Medicaid intermediaries, FBI, U.S. Attorneys, and HCFA. These meetings have fostered an understanding of the areas of responsibility of the different agencies and allowed for a sharing of information which prevent a

duplication of efforts in some instances and support a coordination of efforts in others.

These unique areas of collaboration have led to the recovery of millions of dollars and the exclusion of many providers.

Question. Does your State fraud and abuse control unit work with the Medicare fiscal intermediaries or the HHS IG?

Answer. Yes! Louisiana has formed a fraud and abuse task force that meets quarterly for the purpose of coordinating fraud and abuse activity. In addition to participation by DHH's Medicaid Office, members include representatives from Unisys (Medicaid's fiscal intermediary), Medicare carriers, State Attorney General, Federal Office of Inspector General, all three U.S. Attorney Offices, HCFA, FBI, CHAMPUS, U.S. Post Office, and other involved parties.

Question. How can State survey and certification agencies better contribute to anti-fraud and abuse efforts in home care?

Answer. All state survey and certification agencies staffs should receive training in the criteria the regional home health intermediaries use in making a determination of whether a service is eligible for payment. Most intermediaries employ health professionals to conduct medical reviews of submitted claims. As it is a HCFA requirement for all state survey and certification agencies to employ qualified health professionals, the state survey surveyors should be utilized not only in reviewing quality of care issues but also in reviewing the appropriateness of services. All state agencies should be well acquainted with their intermediaries for home health agencies and should establish a procedure to communicate to the intermediary any findings of possible abuse and aberrant billing. State agencies and regional home health intermediaries should coordinate efforts when planning to audit an abusive provider. A quality of care review should be conducted during the time a provider is being audited for billing problems. Our state pilot initiatives have proven that an agency that is an aberrant biller is very likely to be a poor provider of quality home health care.

TESTIMONY

TO THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

JULY 28, 1997

ON BEHALF OF THE

HOME CARE ASSOCIATION OF AMERICA

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Mr. Chairman and Members of the Committee,

Thank you for the opportunity to offer written testimony on the critical subject of Health Care Waste, Fraud and Abuse. My name is Dwight Cenac and I am the Chairman of the Board of Home Care Association of America (HCAA). HCAA represents over 400 freestanding home health agencies across the United States.

Mr. Chairman, members of HCAA agree with you that **nothing is more important to the integrity of Medicare than combating fraud.** Unfortunately, the Health Care Financing Administration (HCFA), under the direction of Administrator Bruce Vladeck and Special Advisor to the Administrator, Judy Berek, have been unwilling to work in a spirit of partnership with HCAA to root out fraud and abuse. In fact HCFA, under the guise of Operation Restore Trust (ORT), has been targeting freestanding, and in some cases, minority agencies to drive them out of the Medicare program without due cause and deny them any opportunity to present evidence of corrective actions before stripping the provider of their Medicare number. Now that Operation Restore Trust has been completed HCFA is now, with significant funds from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191), expanding its investigation of primarily freestanding home health agencies across the nation.

Members of Congress and HCFA are under the mistaken impression that freestanding agencies are the primary perpetrators of Medicare fraud and that the time-tested periodic interim payment (PIP) method should be eliminated. Certainly, freestanding agencies who violate the law should be prosecuted to the fullest extent of the law, and HCAA wants to work in partnership with HCFA to ensure that these thieves are out of the Medicare program. However, we would like to share these facts with the committee.

THE FOLLOWING NEWS STORIES CONFIRMS HCAA's CONCERNS :

- Cost Of Home Health Care ("More expensive for federal taxpayers when it's done by hospital- based home health care agencies")
  (Source: April 20, 1997; News - Press, Ft Myers, Fl)
- Hospitals Profit by Upcoding Illnesses
  (Source: April 17, 1997; The Wall Street Journal)
- Columbia targets $ 188 Million in home care profits and 85% of referrals
  (Source: April 8, 1997; The Wall Street Journal)
- Columbia Bills Medicare Aggressively ... Outside as well as inside the Hospital
  (Source: March 28, 1997; The New York Times)
- Columbia to partner with area docs
  (Source: March 21, 1997 Jacksonville Business Journal)
- Five Key Benefits Home Care Offers to the Hospital (*"The essence of cost based reimbursement is that hospitals are able to shift existing financial overhead existing in the hospital to the home care program which increases the costs of the agency."*)
  (Source: March /April, 1996 The Remington Report)

THE MAJOR REASON MEDICARE HOME HEALTH COSTS HAVE SKYROCKETED IS BECAUSE OF HOSPITAL-OWNED AGENCIES COMMITTING LEGAL ABUSE (OR ILLEGAL FRAUD)

Between 1994 and 1995 spending on **hospital-based home care services rose at a rate of 22.1%**, as compared to a rate of spending **growth of 8.6% for freestanding home health agencies.** The gap in spending growth between hospital-based and freestanding HHAs began widening dramatically in 1993, when the rate of growth in hospital-based HHA spending was 9.6% higher than for freestandings. In 1994, the gap grew to 11% and in 1995, the gap in year-to-year spending increases shot up to an alarming 13.5%.
(Source: February 17, 1997; home health line magazine)

HCAA believes that improper hospital self-referrals drive up costs, eliminate competition and deny patient choice. This "legalized" fraud costs our Medicare system millions (and potentially billions) of dollars, because hospital-owned agencies "double-dip" the Medicare system.

WHY DO HOSPITAL-OWNED AGENCIES COST MORE THAN FREESTANDING HOME HEALTH AGENCIES? HOSPITALS "DOUBLE-DIP" MEDICARE.

Technical Explanation of the "HOSPITAL DOUBLE-DIP:"

Under the long-standing Prospective Payment System (PPS), **hospitals are paid a predetermined amount per discharge for inpatient hospital services, identified by the diagnosis-related group (DRG) into which each patient case is classified.** With few (specified) exceptions (called "outliers"), the Medicare program intends for the DRG to cover **all operating and capital-related costs** (other than patient deductibles and coinsurance) that the hospital incurs on behalf of Medicare beneficiaries.

Hospitals which establish (provider-based/owned) home health agency components <u>also establish</u> SEPARATE HHA UNITS TO PERFORM ADMINISTRATIVE SERVICES EXCLUSIVELY FOR THE HHA COMPONENT and these separate administrative costs are directly costed to the agency. In fact many agencies have been acquired by hospitals and, as part of the acquizition, the hospital WANTS to know that EXISTING agency management will remain (home health line interview with Columbia's director of home care acquizitions-Roland Alonzo, July, 1996). In a hospital setting you have Medicare's flawed reimbursement methodology "legally" paying the hospital for both the existing costs of such administration in the agency PLUS another amount which represents the Hospital allocation of it's already existing administrative costs (called the ADD-ON costs by HCFA, see page 5 - point 7, but are more appropriately called the double dip costs by HCAA), to the newly established/acquired hospital agency. These hospital administrative ADD-ON costs were included already by Medicare in the hospital's DRG "charge"rate and are now improperly paid the hospital again (the double-dip) in it's agencies "cost" reimbursement rate.

THEREIN LIES THE PROBLEM: The hospital's inpatient charges have ALREADY accounted for the subject A&G costs (in their DRG Payment) BUT the hospital <u>AGAIN receives payment</u>--through its hospital-based home health component's COST-REIMBURSEMENT-BASED Medicare annual cost report--for these very same A&G expenses.

<u>HCAA RECOMMENDS THAT CONGRESS:</u>
Close the loop-hole allowing hospital's to double-dip Medicare (by eliminating reimbursement of existing hospital A & G costs).

Periodic Interim Payments (PIP)

In Secretary Shalala's February 12, 1997 written testimony submitted to the full House Ways and Means Committee, she states, *"We will eliminate periodic interim payments for home health agencies, which were originally established as an incentive for new agencies to serve Medicare patients. With 100 new agencies joining Medicare each month, this incentive clearly is no longer necessary."* On July 23, 1996, HCFA Adminstrator Bruce Vladek issued almost the same comments (pg. 15 of HCFA report), to your Committee.

Both Secretary Shalala and Administrator Vladeck are incorrect in stating that PIP was originally established as an incentive for new agencies. According to HCFA Pub.15, Part I, Section 2407, in order for a provider (a home health agency) to receive PIP reimbursement, the provider must; (1) submit a request in writing, (2) the provider must have filed at least one completed Medicare cost report, (3) The provider must have an estimated annual Medicare payment for Part A and Part B services of at least $25,000 computed under the PIP formula, or in the case of home health agencies, estimated Medicare reimbursement of at least 50 percent of total costs.

In addition, all Medicare fiscal Intermediaries impose these additional requirements (one staff member of a Regional Medicare Intermediary, Palmetto Government Benefits Addministrators, stated "PIP IS A PRIVILEGE"):

(1) A provider must have filed at least one full 12-month cost report on time without a request for extension, unless the extension was for clearly extenuating circumstances beyond the provider's control,
(2) the cost report must have been both desk reviewed and field audited (which means the provider would be 2 or 3 years old before even being considered),
(3) the audit must confirm that the provider is satisfactorily meeting all cost reporting and record-keeping requirements,
(4) cost determined to be unallowable may not have exceeded 10 percent of total reported costs and,
(5) the provider must not be subject to any form of intensified or specialized prepayment review at the time of the request for PIP payments.

Do these requirements confirm Secretary Shalala's contention that PIP was created to bring new agencies into the Medicare system? Absolutely NOT! PIP is a system to ensure prompt and accurate payment, to providers, of claims submitted. As a citizen, you know that receiving a paycheck every two weeks is imperative to budgeting, paying bills, conducting business with banks and other financial institutions, and even buying groceries. Without PIP, established agencies that have earned the privilege of receiving timely payments (to pay staff, pay for supplies and pay for utilities) will be forced out of business.

It is imperative that the standards for PIP remain strong. It is also imperative that PIP remain in force to ensure that agencies are paid on time, that nurses are paid on time, and that payroll taxes are paid on time.

Periodic Interim Payments (PIP) should be continued because:

1) It ensures a more accurate reimbursement rate (based on actual cost); because the providers costs are required to be reviewed on a quarterly basis and any subsequent over/underpayment is immediately recouped from, or paid to, the provider. Whereas, a provider paid on a per diem basis, the provider's costs are only required to be reviewed annually. In this instance, a provider paid on a per diem basis could go as long as 12 months before an overpayment is discovered.

2) Even HCFA recognizes the cash flow significance of PIP, as noted in FEDERAL REGISTER, Vol. 49, No.1, Tuesday, January 3, 1984, Rules and Regulations. It states in part.... "We recognize that the method contained in the interim final rule may in some instances have cash flow consequences for some hospitals, **especially those not receiving periodic interim payments.**"

3) It supports 42 CFR 413.64(b) which states... "Whatever estimated cost basis is used determining interim payments during the year, the intent is that interim payments shall approximate actual costs as nearly as practicable so that the retroactive adjustment based on actual costs will be as small as possible." And, (HCFA Pub.15, Part I), Section 2406 states in part... that the provider's current interim rate be timely adjusted to bring it into line with estimated reimbursable cost for the period."

The intent of these regulations can only be accomplished through the PIP method of reimbursement.

HCAA RECOMMENDS THAT CONGRESS:
Congress needs to Reject HCFA's proposal to eliminate PIP.

HOSPITALS ARE THE REASON HOME HEALTH CARE COSTS ARE SKYROCKETING. HERE ARE THE RESULTING EIGHT PROBLEMS:

1. HCFA ALLOWS HOSPITALS TO BREAK THE LAW AND SELF-REFER!

The existing regulation (42 CFR 424.22), which prohibits compensated physicians who earn more than $25,000 from certifying home care plan of treatments to that entity, is not being enforced by HCFA against hospitals. Mr. Vladeck met with HCAA representatives, but refused to further address his refusal to enforce the law. Mr. Hoyer, with HCFA, however, wrote two separate and exhaustive letters clearly stating that 42 CFR 424.22 should be enforced against hospitals which persist in self-referring. In March of this year, Mr. Hoyer publicly told HCAA representatives that his letters have not been withdrawn by HCFA --- yet HCFA refuses to enforce 42 CFR 424.22?

42 CFR 424.22 entitled, "Requirements for home health services" states:

(d) Limitations on the performance of certification and plan of treatment functions.-

(1) Basic rule. Beginning November 26, 1982, and except as provided in paragraph (e) of this section, need for home health services to be provided by an HHA may not be certified or recertified, and a plan of treatment may not be established and reviewed by any physician who has a significant ownership interest in, or a significant financial or contractual relationship with, that HHA.

Section (e) states: Exception to limitations- (1)Exceptions for governmental entities. The limitations of paragraph (d) of this section do not apply to an HHA that is operated by a Federal, State, or local governmental authority.

In addition, 42 CFR 424.22 section (3) states:

Significant financial or contractual relationship. Beginning November 26, 1982, a physician is considered to have a significant financial or contractual relationship with an HHA if he or she-

(i) Receives any compensation as an officer or director of the HHA; or

(ii) has direct or indirect business transactions with the HHA that, in any fiscal year, amount to more that $25,000 or 5 percent of the agency's total operating expenses, whichever is less. Business transactions means contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, and space and, after August 29, 1986, salaried employment.

History

HCAA has always believed that this regulation is crystal clear. Hospitals are prohibited from having doctors certify or recertify plans of treatment to hospital based/owned agencies if the doctor is employed by the hospital, and that doctor receives compensation over $25,000. Opponents of this regulation say that new health care systems developed over the past several years have made this regulation outdated and obsolete. The American Hospital Association (AHA) has successfully lobbied Health and Human Services Secretary Shalala in not enforcing 42 CFR 424.22. The failure of HCFA to vigorously enforce 42 CFR 424.22 has placed the Part A Medicare Trust Fund in grave jeopardy.

In a misleading letter to home care agencies in its California community, **Scripps Memorial Hospital**, in San Diego, California, stated, ***"It is the intention of Scripps to give to our patients reasonable choice in their selection of healthcare providers."*** The real truth of its intentions is shown, however, in its February 16, 1996 secretive internal memo written to its Medical Staff (as a basis for restricting freestanding home care agencies from receiving referrals). It read, ***"We believe it is critically important to keep patients within the Scripps health system whenever possible. This enables Scripps to deliver its premier quality care while assuring continuity of patient care throughout the system. When patients leave the system and are enrolled in other home care agencies, we lose jobs for Scripps employees, dollars for the Scripps system, and risk adverse patient outcomes as a result of care that may be less than the Scripps standard."*** Caught red-handed in its deceit, Script gave this arrogant, and yet weak, defense for its actions: alleging that, somehow, care **given by others is not up to its premier standards; *"patients are encouraged to use Scripps' facilities because the recommending personnel have first-hand knowledge of the quality of those services."***

COMPETITION IN HEALTH CARE

I recently read a quote from Representative Thomas Bliley of Virginia pertaining to competition. Representative Bliley stated, **"Last Congress, we broke up one of the biggest monopolies still standing, giving consumers a choice in local telephone service. It's time we did the same thing with electricity."** Also he said, **"no economist can quarrel with" the notion that "competition lowers prices, competition improves productivity, and monopolies are always inefficient and expensive -- always. That's not opinion, it's fact. You know it, I know it, ... and history proves it."**

Chairman Bliley is correct in his comments. **Competition is the key to lower prices, higher quality and patient satisfaction.** When telephone companies, airlines, cable television operators and fast food restaurants are allowed to compete, prices go down and quality goes up. However, that doesn't mean that safeguards are done away with. It is imperative that regulations remain in place to ensure companies do not sacrifice quality in favor of profit. Federal agencies, like the FDA, are necessary to ensure that food is safe to eat. In the same way, HCFA and the Department of Justice should ensure that, in the health care sector of our economy, patients have the freedom to choose their own health care provider, especially home health care.

The freedom to compete for providing health care services is also a concern. HMOs and hospitals have the financial resources to place **FULL PAGE ADS** in newspapers and have **LARGE ADVERTISING BILLBOARDS** to lure patients into their care. Freestanding home

health agencies do not have the resources to compete with this type of advertising. Certainly, Medicare provides reimbursement for limited types of education, but HCFA refuses to pay for any advertising, except in the case of recruitment.

2. HOSPITALS OVER REFER!

It has been said that the way to reduce home care expenditures is to cut overutilization of visits to patients. Little has been said though about the "overutilization of patients" by hospitals. Reports from the GAO to Congress state that hospitals do less care per patient than freestanding agencies, but these same reports make no mention of the fact that hospitals are self-referring patients that otherwise would not be candidates for home care. In June 1996, the *Prospective Payment Assessment Commision "Report to the Congress"* disclosed this significant impropriety, page 99, **"Hospital-based providers also were likelier than free-standing ones to treat beneficiaries who had been in the hospital."**— yet HCFA/ORT has chosen not to investigate hospitals to the same grueling on-site surveys being targeted at the throats of small, freestanding agencies. Certainly, you have not received word of any hospital being Decertified by HCFA/ORT for such overutilization-of-patients violations.

3. HOSPITALS WHICH SELF- REFER GET PAID TWICE BY MEDICARE (DOUBLE-DIP)!

Today's flawed reimbursement to hospital-owned agencies (and SNFs) essentially allows hospitals to commit legalized fraud/abuse by "double dipping" Medicare funds. Today, hospitals are rapidly jumping into home health care and are unethically blocking referrals to freestanding agencies because they've discovered a reimbursement loop-hole that allows hospitals to get paid twice. They are able to do this once with their Medicare DRG rate, which includes their administrative costs, **and then** by allocating these very same administrative costs to their hospital-owned agency. In fact, hospitals are even purchasing agencies whose owners have been convicted of fraud (such as Healthmaster). Hospital Medicare reimbursement needs to be changed to stop hospital administrative "double-dipping," falsely called "cost shifting." A "cost shift" means just that! **It means shifting a cost to another location. It does not mean "duplicating" the cost** somewhere else! Patients were supposed to be guaranteed a choice of health care providers! HCAA's findings can best be compared to the testimony given by Susan S. Bailis, representing the 11,000 freestanding SNF's which make up the American Health Care Association (AHCA). Ms. Bailis shared, in her testimony, the need to stop rewarding inefficient hospitals through Medicare's failure to recalibrate DRGs (improperly allowing hospitals to double-dip Medicare in the SNF market as well). HCAA shares Ms. Bailis' concerns about HCFA's unwarranted "desire to continue to subsidize less efficient and more-costly hospital-based care." Identical to HCAA's concerns, Ms. Bailis testified as to "incentives for hospitals to allocate labor, administrative, and general costs over to PPS-exempt SNF units" (one Executive identified $50,000 per bed as a common figure) "and the ability of hospitals to receive a cost-based payment higher than a freestanding SNF, <u>in addition to the full DRG payment.</u>". AHCA proposed, and HCAA agrees, that hospital "DRGs be examined and recalibrated according to severity of illness and length of stay." Although most experts (including Ms. Bailis and Joseph P. Newhouse Ph.D., Chairman of ProPAC) agree that the recalibration of DRGs is needed, they seem to be at a loss with regard to how to get it done. HCAA proposes, therefore, that the only other appropriate interim solution is to simply STOP hospitals' double-dip allocation (to Medicare), of administrative costs (already included in their charge-based DRG), to cost-reimbursed home health care or SNF care rendered in facilities owned by the hospitals. HCAA has calculated that Medicare could save $1.2 Billion annually (in the home health care market, alone) by stopping this double-dip. AHCA calculates that Medicare could save "$9 Billion per year" (in the SNF market)!

4. HOSPITALS HAVE FOUND A WAY TO GET PAID TWICE FROM SELF-REFERRALS !

In the March/April 1996 issue of, "The Remington Report" an article entitled, "Five Key Benefits Home Care Offers to the Hospital" written by Carol L. Schaffer. JD.,RN.,MSN., President & CEO of CCF Health Care Ventures., Inc., she states. ***"Home health care brings to the hospital new revenue today and lowered cost of care across the continuum under a future global capitated system. At present, a great deal of home health care is offering a new source of revenue...The essence of cost based reimbursement is that hospitals are able to shift existing financial overhead existing in the hospital to the home care program which increases the costs of the agency. The cost of care increases up to the cost limits, and increases the amount of reimbursement that the hospital receives for the home care visits. The cost shift then is essentially the profit that the hospital receives. Under the present situation it is still valuable for the hospital to operate a Medicare certified agency."***

In addition, in the December 4, 1995 issue of home health line entitled *"Columbia/HCA wants to buy your HHA--if you match up"*, the article quotes Roland Alonzo, executive VP of Development for Columbia Home Care, ***"Financial performance and earnings potential: Columbia converts freestanding agencies to hospital-based ones, and expects to allocate hospital overhead to its agencies. That means that acquisition candidates have to operate below cost-limits to leave some room for hospital overhead."*** This is but another example of why hospitals are so eager to get into the home health business. The "double-dip" of Medicare.

5. HOSPITAL SELF-REFERRALS (DOWNSTREAMING) IS OUT-OF-CONTROL!

HCAA wishes the Subcommittee to know that this vital issue (self-referrals) is not one evolving from the interest of hospitals in patient care, as there were few hospitals rendering home health care before DRGs. **The issue is clearly one created by a hospital's ability to be paid twice (see paragraph 3, above, on the "double-dip") and to get paid "twice as much" by (improperly) monopolizing referrals.** Specifically, there are two well-known industry suits recently filed (in Texas) against Columbia/HCA on the very issue of improper hospital self-referrals. One suit is a "whistle-blower" action filed by Dr. James Thompson, a family practitioner in Corpus Christi, Texas who contends, (according to a November 11, 1995 Associated Press story) that "Columbia-HCA Healthcare Corp., the nation's biggest hospital chain, paid doctors illegal kickbacks (including cash, free vacations and cheap office rentals) in exchange for patient referrals." The second is a class-action suit filed on January 17, 1996, again, against Columbia-HCA, by a freestanding proprietary agency (CHS of El Paso, Inc - El Paso, Texas) alleging that Columbia-HCA owns four hospitals in El Paso and is employing monopolistic practices by having "pressured physicians with staff privileges" and "profit incentives" if they'll stop referring patients to CHS companies. These instances of impropriety, which are rightfully getting publicity nationwide, are not isolated occurances. Further examples of such hostile self-referral tactics are recounted here, as quoted from the June 3, 1996 issue of <u>*Eli's Home Health Care Report*</u>: *" 'As we continue to see more hospitals get involved in the home health side of the business, outside the confinement of the hospital, our referrals continue to dry up,"* notes Glen H. Beussink, Executive Director of a Cape Girardeau, MO-based home care provider, Health Data Services, Inc. Marilyn LeVasseur, MS, RN, and Administrator of Family Nurse Care in Brighton, MI, also says that her revenues have been hurt by a local hospital. *"In April of this year, the only hospital in the county became affiliated with a multi-hospital organization, and our referrals decreased 30 percent,"* LeVasseur says. According to Beussink, *"many of the physicians are pressured ever so slightly to use the hospital services."* The American Federation of Home Health Agencies (AFHHA) also notes that *"we have received many reports that physicians*

have refused to sign home care orders unless the patient agrees to use the hospital-based home health agency." The National Home Infusion Association (NHIA) agrees, noting that *"our organization routinely receives calls from both outpatient providers and physicians indicating that hospitals are increasingly pressuring physicians and patients, both directly and indirectly, to utilize the hospitals' own services."*

Phyllis W. Fredland, RN, Director of Nursing for Health Personnel Incorporated in McKee's Rocks, PA, also observes that *"here in Pittsburgh, if doctors refer to another entity outside the hospital, the hospital can revoke their privileges." She adds, "In our area, they are nothing less than predatory."* According to Robert J. Brock, vice-president of At Home Health Care in Redwood City, CA, *hospitals "discard literature we deliver to the hospital."* HCAA uncovered another contemptible tactic used effectively by hospitals to prey on their medical staff. In a misleading letter to home care agencies in its California community, Scripps Memorial Hospitals, in San Diego, CA, stated, "It is the intention of Scripps to give to our patients reasonable choice in their selection of healthcare providers." The real truth of its intentions is shown, however, in its February 16, 1996 secretive internal memo written to its medical staff (as a basis for restricting freestanding home care agencies from receiving referrals). It read, "We believe it is critically important to keep patients within the Scripps health system whenever possible. This enables Scripps to deliver its premier quality care while assuring continuity of patient care throughout the system. When patients leave the system and are enrolled in other home care agencies, we lose jobs for Scripps employees, dollars for the Scripps system, and risk adverse patient outcomes as a result of care that may be less than the Scripps standard." Caught red-handed in its deceit, Scripps gave this arrogant, and yet weak, defense for its actions: alleging that, somehow, **care given by others is not up to its premier standards (forget Medicare's)**; "patients are encouraged to use Scripps' facilities because the recommending personnel have first-hand knowledge of the quality of those services."

6. HOSPITAL SELF-REFERRALS (DOWNSTREAMING) VIOLATES THE PATIENT'S RIGHT TO CHOOSE!

The main issue you should consider is **PATIENT CHOICE.** It is imperative that the patient is allowed, without coercion or manipulation, **the freedom to choose a post-acute provider, and the choice must be honored by the hospital. Patient choice must be the primary factor for hospitals, not "downstreaming" hospital patients into the hospital-based, post-acute facility for profit at the expense of Medicare.** Consider that the hospital has a "captive patient." The patient has received services while in the hospital and then, when the patient is discharged to home health care, it is logical that the hospital would want to have that patient remain in the hospital system for financial reasons. The excuse a hospital may use in one-on-one patient meetings is, "we want to ensure continuity of care" or "we can guarantee quality care ONLY IF you use our program." Even more sinister is the fear imposed on bed-bound, elderly patients, by hospitals such as Columbia, who mandate that a patient "sign a waiver of liability" if the patient wishes to choose another Medicare-certified agency not owned by the hosptial. Even when the patient has been under the care of a freestanding home health agency in the community, before the hospitalization, the hospital employs such tactics because it is reluctant to lose the additional Medicare dollars associated with that patient (from both the upcoming home care services and the potential that, if the patient returns to the hospital after being discharged from either the hospital or the hospital-owned home health agency, the hospital may be able to readmit that patient under a new DRG and again drive up health care costs).

In a recent expose on home care costs (News-Press, April 20, 1997) Mike Hoyem, News Press staff writer, uncovered that hospital-owned agencies are denying competition and patient choice. ***When Mr. Hoyem questioned Columbia/HCA spokeswoman Beth Tuttle she responded, "That is just not true. They can tell you that, but can they give you documentation of that? We're very proud to say that more patients and their physicians are choosing to use Able Care. That's what competition is all about.." But Mr. Hoyem uncovered a different story on competition from Mr. Chip Shannon, President of Metro Home Care, Inc. and Phil Malone, regional director of Lifeline Home Health Care, both are freestanding agency competitors of Columbia. Shannon says "he's documented numerous cases in which hospital employees tried to take his patients." Malone agreed., "We have patients where the physicians will actually go to their room and try to talk them out of going with Lifeline.... It is the patient's choice, but how many people go against their doctors?"***

7. BECAUSE OF THESE REIMBURSEMENT FLAWS HOSPITAL AGENCIES COST $12 MORE PER VISIT!
AND WHAT ABOUT HOSPITAL ACQUISITIONS OF HOME CARE — MEDICARE IS PAYING FOR THOSE TOO!

The Federal Register, February 14, 1995 page 8399, succintly points out that hospital-owned agency costs per-visit are significantly larger than freestanding agencies costs per visit (called in HCFA's Table II **"A & G ADD-ON AMOUNTS FOR HOSPITAL- BASED HOME HEALTH AGENCIES "**). *This HCFA report declared that hospitals, because of their additional (double-dip) administrative and general costs (A & G), were to be allowed $12.20 MORE per visit for a hospital-owned agencies skilled nursing visit in a MSA location and $14.99 more in a Non-MSA location (home health aide visits, by hospital-owned agencies were according to HCFA, $5.50 and $6.01 MORE per visit respectively than a similar visit by a freestanding agency).*

In the same recent expose on home care costs (News-Press, April 20, 1997- see above comments) Mike Hoyem, News Press staff writer, uncovered that hospital-owned agencies are costing Medicare significantly more than freestanding agencies. Mr. Hoyem emphasized that "Home health care visits in Florida cost Medicare more than $1.3 billion. The average home health care cost per-visit statewide was $72.90. The average in District 8, which includes Lee, Collier, Charlotte, Sarasota, Hendry, and DeSoto counties, was $74.06. ***Statistics show home health care in Florida is more expensive for federal taxpayers when it's done by hospital-based home health care agencies:***

- Last year there were 64 agencies whose average bills for a home health care visit were $80 or more. Forty-four of them were hospital-based, and 20 more were independent.
- 140 agencies charged $70 or more; 93 were hospital-based, and 47 were independent.
- Sixty-nine agencies had bills averaging under $60; 19 were hospital-based, and 50 were independent.
- Thirty-two agencies had average bills under $50; 25 were independent, and seven were hospital-based. "

Mr. Hoyem went on to report that Medicare's homecare cost per visit skyrocketed, by the same agency (Able Care- Fla.), immediately after it was acquired by Columbia. *Mr. Hoyem uncovered the change in cost per visits AFTER Columbia's aquisition : Able care of Naples cost jumped up for $71.44 to $79.71; Able Care of Charlotte jumped up from $47.80 to $81.84; and Able Care of Ft Myers jumped up from $74.85 to $82.31... only Able Care of Lehigh showed a decrease from $55.55 to $53.97).* ***Well, so much for competition, cost reduction, and of course the acquisition costs is paid, not by stockholders, but by Medicare through such reimbursement flaws.***

In my hometown of Jacksonville, FL we (Welcome Home Care) encounter these same abuses by hospital-owned agencies. After reading these reports we gathered the following cost data on the three hospital-owned home care agencies in our area, showing they cost

significantly more per visit than freestanding agencies:

Agency Name	Hospital-Owned / Freestanding	Cost Per Visit
St. Vincent's Home Health	Hospital-Owned	$87.73
Memorial Home Care	Hospital-Owned (Columbia/HCA)	$84.55
St. Luke's Home Health Service	Hospital-Owned	$75.48
Welcome Home Care	Freestanding	$61.20

8. BECAUSE OF THESE REIMBURSEMENT FLAWS HOSPITALS ARE EVEN BUYING FRAUDULENT AGENCIES! — AND MEDICARE IS PAYING FOR FRAUD TWICE — HERE'S HOW!

Jeannette Garrison owned Healthmaster, Inc., First American's biggest competitor. She is now serving a prison term for stealing $14 million from the Medicare program. United States Inspector General, June Gibbs-Brown, mentioned both cases in her March 21, 1995 testimony before Congress on Medicare fraud and abuse.

What Congress never heard, in Mrs. Gibbs-Brown's testimony, was the fact that Ms. Garrison was able to sell her agency to a hospital (Medical Center of Georgia) for $54 million. That's a $40 million profit, after you subtract the $14 million she had to repay Medicare. A felon making (not paying) $40 Million-is this justice? But the real injustice is that American taxpayers are paying TWICE for fraud and here's how:

Congress wasn't told that it was a hospital that paid the $54 million and that the hospital now could legally scam Medicare the millions they paid, because of Medicare's faulty reimbursement formulas allowing hospitals to "double-dip." Yes, Jeannette should be punished. But, the bigger, untouched legal crime is hospital-based reimbursements costing taxpayers millions, and us our referrals.

The alarm these two cases have generated is understandable. However, as our elected officials, you would be mistaken if you thought these gross abuses of the Medicare system are representative of freestanding home care agencies.

Hospitals are Legally Double-Dipping Medicare, and Medicare is paying for FRAUD TWICE —HERE'S How:

Hospital pays $54 million to home care felon. Wonder why, and what they hope to gain? Now for the real story: You were told by the OIG about Healthmaster's (a Georgia private home care agency) fraudulent practices. But this is what the OIG failed to tell Congress: Medicare pays-again, after the thief is caught! Hospital based agencies can rip Medicare off, legally. Any wonder why hospitals want to jump into home care and want Congress to grant a moratorium on enforcing regulations that guard against self-referrals?

THE HEALTHMASTER (Owned by a Convicted Felon) STORY TELLS IT ALL:

Sale proceeds to Jeannette Garrison	$54 Million
Garrison's (minor) payment to Medicare for her theft (2.5 Million in fines & 11.5 Million in restitution)	$14 Million
Annual Healthmaster costs (Eli Report)	$100 Million
Average cost per visit (estimated)	$60
Estimated annual Healthmaster visits	$1,670,000 vs.
Average per-visit hospital allocation add-on (hospital "legalized" cost shifting add-on per the Federal Register)	$12
MEDICAL CENTER OF GEORGIA'S ANNUAL "LEGALIZED " POTENTIAL COST SHIFTING (DOUBLE-DIP) TO MEDICARE (The hospital which purchased Healthmaster)	$20 Million
The real story here is that the above is not an isolated instance! This is why hospitals are so eager to get in home care, and it's why home care costs are skyrocketing,	
Hospital Legal Overcharges to Medicare--	$1.2 Billion "Annually"

<u>**HCAA RECOMMENDS THAT CONGRESS:**</u>

We also urge the committee to ask HCFA to maintain and vigorously enforce the "Hoyer Commentary" pertaining to 42 CFR 424.22 and ensure that hospitals allow freedom of choice to patients for post-acute care services. By enforcing 42 CFR 424.22, the Part A Medicare Trust Fund will be in far less jeopardy than it is in today.

THE SECOND EXAMPLE OF "LEGALIZED FRAUD" IS HCFA'S OVERPAYMENT TO MEDICARE HMOs.

The following General Accounting Reports state these alarming facts about Medicare HMOs:

"Although the Congress anticipated that HMOs would save money for the Medicare program, government researchers and outside analysts have claimed that providing services to Medicare beneficiaries through HMOs can be more expensive than fee-for-service care. According to these analysts, beneficiaries enrolled in Medicare HMOs are healthier (and less costly to care for) than beneficiaries in the fee-for-service sector, and Medicare's payments to HMOs do not fully reflect these differences in costs." **GAO, September 1994, Medicare. Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs. (GAO/HEHS-94-119)**

"With new legislative authority, HCFA could require steeper discounts from HMOs than the present 5-percent discount off the estimated local fee-for-service cost. Although this would lower payments to HMOs, it may not necessarily have a large impact on their participation in Medicare risk contracts. Previous research indicates that enrollment of healthier than average beneficiaries, combined with an imperfect method of risk adjustment, results in excessive payments to HMOs--even after factoring in the 5-percent discount. Recent evidence suggests that HMOs find participation in the risk contract program to be lucrative under current payment rates."
GAO, November 1995, Medicare Managed Care. Growing Enrollment Adds Urgency to Fixing HMO Payment Problem. (GAO/HEHS-96-21)

"Medicare's HMO rate-setting problems have prevented it from realizing the savings that were anticipated from enrolling beneficiaries in capitated managed care plans. In fact, enrolling more beneficiaries in managed care could increase rather than lower Medicare spending--unless Medicare's method of setting HMO rates is revised." **GAO, February 25, 1997, Medicare HMOs. HCFA Could Promptly Reduce Excess Payments by Improving Accuracy of County Payment Rates. (GAO/T-HEHS-97-78)**

It is clear that Medicare HMOs, their CEOs and stockholders are profiting at the expense of the Medicare Trust Funds. HMOs have been overpaid by HCFA and this type of "legalized fraud" must stop immediately. HCAA agrees with the Administration's proposal to reduce the Medicare payment from 95 percent per capita cost or AAPCC to 90 percent to HMOs. However, HCAA believes that this reduction should be implemented immediately, versus delaying this correction until the year 2000 as proposed by the Administration.

HCAA RECOMMENDS THAT CONGRESS:
HCAA recommends Congress pass HMO legislation to save Billions in Medicare dollars annually by requiring HMO Medicare reimbursements to incorporate a "case-mix" capitation adjustment. Currently, HMO's are paid an average of $4,500 per Medicare beneficiary, which was falsely computed based upon the naive assumption that HMO's would enroll a case-mix of both healthy and sick Medicare benficiaries. Because it has now been proven that HMO's target the healthy elderly, and because these healthy enrollees cost Medicare less than $500 a year under traditional Medicare and not the $4,500 charged Medicare currently by HMO's(Consumeers' Research 7/95) a "case-mix adjuster" is needed for all HMO PAYMENTS. Also, HCAA recommends that Congress stop false/misleading HMO sales propaganda by requiring that, three weeks prior to the effective date of HMO coverage, the HMO formally notifies the patient's current home care agency that the patient "has chosen" to convert to HMO. Also, require HMOs to accept "any willing" provider and to submit on-going documentation that they are "actually providing" the same level of home health care services (in terms of number of visits authorized and paid for) that beneficiaries would receive if they were not in a HMO.

HCAA HAS ALERTED HCFA ABOUT FRAUD IN THE PAST, BUT HCFA HAS TURNED A DEAF EAR TO OUR WARNINGS.

No one industry organization has shown more concern over fraud and abuse in home care than HCAA. In fact, HCAA's Chairman, Dwight Cenac, delivered a scathing report to HCFA on November 11, 1992 pinpointing abusive activities by both ABC (a $600-million, 400-office chain operation) and other mega agencies utilizing subcontracted staff at greatly inflated prices. In a subsequent telephone follow-up, Mr. Cenac queried HCFA's Mr. Eric Yospe, a HCFA official bearing some responsibility for the audits of home care expenditures nationwide, on dealing with these abusive issues, and provided him additional information on how a major abuser of subcontract services in Miami, Florida (Hospital Staffing Services, Inc. (HSS), a $90-million, multi-office chain) was improperly milking the Medicare program millions each month. For the most part, the activities reported by Mr. Cenac were discarded by HCFA--although, MUCH LATER, a great deal has been said to Congress about these activities; and no credit has been afforded to the freestanding agencies for our attempts to help police such mega felons. In fact, years before the OIG prosecuted these felons, HCFA's Yospe stated in response to the allegations of impropriety raised by Mr. Cenac, that HCFA had no way of ascertaining the fair value of subcontracted services; and that there was nothing wrong with HSS 's exclusive utilization of subcontracted nurses--even after he was informed by Mr. Cenac that such subcontracts were from separate corporation(s) *OWNED* by the referring physicians. What is greatly troubling to HCAA is HCFA's and the OIG's misrepresentations that freestanding proprietaries (who generally bill less than $10 million annually) are, somehow, similar to these mega chains and self-referring physician practices and, somehow, should be subjected to increased scrutiny--now under the umbrella of ORT--because of such felons. HCAA is not opposed to investigations of fraud and abuse. In fact, as stated above, HCAA has attempted to bring such issues of fraud and abuse to light --**years before they were brought to Congress, or for that matter, before the felons were caught.** What HCAA is opposed to, however, are two issues: first, the unwarranted singling out of freestanding agencies--while, at the same time, the unwarranted selective exclusion of HMOs, hospital-owned agencies and chains from ORT's process; and second, the improper use of excessive force by ORT's inexperienced and overzealous surveyors aimed at expelling freestanding agencies from Medicare participation by improperly interpreting guidelines **that they are NOT similarly and simultaneously applying against hospitals and chains.** It is in this spirit of

fair play that HCAA appeals to this Subcommittee (1) to properly and uniformly channel the ORT task force; and (2) to request the incorporation of valid industry input, such as HCAA, into the selection and investigation of today's sophisticated health care thief. Although **Peg Cushman** testified on behalf of NAHC and the home care industry, she later told HCAA that NAHC's legal counsel, **Mr. Bill Dombi**, failed to notify her of the ORT abuse hearing he attended on behalf of NAHC member CSM (a freestanding agency in California). HCAA was concerned regarding the failure, in the testimony given, to reference the real atrocities occurring against the freestanding agencies under the umbrella of ORT.

OPERATION RESTORE TRUST

In California, one of the first states targeted by Operation Restore Trust, one home health agency attempted to stand up to HCFA, and has apparently lost its battle to serve its patients. CSM Home Health Services, Inc., is a 10-year-old Los Angeles agency, which has spent more than $100,000 on legal and consulting services to fight its improper Medicare decertification after an ORT survey.

History of the CSM Case

On March 1, 1996, HCFA and the California State survey agency conducted a compliance survey of CSM. Based on that survey, CSM was found not to be complying with eight conditions of participation. HCFA and the California State survey agency conducted a second survey of CSM which was completed on May 30, 1996. On June 26, 1996, HCFA notified CSM that, based on the second survey, HCFA had determined that CSM was not complying with four conditions of participation. On July 25, 1996, HCFA terminated CSM's participation in Medicare.

The first judge in the CSM case, **the Honorable John G. Davies (Case No. CV 96-4651-JGD), United States District Court -Central District of California, could find no legal grounds to grant CSM relief, although he definitely wanted to. Judge Davies said of the ORT process, "I think the surveyors -- I think CSM Home Services has a case. The evidence that is before me that I have perused, read, considered, leads me to those conclusions. The Surveyors, I had the Impression, were not reticent to wear their power on their cuff and to manifest it and exercise it in ways that are undesirable in today's society. The bureaucracy overreacted once again. That is my view of this case. But, what relief can I give you?"**

After Judge Davies was unable to give relief to CSM, the case was referred to Administrative Law Judge Steven T. Kessel. Judge Kessel reviewed the case in which HCFA decertified CSM. In Judge Kessel's October 11, 1996 ruling he stated, ***"I decide that the Health Care Financing Administration (HCFA) incorrectly determined to terminate the participation in the Medicare program of Petitioner, CSM Home Health Services, Inc. In this case, HCFA asserted that Petitioner failed to comply with four conditions of participation in Medicare. I find that the preponderance of the evidence is that Petitioner complied with all of these conditions."*** In addition, Judge Kessel states, ***"In many instances, HCFA rests its allegations on characterization of facts which are not supported by the evidence. In some instances, HCFA asserts that nurses employed by Petitioner failed to discharge specific directives in patients' plan of care when, in fact, the record proves that they did precisely what they were ordered to do. HCFA asserts also that Petitioner failed to conduct a required program evaluation despite overwhelming evidence that Petitioner performed the evaluation."***

What follows is a portion of the sworn testimony of one of CSM's key employees. It is given this Subcommittee as a reference point of the type of agency being abused by the unbridled ORT process, as it currently operates. "I, Jean R. Murphy, R.N., have been a registered nurse for over twenty years, a portion of which was served as an officer and flight nurse in the United State Air Force. I have approximately thirteen years of experience in home health care as an administrator and/or consultant. I am currently administrator of CSM Home Health Services, Inc. I have held this position for four years. CSM has been serving Los Angeles' underserved minority communities since 1985. These communities include the Rampart District, South Central Los Angeles, Koreatown and other primarily minority communities. ***CSM's clerical and field staff are also primarily minority. CSM staff continued to serve their clients during the 1992 riots under security guards. During the Northridge earthquake, my staff forsook their families to rush to the aid of their patients. One black certified home health aide was present in a board and care facility during the earthquake; and placed several residents under mattresses to protect them as she, herself, braced and quieted their fears.***

The CSM Director of Nurses stood in water without power using her cellular phone to try to reach staff and patients to ensure their safety, despite the fact that she, herself, was in peril because the gas supply in her apartment had not been turned off and had been evacuated for fear of explosion. One of CSM's clinical supervisors was carjacked and robbed at gunpoint while she sat in her car solving a patient crisis on her mobile phone.

Another registered nurse, whose husband had driven her to a patient's home after the riots, was shot as they sped away to avoid being carjacked or killed. CSM has undergone Medicare recertification surveys annually since its founding. These surveys have been conducted by the surveyors from the Department of Health Services, who have found only minor deficiencies with CSM's compliance with Medicare Conditions of Participation. CSM responded to these deficiencies with corrective action plans; and there have never been any termination actions initiated against CSM as a result of these minor deficiencies."

HCAA asks these questions:

1. **Does the Subcommittee believe that CSM is the type of agency at which ORT should be targeted?**

2. **When two judges rule in favor of a home health agency, should HCFA appeal the decisions?**

HCFA has chosen to appeal Judge Kessel's October 11, 1996 decision. Here is a letter dated January 31, 1997 to HCAA Chairman Dwight Cenac from CSM owner Marianno Velez which states his thoughts about his ordeal:

"These past few months have been terrible for me, and I fear the burden has gotten the best of me, causing the worst case of depression

that I have encountered, so much so that I felt a deep sense of fatigue, a loss of energy, as well as spirit, to continue living from day to day. I share this with you because what happened to me should not happen to anyone else. ... As you probably know already, HCFA has filed their appeal to reverse the ALJ (Judge Kessel's) ruling on CSMs case. And because of our outstanding debt to our lawyers, we have not been able to reply to HCFA's appeal. I am afraid all is lost--for the industry as well--if the ruling is reversed."

HCAA RECOMMENDS THAT CONGRESS:
We ask Congress to urge HCFA to recertify CSM Home Health Services Inc. immediately, in accordance with Judge Kessel's order. In addition, we believe that HCFA should expand its investigation of waste, fraud and abuse to large home care chains and hospitals.

ONE KEY TO STOPPING WASTE, FRAUD AND ABUSE; IMPLEMENT A PER-VISIT PPS SYSTEM FOR HOME CARE.

ANY PROSPECTIVE PAYMENT (PPS) PLAN SHOULD GUARANTEE FIVE THINGS:

1. **That we pay for what patients receive (Not for what they don't).** There should be incentives to provide needed care, not incentives to deny it when our elderly need it most.
2. **That the Government has the opportunity to share in savings.**
3. **That Medicare expenditures are "truly" contained.**
4. **That Medicare fraud/abuses are curtailed.**
5. **That a Medicare Review Program is in place to ensure quality care is being given.**

HCAA'S PPS "PER VISIT" PLAN GUARANTEES SAVINGS AND QUALITY CARE:

At the very core of HCAA's proposed PPS Plan is our guarantee to provide care to the nation's elderly at an agreed-upon national cap for home care expenditures, thereby controlling cost increases, and realizing a savings for the Medicare program. Let's not repeat the **tragic premature implementation of PPS** in home health care that occurred in 1983 for hospitals, by implementing an untested "per-episode" DRG PPS plan, resulting in today's four-fold cost increase. HCAA proposes a PPS plan that is based on per-visit (thus, guaranteeing the incentive is on providing care, not on denying care). Our plan also promised the opportunity for the government to share in savings (unlike a per-episode method wherein the payment becomes the ceiling and the government is thereby denied any opportunity for savings). **To guarantee that the rate of growth for home care Medicare expenditures is truly contained, HCAA proposes that there be a national cap on home care expenditures, adjusted only for two factors:** First, an annual cost of living increase; and Second, an annual adjustment based on the actual percentage growth in the beneficiary population. HCAA's "per visit" plan calls for a payment method that is both fair (eliminates the inducements to self-refer) and offers providers incentives and abilities to self-police, and expose today's sophisticated health care abusers. Congress has already received testimony that a flat, "per-episode" pay rate (similar to HMOs/DRGs) does not have the controls and safeguards in place to ensure necessary care is given, whereas HCAA's "per-visit" reimbursement rate, based on care actually provided, already has a quality assurance program in place within the current Medicare Intermediary system.

HOW TO IMPLEMENT HCAA'S PPS "PER-VISIT" PLAN:

- *HCAA's Plan is the Only Plan With a Fail-Safe National Cap:*

Statistics are readily available for current home care expenditures nationally, by state, and by local geographic area. HCAA proposes that these be used to establish a fail-safe cap and that this would be the only manageable basis to truly establish the control on the growth in Medicare expenditures. This fail-safe national cap would be modified only for the two adjustments described above: one, a cost of living increase; and two, beneficiary growth. For management purposes, the fail-safe national cap is to be further divided by state, and then by area. To manage (and curtail) fraud/abuse HCAA recommends that, FOR THE FIRST TIME, agencies be given authority to appoint representatives to monitor monthly area claim expenditures made by intermediaries, thus forming a "WE" team between government and providers. Abuses and unnecessary services can be more readily monitored by including the providers in the enforcement process. In the event of demographic population changes, an adjustment could be made between these smaller, manageable components - without altering the national cap.

- *HCAA's Plan is based on a "Per-Visit" PPS Rate - Thus Guaranteeing Care*
  ("Per-Visit" is similar to the "Per-Diem" method HCFA endorses for the SNF industry)

The current visit rates are already known. A geographic phase-in can be made, similar to the DRG phase-in with the exception that a mileage factor be included, in addition to a labor factor. Additionally, to stop hospital inducements to deny patient choice, payments to hospitals need to be "lowered" to reflect administrative costs already covered in their existing hospital DRG inpatient rates. Also, three further restrictions are necessary: First, a hospital cannot be entitled to receive more than 30 percent of its own referrals and should be prohibited from receiving referrals from other community sources. Second, there can be no more than a minimal amount of independent contractors for nursing or aide services (we recommend a 10 percent ceiling on such contracts). Third, physicians may not participate in home care remunerations. There is only one exception, the "sole" community provider. Also, during the phase-in period, agencies must be permitted to market their services in the community, similar to the marketing used by HMOs and other health care providers in their area (with, of course, cost caps remaining during the phase-in).

HCAA RECOMMENDS THAT CONGRESS:
Ensure the following is the minimum criteria standards for any ProspectivePayment Plan (PPS) for home care :

a. **No self-referrals from compensated physicians.**
b. **That Medicare only pays for why patients receive (Per-Visit).**
c. **That home care services are not bundled.**
d. **That home care beneficiaries are not charged a sick tax (co-insurance).**
e. **That a national cap be established (increased only by two factors: First, a cost-of-living increase; and Second, a beneficiary population increase).**

FRED THOMPSON, TENNESSEE, CHAIRMAN

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CARL LEVIN, MICHIGAN
JOSEPH I. LIEBERMAN, CONNECTICUT
DANIEL K. AKAKA, HAWAII
RICHARD J. DURBIN, ILLINOIS
ROBERT G. TORRICELLI, NEW JERSEY
MAX CLELAND, GEORGIA

HANNAH S. SISTARE, STAFF DIRECTOR AND COUNSEL
LEONARD WEISS, MINORITY STAFF DIRECTOR

United States Senate

COMMITTEE ON
GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510-6250

September 17, 1997

The Honorable Charles Grassley
Chairman
Senate Special Committee on Aging
G31 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

I am writing to request that the attached materials be inserted into the official hearing record related to the home health care fraud hearing that you chaired on July 28, 1997.

Specifically, the attached materials include the Healthmaster, Inc. (Healthmaster) indictment (relevant pages), trial testimony, and various news articles related to the Healthmaster trial. I am requesting that these materials be made part of the official hearing record because it appears, based on further investigation, that a witness at the hearing Jeanette Garrison, the convicted owner of Healthmaster, was less than forthcoming in responding to my questions concerning the relationship Healthmaster maintained with the Medicare auditors responsible for auditing their Medicare cost reports.

During the hearing, I asked Ms. Garrison if she provided the Medicare auditors any inducements to give them a clean audit report. In her response, Ms. Garrison stated that since she had never worked with the auditors she did not have any knowledge of any inducements being made.

Additionally, during her testimony Ms. Garrison suggested that the government was deficient in combating Medicare fraud, in part, because government auditors are not up-to-speed with the rules and regulations pertaining to Medicare Part A providers. This seems a bit disingenuous of Ms. Garrison considering, as mentioned in the trial testimony (beginning on p. 33) and in the attached newspaper articles, her company was caught providing Medicare auditors with the services of a prostitute as well as other benefits including her offering them the use of a vacation condominium. Specifically, during the Healthmaster trial, Mr. Glen Voight, an auditor, testified under oath that Ms. Garrison offered him the use of a vacation home. The auditors testimony includes the following examination:

Q: Were you offered the use of any condominiums or automobiles while you were at Healthmaster?

A: I think there was some extension of that of that, yes.

Q: Who offered to you?

A: I think Ms. Garrison stated that if I wanted to take a vacation or something.

Q: At her condominium?

A: Um-hmm.

(Trial transcript at 45-46)

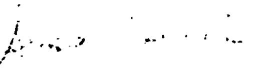
This testimony appears to be inconsistent with Ms. Garrison's response to my question at the July 28, 1997 hearing.

Further, as part of the Healthmaster indictment (relevant pages attached), a Healthmaster official was charged with the obstruction of a federal audit in connection with these issues. This is the same federal indictment that charged Ms. Garrison with several counts of health care fraud.

So that the hearing record is complete and accurate, I am respectfully requesting that these materials be made part of the record.

Thank you for your consideration of this request.

Sincerely,



Susan M. Collins
United States Senator

SMC/tjs:jmf

Former chief financial officer for Healthmaster Inc., Dennis J. Kelly (left), enters federal court Thursday on the second day of hearings. Healthmaster is owned by Jeanette Garrison, who pleaded guilty Wednesday to 10 felony charges.

Auditors: Company sent hooker

By Ben Palmer
Staff Writer

Three former Medicare auditors testified Thursday a prostitute was sent to entertain them on the last day of a two-week audit of Healthmaster Inc. in 1991.

The encounters occurred in a room at the Radisson Riverfront Hotel Augusta the morning after a night of dining, drinking and visiting nightclubs with Healthmaster's former chief financial officer Dennis J. Kelly, the former auditors testified in federal court.

The three auditors also said Mr. Kelly was present at the hotel room on the morning of the encounters.

"Dennis Kelly stuck his head in the room, then left," said Paul Auffant, who was then an auditor for Aetna Life Insurance Co. of Clearwater, Fla.

"Mr. Kelly came in and told us a girl – Kandi – would be coming very shortly," said former Aetna auditor Loren Dyer. "We waited a few minutes. Then Kandi did come in."

Two of the auditors said they had sex with the woman. The third said he spent time with her, but was unable to have sex.

Aetna serves as a government intermediary, overseeing home health care agencies that receive reimbursement under the federal Medicare program.

Government prosecutors accuse Mr. Kelly of attempting to obstruct or impede a federal audit by making available to the auditors the services of a prostitute.

Please see TRIAL *on* 3B

■ Editorial /4A

Continued from 1B

The auditors' testimony came on the first day of Mr. Kelly's trial on wide-ranging Medicare fraud charges. Also on trial is David W. Suba, president of Managed Risk Services and a former Healthmaster employee.

Managed Risk Services is owned by Jeanette G. Garrison, Healthmaster's owner and chief executive officer, who pleaded guilty Wednesday to 10 felony charges and agreed to repay $11.5 million diverted from Medicare and Medicaid for her part in the fraud schemes.

In earlier testimony Thursday, several government witnesses said the former owners of an Albany, Ga., home health care agency bought by Mrs. Garrison were paid as full-time Healthmaster employees for four years, even though they did no work.

Mrs. Garrison purchased River Valley Home Health Agency from the Galloway family in 1986 for about $3.6 million.

Ex-Medicare auditors admit encounter with prostitute

Healthmaster official alleged to have arranged visit by 'Kandi'

By Ben Palmer
Morris News Service

AUGUSTA, Ga. — Three former Medicare auditors admitted Thursday to a sexual encounter with a prostitute at the end of their two-week audit of home health giant Healthmaster Inc. in 1991.

The prostitute visited them at the Radisson Riverfront Hotel after a night of dining, drinking and nightclubbing with Healthmaster's former chief financial officer, Dennis J. Kelly, the auditors testified in federal court.

The three auditors — all of whom have since left the contractor that examines home health companies for Medicare — said Kelly was present at the hotel room on the morning of the encounters.

"Dennis Kelly stuck his head in the room, then left," said Paul Auffant, who was then an auditor for Aetna Life Insurance Co. of Clearwater, Fla.

"Kelly came in and told us a girl — Kandi — would be coming very shortly," said former Aetna auditor Loren Dyer, who now works for one of Healthmaster's leading rivals. "We waited a few minutes. Then Kandi did come in."

Aetna serves as an government intermediary, overseeing home health care agencies that receive reimbursement under the federal Medicare program.

Auditors Auffant and Glenn Voigt admitted to accepting oral sex from the woman, while Dyer said he attempted to have sex with the woman but was unable.

Prosecutors accuse Kelly of attempting to impede a federal audit by supplying the prostitute's services. Kelly's lawyers counter that the auditors solicited and paid the prostitute on their own.

The testimony came at the opening of Kelly's trial on wide-ranging Medicare fraud charges. Also on trial is David W. Suba, president of Managed Risk Services and a former Healthmaster employee.

Managed Risk Services is owned by Jeanette G. Garrison, Healthmaster's owner and chief executive officer. Garrison pleaded guilty Wednesday to 10 felony charges and agreed to repay $11.5 million diverted from Medicare and Medicaid for her part in the fraud schemes.

> **Aetna serves as an government intermediary, overseeing home health care agencies that receive reimbursement under the federal Medicare program.**

Garrison could testify against Kelly and Suba as a result of her plea agreement that was accepted by Senior U.S. District Judge Anthony A. Alaimo.

Also Thursday, several government witnesses testified that the former owners of an Albany, Ga., home health care agency bought by Garrison were paid as full-time Healthmaster employees for four years, even though they did no work.

The salaries of those non-working employees were reported to Medicare illegally as reimbursable costs, prosecutors contend.

Garrison purchased River Valley Home Health Agency from the Galloway family in 1986.

Under terms of the sale, each of the four family members would initially receive $100,000, then $80,000 each annually for the next 10 years, Robert Galloway testified.

The payments were made annually until 1990, when family members began receiving "payroll-type checks" every two weeks, Galloway said.

"Healthmaster changed it. It was not our idea," he said.

Galloway said he and his family had "no complaints about the deal. It was more than a fair price."

Joe Norman, former vice president for finance for Healthmaster who was involved in the 1986 purchase of River Valley, said he discussed with Kelly the possibility of "putting the Galloways on the payroll and how the purchase price would be handled.

"He said 'there's got to be some way we can write it off.' I told him, absent of Medicare fraud, I'm not aware of any way we can do it," Norman said.

"And what was Kelly's response?" asked assistant U.S. Attorney Richard Goolsby.

"I recall him saying some profanity, like 'damn' or something. He was not a happy camper," Norman said.

More than 15 witnesses were called by the government Thursday. Testimony resumes today.

UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF GEORGIA

AUGUSTA DIVISION

UNITED STATES OF AMERICA v. JEANETTE G. GARRISON, DENNIS J. KELLY, DAVID W. SUBA, HEALTHMASTER, INC., MASTER HEALTH PLAN, INC. AND MANAGED RISK SERVICES, INC. DEFENDANTS	INDICTMENT NO. VIOLATIONS: 18 U.S.C.§371 CONSPIRACY TO DEFRAUD THE UNITED STATES (COUNT ONE) 18 U.S.C.§1001 FALSE STATEMENTS (COUNTS 2 - 32) 18 U.S.C.§1516 OBSTRUCTION OF FEDERAL AUDIT (COUNT 33 - 35) 18 U.S.C.§1341 MAIL FRAUD (COUNTS 36 - 78, 110 - 115) 18 U.S.C.§664 EMBEZZLEMENT FROM AN EMPLOYEE BENEFIT PLAN (COUNTS 116 - 121) 18 U.S.C.§1344 BANK FRAUD (COUNT 131) 18 U.S.C.§1956 MONEY LAUNDERING (COUNTS 79 - 109) (COUNTS 122 - 130, 132) 18 U.S.C.§982 CRIMINAL FORFEITURE (COUNT 133) 18 U.S.C.§2 AIDING AND ABETTING

Medicare which fraudulently failed to disclose MANAGED RISK SERVICES, INC. [hereinafter MRS], and/or Advanced Medical Supplies, Inc. [hereinafter AMS], as "related" companies or organizations; done in violation of Title 18, United States Code, Sections 1001 and 2.

Count/Date	Concealed "Related" Company	Cost Report Document
Count 27 3/30/90	AMS	1989 Fiscal Year Augusta Component Supplemental Worksheet A-6 Section C
Count 28 4/3/91	AMS	1990 Fiscal Year Augusta Component Supplemental Worksheet A-6 Section C
Count 29 4/9/92	AMS	1991 Fiscal Year Augusta Component Supplemental Worksheet A-6 Section C
Count 30 4/3/91	MRS	1990 Fiscal Year Home Office Cost Report Schedule D, Part C
Count 31 4/9/92	MRS	1991 Fiscal Year Home Office Cost Report Schedule D, Part C
Count 32 3/30/93	MRS	1992 Fiscal Year Home Office Cost Report Schedule D, Part C

All done in violation of Title 18, United States Code, Sections 1001 and 2.

COUNT 33
(Obstruction of a Federal Audit)
(The Prostitute Allegation)

THE GRAND JURY FURTHER CHARGES THAT:

The General Allegations section of this indictment is hereby incorporated as if fully set forth herein.

On or about May 17, 1991, in Richmond County, within the Southern District of Georgia, the defendant herein:

DENNIS J. KELLY

with intent to deceive and defraud the United States, endeavored to influence, obstruct, and impede a Federal auditor in the performance of official duties relating to HEALTHMASTER, INC., which received in excess of $100,000.00 from the United States each year under a contract, that is, a provider agreement with the United States Department of Health and Human Services, to-wit: during the fiscal year 1989 on-site audit in Augusta, Georgia, by intermediary Aetna Life Insurance Company, (conducted in May, 1991), DENNIS J. KELLY made available the services of a prostitute to an Aetna auditor at an Augusta motel; done in violation of Title 18, United States Code, Section 1516.

COUNT 34
(Obstruction of a Federal Audit)
(The Prostitute Allegation)

THE GRAND JURY FURTHER CHARGES THAT:

The General Allegations section of this indictment is hereby incorporated as if fully set forth herein.

On or about May 17, 1991, in Richmond County, within the Southern District of Georgia, the defendant herein:

DENNIS J. KELLY

with intent to deceive and defraud the United States, endeavored to influence, obstruct, and impede a Federal auditor in the

ORIGINAL

U.S. DIST COURT
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SO. DIST. OF GA.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF GEORGIA
AUGUSTA DIVISION

UNITED STATES OF AMERICA,	:	Case No. CR195-11
Plaintiff,	:	
vs.	:	
DENNIS J. KELLY, DAVID W. SUBA, MANAGED RISK SERVICES, INC.,	:	
Defendants.	:	Augusta, Georgia July 27, 1995

TESTIMONY OF BRENDA CHEWNING, GLEN VOIGT,
PAUL AUFFANT & LOREN DYER
TRIAL PROCEEDINGS
BEFORE THE HONORABLE ANTHONY A. ALAIMO
United States District Judge and a Jury

APPEARANCES:

For the Government:

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FREDERICK W. KRAMER, III
Assistant United States Attorneys
HARRISON KOHLER
Special Assistant United States Attorney
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Reported By:

Norma Hatfield
Official Court Reporter
801 Gloucester Street, Room 237
Post Office Box 1316
Brunswick, Georgia 31521-1316
(912) 262-9989

APPEARANCES (Continued):

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	WILLIAM H. LUMPKIN, ESQUIRE 505 Courthouse Lane Augusta, Georgia 30901 (706) 722-0815
For Defendant David W. Suba:	ANTHONY L. COCHRAN, ESQUIRE Chilivis & Grindler 3127 Maple Dr., N.E. Atlanta, Georgia 30305 (404) 233-4171

1 P R O C E E D I N G S
2 * * * * * * * * * * * * *
3 BRENDA CHEWNING, GOVERNMENT'S WITNESS, PREVIOUSLY SWORN
4 THE CLERK: Please state your full name, spell your
5 last, state your residence and occupation.
6 THE WITNESS: Brenda S. C-H-E-W-N-I-N-G. My
7 address is 18302 Keystone Boulevard, Odessa, Florida.
8 THE COURT: Use that mike, please.
9 THE WITNESS: 33556. I'm sorry. What was the last
10 part of the question?
11 THE CLERK: Your occupation.
12 THE WITNESS: I am a senior audit representative
13 for the Aetna Life Insurance Company.
14 DIRECT EXAMINATION
15 BY MR. GOOLSBY:
16 Q. How long have you worked with Aetna?
17 A. I have been with Aetna seven years.
18 Q. Where is Aetna located?
19 A. Clearwater, Florida.
20 Q. What are your duties?
21 A. As a senior audit representative, I supervise a team of
22 Medicare auditors.
23 Q. Has Aetna contracted with the federal government to
24 conduct Medicare audits on health care providers like
25 Healthmaster located here in Augusta?

1 A. Yes, they have.
2 Q. Would you very briefly describe what Aetna does?
3 A. Aetna, under the contract with the federal government
4 for Medicare, we have one office that does claims
5 processing. We refer to that as our benefits
6 administration office.
7 And then we have an audit reimbursement office which
8 handles payments to providers.
9 Q. What states does your office in Clearwater cover?
10 A. We cover Florida, Georgia, Mississippi, and Alabama.
11 Q. About how many auditors do you have to cover those four
12 states?
13 A. We have fifteen to eighteen auditors at a given time.
14 Q. Can you give the jury some perspective of about how many
15 home health care agencies and health care providers like
16 Healthmaster these auditors have to cover in these four
17 states?
18 A. The auditors cover -- handle three hundred and fifty,
19 approximately, home health agencies.
20 Q. Do you have time to audit each of those three hundred
21 and fifty agencies every year?
22 A. No, we do not. We --
23 Q. Do -- excuse me. Go ahead.
24 A. We audit approximately 10 percent, 10 to 15 percent.
25 Q. Have you participated in audits at Healthmaster here in

1 Augusta?
2 A. Yes, I have.
3 Q. In what years?
4 A. In 1991, I participated in the audit for the fiscal year
5 ending 12/31/89. And I believe in 19- -- late '88 and early
6 '89, I participated in the audit of the 12/31/87 cost
7 report.
8 Q. Regarding the 1989 fiscal year audit which was conducted
9 in 1991 --
10 A. Yes.
11 Q. -- about how long was your audit team on site, that is
12 at Healthmaster here in Augusta?
13 A. To my recollection, the audit team was on site four or
14 five weeks. We audited the home office and I believe it was
15 five agencies for that fiscal year-end.
16 I believe two members of the audit team had come out for
17 one week early in the year to set up the audit, sort of a
18 preparatory trip. I was on-site for two weeks in April, and
19 I believe there were three others on-site possibly in May.
20 And there were two other auditors with me when I was
21 on-site in April.
22 Q. What was the purpose of your visit to Augusta in April,
23 that part of the five agencies?
24 A. It was -- to do part of the audit, we do financial
25 compliance audits for Medicare.

1 So it would have been to review the provider's cost
2 reports and to, on a sample basis, trace costs that were on
3 the cost report back to supporting documentation.
4 Q. What was the purpose of the other auditors coming to
5 Augusta in May of '91, at the end, for a couple of weeks?
6 A. It would have been for the same purpose. It was just
7 not possible to do it in a two-week period. And we try not
8 to have the auditors be out of town for more than two weeks
9 at a time.
10 Q. Do you audit or analyze all the financial transactions?
11 A. No, not by any means.
12 Normally what we do is before we go on-site, an auditor
13 will review the cost report in the office. They will
14 compare the cost report that we're auditing to the prior
15 year.
16 We will do an analyses of the general ledger, comparing
17 both years and try to identify accounts where expenses have
18 increased or decreased significantly.
19 We will then prepare a scope which is identifying only
20 certain accounts that we will look at.
21 We notify the provider approximately thirty days ahead
22 of time as to which accounts we will be reviewing. And a
23 lot of times we will be asking for specific transactions.
24 So we limit the number of accounts we look at. And when
25 we look at a particular account, we also look at the number

1 of transactions that we review.
2 Q. Do you take just a small random sample?
3 A. We don't do statistical random sampling. We don't use
4 those types of techniques due to time constraints.
5 We will do things such as review all entries $2,000 or
6 more. We might look at three months or four months, try to
7 look at all the transactions in those months, or we might
8 try to look at at least one invoice for each vendor in the
9 account.
10 But we cannot -- we just don't have the time to look at
11 every account or every transaction.
12 Q. You mentioned in 1991, you looked at the home office and
13 five agencies.
14 What did you mean by five agencies?
15 A. We also review five home health agencies' cost reports
16 in addition to the home office cost reports.
17 Q. Is that five of many satellite offices of Healthmaster?
18 A. Yes.
19 Q. Rather than all of the satellite offices of
20 Healthmaster?
21 A. That's right.
22 Q. Are your audits designed to detect fraud?
23 A. No. We do not do a fraud audit. We're merely doing a
24 compliance audit, are they complying with the reporting
25 requirements issued by the government.

1 It's not our responsibility to do a fraud audit. To try
2 to do so would be stepping outside the bounds of what we are
3 contracted to do with the government.
4 Q. For example, do you follow employees to see whether
5 they're reporting to work at Healthmaster?
6 A. No, we do not.
7 Q. When you say it's a compliance audit, do you mean to
8 comply with Medicare regulations?
9 A. That's right. If I may add, we -- if we suspect that
10 there is a potential that there could be fraud, if something
11 -- a situation presents itself that if there is that
12 possibility, we are required to refer that to the Office of
13 the Inspector General.
14 And they are the investigative unit for fraud.
15 Q. Very briefly, what costs of a home health are provider
16 like Healthmaster will Medicare regulations allow
17 reimbursement of?
18 A. Medicare allows reimbursement of regular business
19 operating costs. That would include salary costs and fringe
20 benefits. It would include the cost of an office, rent,
21 utilities, office supplies, equipment -- you know, computers
22 copiers.
23 Most costs that are associated with the running of a
24 normal business would be allowable.
25 THE COURT: How about legal expenses?

1 THE WITNESS: Legal expenses?
2 THE COURT: Are they allowable?
3 THE WITNESS: Yes. What we look at is is it
4 related to patient care.
5 BY MR. GOOLSBY:
6 Q. Would that be legal expenses related to patient care?
7 A. That's right. All the expenses that I mentioned would
8 be only if they were related to patient care.
9 Q. What about legal expenses related to buying other
10 companies?
11 A. No. That would not be an allowable expense.
12 Q. Also, very quickly, would you please explain what role
13 the cost reports play in the reimbursement process?
14 A. The providers are required to complete a cost report
15 usually every twelve months.
16 The cost report is to present to Medicare what the cost
17 of running the business was for that twelve month period.
18 And that is the report that we audit. That is what we use
19 to conduct our audit.
20 Q. Are you familiar with terms like "reasonable" and
21 "necessary"?
22 A. Yes, I am.
23 Q. Would you explain very quickly, what is the standard for
24 reimbursement?
25 A. For a cost to be allowable for Medicare, it must be a

1 reasonable and necessary cost in providing patient care. It
2 must be needed.
3 Providers are required to maintain documentation that a
4 capable auditor can go in and review and see that the costs
5 were reasonable and necessary and related to patient care.
6 Q. Ms. Chewning, are you also familiar with the Medicare
7 regulations relating to related parties, that is,
8 transactions between a home health care provider, like
9 Healthmaster, and a company that it either owns or controls?
10 A. Yes, I am.
11 Q. What do those regulations provide?
12 A. The regulations provide that if a provider is dealing
13 with a related party, that the related party be disclosed,
14 and that any costs be included on the cost report that were
15 paid to the related party for goods or services be stated at
16 the cost to the related party.
17 Q. Are home health care providers allowed to make a profit
18 off their dealings with related companies?
19 A. No, they're not. They are only allowed to claim the
20 cost to that company.
21 Q. Are they required to report transactions with related
22 parties in the cost reports?
23 A. Yes, they are.
24 Q. Do you recall what related parties Healthmaster reported
25 in the year you were responsible for audits there?

1 A. On the 12/31/89 cost report, they reported Rose Hill
2 Limited, which was a real estate partnership owned by the
3 Garrisons.
4 And the home office, I believe it was, rented a building
5 that that partnership owned.
6 Q. Can you tell these people over here whether or not
7 Healthmaster ever disclosed Managed Risk Services, Inc. as a
8 related party in the cost reports?
9 A. No, not that I'm aware of.
10 Q. Who at Healthmaster did you primarily deal with
11 concerning the audit?
12 A. I dealt primarily with Dennis Kelly.
13 Q. What was his position then as you understood it?
14 A. He was the chief financial officer for Healthmaster,
15 Inc.
16 Q. Did Healthmaster also have a director of reimbursements
17 during this time period?
18 A. Yes, they did.
19 Q. Who?
20 A. Mike Haddle.
21 Q. Was it unusual in your experience or anything out of the
22 ordinary for you to deal with the chief financial officer,
23 Mr. Kelly, instead the director of reimbursements,
24 Mr. Haddle?
25 A. It was somewhat unusual. Normally, we would deal with

1 the reimbursement person, whatever their title was.
2 It's not necessarily unusual that we would deal with the
3 chief financial officer if their function also included
4 reimbursement. Some providers do not have a separate
5 reimbursement specialist or director of reimbursement.
6 But in this particular case, we did deal, especially
7 when we were on the audit, almost exclusively with Mr. Kelly
8 and not much at all with Mr. Haddle.
9 Q. Do you recall any instructions about whether or not
10 Mr. Haddle would have access to all the financial
11 information which you examined when you were on-site
12 conducting your audits?
13 A. What I recall is with regards to payroll information, we
14 were instructed that that was confidential and should not
15 be seen by anyone. And my understanding was that was
16 Mr. Haddle.
17 Q. Who gave you that instruction?
18 A. Mr. Kelly.
19 Q. Who participated in the 1989 fiscal year audit, which
20 actually happened in 1991, besides you?
21 A. There was also Glen Voigt, a senior representative with
22 Aetna, Paul Auffant, and Loren Dyer.
23 Q. What role did Glen Voigt play in that audit that
24 actually took place in 1991?
25 A. Glen Voigt was the auditor in charge. He had ultimate

1 responsibility for what took place on the audit.
2 Q. Were you there the last two weeks when these three men
3 you just named were actually at Healthmaster conducting
4 their audit?
5 A. I was not there on the last two weeks, no.
6 Q. Were you ever offered any gifts or gratuities by anyone
7 at Healthmaster?
8 A. Yes. On one occasion, they purchased a lunch for us.
9 On another occasion, they purchased a dinner.
10 We were there for a two-week period, and over that
11 weekend they offered us the use of a condo in Hilton Head
12 and also the use of a company-owned vehicle, which we
13 declined on both of those.
14 Q. Who offered you these things? Who provided these things
15 that were provided?
16 A. Mr. Kelly. And I believe at one point Mrs. Garrison
17 might have also stopped in.
18 Q. Do you remember which occasion that was?
19 A. It would have been at the same time.
20 Q. Do you recall any -- were any gifts in particular -- any
21 picture of scenes of the Augusta National Golf Course
22 provided to any of the auditors while you were there?
23 A. While I was there in 1988 or early '89 on the 12/31/87
24 audit, a picture -- I didn't actually see it, but I was
25 aware that a picture had been presented Glen Voigt.

1 My knowledge of the situation is that he ultimately
2 purchased the picture himself.
3 Q. Do you know about how much he paid for it?
4 A. No, I don't.
5 Q. Do you know who provided or gave or sold it to him?
6 A. Not specifically, no.
7 Q. Were you aware that Healthmaster had bought River Valley
8 Home Health Care Agency?
9 A. Yes.
10 Q. Did your audits detect the practice of the Galloways
11 being put on the Healthmaster payroll?
12 A. No, it did not.
13 Q. In your opinion, assuming that the Galloways actually
14 did not work full-time as Healthmaster employees and that
15 their so-called salaries were equal to the purchase price,
16 would this be properly reimbursable by Medicare?
17 A. It would not be properly reimbursable if they were not
18 performing functions that were allowable and related to
19 patient care.
20 They would actually have to be performing services not
21 to have just sold something to Healthmaster.
22 Q. Let me ask you just a couple of questions about what
23 your audit did detect.
24 For example, do you recall any Christmas gifts purchased
25 for Mrs. Garrison by Dennis Kelly?

1 A. Yes. I recall one instance -- I believe it was on the
2 12/31/91 cost report where there was a gift, a glass bowl
3 worth approximately $2,500, that was purchased and claimed
4 for reimbursement.
5 Q. What position did you take?
6 A. We disallowed the expense.
7 Q. Briefly what is an exit conference?
8 A. An exit conference is a meeting held usually at the
9 conclusion of the field work, or the if there were
10 significant open issues, it might be held at a later date.
11 It is a time when we sit down with the provider, discuss
12 any adjustments to be made or any potential areas of
13 disagreement where they provide us with additional
14 documentation.
15 Q. Are these generally held at the conclusion of an audit
16 at a home health care provider like Healthmaster?
17 A. Most times they are.
18 MR. GOOLSBY: Thank you.
19 THE COURT: Ms. Jones.
20 CROSS EXAMINATION
21 BY MS. JONES:
22 Q. Good morning, Ms. Chewning. My name is Celeste Jones,
23 and I represent Mr. Kelly.
24 Ms. Chewning, how long have you been working at Aetna?
25 A. Seven years.

1 Q. And during the period of time of this '89 cost report
2 audit at Healthmaster, you weren't senior representative
3 then, were you?
4 A. No, I was not.
5 Q. Mr. Voigt was the senior representative.
6 A. That's right.
7 Q. And to be the senior representative on one of these
8 audits means that you're in charge of the overall audit,
9 doesn't it?
10 A. That's right.
11 Q. But it doesn't necessarily give you the authority to
12 make any final decisions, does it?
13 A. Final decisions? I'm not sure exactly sure what you
14 mean. It would give you --
15 Q. As to what would be allowed or not allowed.
16 A. Well, it would -- the senior in the field would, of
17 course, have an opinion on proposing an adjustment for
18 something to be disallowed. But there would be an
19 additional review done back at the office.
20 Q. That's what I wanted you to explain, if you would,
21 please.
22 When you were out in the field and when you were at
23 Healthmaster and there were things on the -- in the cost
24 report that you were disallowing, you had to take that back
25 to your home office.

1 And you made your recommendation and told your
2 supervisors what you thought. And then the decision was
3 made; isn't that right?
4 A. That's right. What we do is we prepare a work paper and
5 our conclusions say propose to or adjust whatever propose to
6 or disallow. And there is an additional review that is done
7 back in the office.
8 Q. On this occasion, the adjustments for 1989, there was
9 basically no review back at the office because nobody at
10 Healthmaster disagreed with any of the adjustments, did
11 they?
12 A. I don't know. One, I did not attend the exit
13 conference, so I can't really state whether they stated
14 objections or not to the adjustments.
15 Q. You don't know?
16 A. I don't know.
17 Q. Okay. And you haven't seen anything about that since
18 then?
19 A. Not that I can recall. I don't recall that there were
20 any major adjustments they were opposed to, but I can't
21 really say that I knew.
22 Q. And you say that when you were there, you were somewhat
23 concerned -- or maybe you weren't concerned -- but you said
24 it was a little different for you to be dealing with
25 Mr. Kelly and not Mr. Haddle; is that right?

1 A. Yes, a little different from other providers.
2 Q. And that was because Mr. Haddle was the one who actually
3 prepared and signed the cost reports, isn't it?
4 A. He prepared and signed the cost reports and, I believe,
5 the interim rate reports.
6 Q. And, in fact, on each cost report, there is a signature
7 block whereby the person who is preparing the cost reports
8 certifies that there has been no intentional
9 misrepresentation, falsification.
10 And they certify that they have read all the information
11 in the statement, that they have examined the statement of
12 allowable home office costs, and the allocation to the chain
13 components of the other supporting schedules for the period
14 in question. And then they certify it to the best of their
15 belief that everything in this cost report is true and
16 correct and has been prepared from the books and records in
17 accordance with your Medicaid regulations; isn't that right?
18 A. Medicare regulations.
19 Q. Medicare regulations.
20 And Mr. Haddle signed these on each occasion that you're
21 aware of, didn't he?
22 A. To the best of my knowledge, yes, he did.
23 Q. And to the best of your knowledge, Mr. Dennis Kelly
24 didn't sign any of them, did he?
25 A. I'm not aware that he did.

1 Q. In fact, if a situation existed in the company where
2 Mr. Haddle had prepared this cost report, specifically for
3 1989, you all don't come in until about a year and a half
4 later to do your audit; isn't that right?
5 A. That's right.
6 Q. If in that interim time period -- I believe you are
7 aware of this, that Mr. Haddle had made a $300,000 mistake
8 in one of the cost reports. He had failed to remove some
9 $300,000 in costs in one cost report that you were
10 specifically involved in concerning people that worked at
11 Master Health Plan; isn't that true?
12 A. That's true. There was a $300,000 income item that was
13 not offset that should have been.
14 Q. And Dennis Kelly brought that to your attention, didn't
15 he?
16 A. No. Mike Haddle brought that to my attention.
17 Q. Are you not aware of -- you are not aware of the -- of
18 anything that went on between Mr. Haddle and Mr. Kelly
19 concerning that issue.
20 A. I can tell you what I know about the issue.
21 Q. You know that there was a mistake on the cost report.
22 A. I know that I received a call from Mike Haddle in -- I
23 believe it was April of 1994, stating that there was this
24 $300,000 income item that should have been offset and was
25 not.

1 And then I requested he send us something in writing.
2 And he sent us a memorandum to that effect.
3 Q. And, if fact --
4 MS. JONES: If I may approach, Your Honor.
5 THE COURT: Yes.
6 BY MS. JONES:
7 Q. He sent you this memorandum that is dated April the
8 22nd, 1994. And in that memorandum, he states that "It has
9 come to our" -- and I quote "our" -- "attention that we made
10 a mistake."
11 A. That's right.
12 Q. Okay. Thank you, ma'am.
13 And if that situation had come up that it had been
14 discovered that Mr. Haddle made such a mistake, would it be
15 unusual for the other company officials to be concerned
16 about the quality of Mr. Haddle's work and start watching
17 him more closely?
18 A. I don't really know what action they would take.
19 Q. You wouldn't find that unusual, would you?
20 A. I wouldn't find it unusual, no.
21 Q. And I believe you testified that Mr. Haddle -- that the
22 people at Healthmaster told you the payroll information was
23 highly confidential.
24 A. Yes.
25 Q. And, in fact, that is true for a great many companies --

1 A. That's correct.
2 Q. -- as well as this company?
3 A. That's common.
4 Q. Payroll information is highly confidential.
5 But were you aware that --
6 MS. JONES: If I may approach, Your Honor.
7 BY MS. JONES:
8 Q. -- that Mr. Haddle received from the payroll department
9 information in order to prepare the cost reports?
10 A. I'm sorry. What was the question?
11 Q. Are you aware that Ms. Carolyn Brantley was the head of
12 the payroll department?
13 A. No, I wasn't.
14 Q. Were you aware that Mr. Haddle received, after reviewing
15 that memorandum and looking at the cost reports -- cost
16 reports have got all kinds of payroll information in them,
17 don't they?
18 A. Certainly, salary information.
19 Q. In order for Mr. Haddle to fill these cost reports out,
20 he would have had to receive some information about the
21 payroll, wouldn't he?
22 A. That's right.
23 Q. And, in fact, that memorandum indicates that he made
24 requests and received it, doesn't it?
25 A. Yes.

1 THE COURT: Is that an exhibit?
2 MS. JONES: Yes, sir. It's Number 179.
3 THE COURT: So the record is clear --
4 MS. JONES: Yes, sir.
5 THE COURT: -- when you're using it, tell us what
6 it is.
7 MS. JONES: Yes, sir.
8 BY MR. COCHRAN:
9 Q. And in addition to the -- let me back up a second.
10 Now you were aware that Healthmaster had purchased River
11 Valley when you did the 1989 audit, weren't you?
12 A. I don't know if I knew of it right at that time. I know
13 that they had purchased that. I can't say at what point in
14 time I became aware of it.
15 Q. Well, in fact, after the 1989 audit, one of
16 Healthmaster's competitors raised some issues about that and
17 challenged whether or not this particular audit had been
18 done properly, didn't they?
19 A. Yes.
20 Q. And you, in fact, were interviewed and work pages and
21 everything was reviewed by the Department of Health and
22 Human Services; is that correct?
23 A. Which papers are you referring to?
24 Q. The '89 audit work papers.
25 A. The '89 Healthmaster work papers?

1 Q. Yes, ma'am. Isn't that correct?
2 A. I believe so, yes.
3 Q. And you were interviewed by a gentleman -- the branch
4 chief of the Department of Health and Human Services, a Mr.
5 Dale Kendricks; is that correct?
6 A. Yes.
7 Q. And isn't it true that Mr. Kendricks, along with
8 yourself, received information about the purchase of the
9 Galloway agency and also received from your office all of
10 the backup information concerning this non-compete
11 agreement; isn't that correct?
12 A. I don't recall discussing that with Mr. Kendricks.
13 The only interview I can recall with Mr. Kendricks was a
14 telephone interview.
15 Q. Let me show this, if I may, Defendant Kelly's Exhibit
16 Number 43.
17 THE COURT: What is it?
18 MS. JONES: That's Mr. Kendricks' report, Your
19 Honor, the one that we're speaking about.
20 BY MS. JONES:
21 Q. That is Mr. Kendricks' report from the Department of
22 Health and Human Services.
23 THE COURT: What is your question?
24 MS. JONES: I was going to ask her about the work
25 papers that are included in there.

1 THE COURT: Sure.
2 BY MS. JONES:
3 Q. If you can just take a minute and look at it.
4 A. Okay.
5 THE COURT: What is your question now?
6 BY MS. JONES:
7 Q. My question is: If you will look at the second -- it's
8 either -- look at the first or the second yellow tab.
9 And those are the work papers that an Aetna auditor
10 prepared in regard to the Galloways in this non-competition
11 agreement. If you would look --
12 A. Okay.
13 Q. Those are the work papers from the Aetna people that did
14 this audit; is it not?
15 A. Yes.
16 Q. Excuse me?
17 A. It appears to be a work paper prepared by Loren Dyer.
18 Q. And it concerns the Galloway family and the River Valley
19 purchase, doesn't it?
20 A. Could you give me a minute to read it?
21 Q. Certainly.
22 Q. Is that what those records --
23 A. I'm sorry. What was your question again?
24 Q. Those are the work papers concerning the Healthmaster
25 purchase of the River Valley agency about the Galloways.

1 A. And the non-compete agreement.
2 Q. And the non-compete agreement.
3 A. That's right.
4 Q. And, in fact, it makes reference to the 1989 cost report
5 where $300,000 was backed out for this non-compete
6 agreement, doesn't it?
7 A. Well, it looks here like they're making an adjustment
8 for $63,000 -- to remove $63,000 -- or $60,000 of that was
9 for the non-compete agreement, and the other 3,000 was for
10 good will.
11 Q. But the money was backed out.
12 A. We backed it out by adjustment.
13 MR. GOOLSBY: Objection. The question answered
14 otherwise.
15 THE COURT: The $63,000 is what she is talking
16 about.
17 BY MS. JONES:
18 Q. Was it 63 or 360?
19 A. We made an adjustment on the cost report. They claimed
20 63,000 in goodwill and non-compete expenses that we removed
21 from the cost report.
22 60,000 of that related to the non-compete agreement of
23 the Galloways. We made the adjustment, not the provider.
24 Q. How much was self-allowed by the adjuster -- I mean --
25 by Healthmaster?

1 A. I'm not sure what "self-allowed" means.
2 Q. Self-disallowed.
3 A. From what I can see, it didn't disallow any of the
4 non-compete agreement. They had claimed -- what they did
5 was -- let me just look here for a minute.
6 Okay. It appears, in total, the non-compete agreement
7 was $320,000. They were amortizing this expense and doing
8 so at $5,000 a month.
9 So in one year, they're amortizing 60,000. They
10 included that 60,000 on the cost report for reimbursement,
11 and we disallowed it. That is not an allowable cost.
12 Q. Thank you. And those were from the Aetna work papers;
13 isn't that correct?
14 A. Yes, they were.
15 Q. So at the time -- and those were prepared when the 1989
16 -- when the audit of the 1989 cost report was done; isn't
17 that right?
18 A. It was prepared on whatever date was marked on there. I
19 didn't notice what the date was.
20 If you will let me see it again, I can tell you what the
21 date is.
22 It would have been 3/5 of '91.
23 Q. That's when you all were doing the audit of the '89 cost
24 report; isn't that right?
25 A. That's right.

1 Q. And these initials "LMD" are the initials of one of the
2 Aetna auditors; are they not?
3 A. Loren Dyer.
4 Q. So the existence of the River Valley Home Health Agency
5 was disclosed, wasn't it?
6 A. Yes.
7 Q. Thank you.
8 And I believe you testified that, in addition, you also
9 disallowed a $2,502.50 on a purchase of a Christmas gift for
10 Dr. and Mrs. Galloway (sic); is that correct?
11 A. Yes.
12 MS. JONES: If I may approach, Your Honor.
13 BY MS. JONES:
14 Q. And during the audit, you requested the documentation on
15 that particular expense; did you not?
16 A. I did not personally, but the auditors who were involved
17 would have.
18 Q. Doesn't it plainly state on the face of that exhibit
19 what it was for?
20 A. Yes, Christmas gift for Dr. and Mrs. Garrison.
21 Q. There is nothing hidden about that, is there?
22 A. No.
23 Q. It's plainly written on there and easier to understand,
24 isn't it?
25 A. That's right.

1 Q. And finally, when you were doing -- when you do these
2 audits and when you were doing this particular audit, you
3 look at the compensation that was paid to the officers in
4 the company like Mr. Kelly and Mr. Haddle and Peter Molloy,
5 the lawyer for the company, and Mrs. Garrison; don't you do
6 that?
7 A. We normally do that. I couldn't state specifically who
8 we reviewed in what year, but that would be reasonable.
9 That's a normal audit step.
10 Q. What you do is you look at the salary the company is
11 paying them, and you compare it to the average salary or the
12 -- what do you compare it to to determine whether or not
13 it's reasonable?
14 A. I really can't tell you what it's compared to. There
15 was a gentleman in our office who is a higher level than
16 myself and does the actual compensation reviews.
17 And he has a data base that he uses. I couldn't tell
18 you what specifically makes up that data base.
19 Q. I believe that you had stated that it was based on
20 statistical studies.
21 A. Yes. I believe it's based on some sort of report that
22 is issued -- I don't know who it's issued by.
23 I would think it would be some sort of a report that
24 relates to health care providers and what the compensations
25 are.

1 Q. And if it's a reasonable, you allow it; and if you find
2 it's not reasonable, then you adjust it?
3 A. That's right.
4 Q. And in order for a company to be reimbursed for
5 anything, even if you challenge it, they have to first put
6 it on a cost report, don't they.
7 A. That's right.
8 Q. They can't appeal or go to some higher decision-maker if
9 it's not on that cost report in the first instance, can
10 they?
11 A. That's right. However, if they know an item is not
12 allowable, they shouldn't identify it as such. And they
13 aren't allowed to report protested items.
14 Q. And in regard to related parties, the reason that you
15 report a related party is you're not supposed to make a
16 profit off of the monies that Medicare is paying; isn't that
17 true?
18 A. That's true.
19 Q. If a related party is not making a profit off of any
20 Medicare monies, then there would be no adjustment, would
21 there?
22 A. If they're not making a profit? If they're just
23 reporting costs, then there probably would not be an
24 adjustment. But it would still need to be reported.
25 Q. And in addition, there is a 10-10 exception for related

1 parties; is there not?
2 A. Yes, there is.
3 Q. Telling me about 10-10 exceptions.
4 A. The 10-10 exception has four criteria. If the provider
5 is able to meet the four criteria, then they do not have to
6 report the related party costs at the cost to the related
7 party.
8 Q. So that would be another -- that's an exception to this
9 rule that you spoke about earlier.
10 A. That's an exception, yes. But they must meet all the
11 criteria, and they must also notify us if they're claiming
12 the 10-10 exception.
13 Q. As you stated that Managed Risk Services was not
14 disclosed, but the Georgia Health Care Provider program was
15 fully disclosed, wasn't it?
16 A. I'm not sure what you're talking about when you say
17 "Georgia Health Care Provider program."
18 Q. The program for the Healthmaster worker's compensation
19 and health insurance programs. Those two things were fully
20 disclosed, weren't they?
21 A. I'm not that familiar with the workers' comp insurance.
22 The health insurance, from what I can recall, in May of '89,
23 they switched to a self-insurance fund.
24 And they created a trust where they would maintain the
25 funds for that insurance program. And we did review that in

1 1989.
2 Q. So you do recall that the information about the health
3 program was fully disclosed.
4 A. The health program was fully disclosed. What wasn't
5 disclosed was that it involved a related party.
6 Q. Ms. Chewning, were you still with the auditors with --
7 in 1991 when they were doing the '89 review when the
8 auditors went out to some honky-tonks in town? Did you do
9 that with Glen Voigt and Loren Dyer and Paul Auffant?
10 A. I was never in Augusta at the same time with Mr. Voigt.
11 I was in Augusta that one time with Loren Dyer and Paul
12 Auffant, but Glen and I were on different trips.
13 Q. Did you ever go out to any of the honky-tonks or strip
14 joints in Augusta?
15 A. We at one point went to a semi-nude dancing bar.
16 Q. Was it the Discotheque Lounge?
17 A. I couldn't tell you what the name of it was.
18 Q. Mr. Kelly wasn't with you, was he?
19 A. Yes, he was.
20 Q. He was with you that night?
21 A. Yes.
22 Q. And you all went to a nude dancing bar?
23 A. Semi-nude, yes.
24 Q. And you went too?
25 A. Yes. I didn't know that's what it was. And we stayed a

1 very short time and left.
2 Q. Did you go any other nights?
3 A. No.
4 Q. Did you go to Mr. Voigt's -- I guess Mr. Dyer's room and
5 watch any adult movies while you were there with him?
6 A. No.
7 Q. Or did you engage in any late night dining with him
8 while you were there?
9 A. No.
10 MS. JONES: Thank you, Ms.Chewning. That's all I
11 have.
12 THE COURT: Mr. Cochran, anything?
13 MR. COCHRAN: No questions.
14 THE COURT: Any redirect?
15 MR. GOOLSBY: Very briefly.
16 REDIRECT EXAMINATION
17 BY MR. GOOLSBY:
18 Q. Ms. Chewning, you indicated that you were aware of the
19 purchase of River Valley.
20 But did Dennis Kelly ever inform you that the Galloways'
21 salaries were included in different satellite offices of the
22 cost reports?
23 A. Not that I'm aware of, no.
24 MR. GOOLSBY: No further questions.
25 * * * * * * * * * * * * * *

1 GLEN VOIGT, GOVERNMENT'S WITNESS, PREVIOUSLY SWORN
2 THE CLERK: You can be seated over at the witness
3 stand, please.
4 Please state your full name, spell your last, state
5 your residence and occupation.
6 THE WITNESS: Glen Frederick Voigt. The last name
7 is spelled V, as in Victor, O-I-G-T. I live at 109 Bay Wind
8 Drive in Niceville, Florida, 32578. And I'm a chief
9 financial officer for a small home health care company in
10 the Panhandle of Florida.
11 THE COURT: Would you use that microphone,
12 Mr. Voigt? Just hold it in your hand.
13 DIRECT EXAMINATION
14 BY MR. GOOLSBY:
15 Q. Have you ever worked at Aetna Life Insurance Company out
16 of Clearwater?
17 A. Yes, I have.
18 Q. When?
19 A. I started working for Aetna in 1982, I believe it was.
20 I spent about two years with them at that point in time.
21 And I left Aetna and went to work for a couple of CPA firms.
22 And I rejoined Aetna in 1987 and worked with them up
23 until about a year and a half ago.
24 Q. What was your position with Aetna?
25 A. I started out as a low level accountant, as an analyst

1 back in 1982. And I had -- at the end of my term with
2 Aetna, I was a senior representative.
3 Q. Briefly, what were your duties?
4 A. I was responsible for the administration of a certain
5 group of home health agencies.
6 I assume you're talking about my last term.
7 Q. Yes, sir.
8 A. -- with at group of home health agencies, maybe
9 thirty-five or so -- excuse me -- about a hundred or so.
10 It would be about thirty per auditor that would be
11 assigned underneath me to administer the PIP reporting, cost
12 reporting, desk review procedures, and so on and so forth
13 that go along with the home health payments process.
14 Q. Did you ever participate in any audits at Healthmaster
15 here in Augusta?
16 A. Yes, sir, I did.
17 Q. When?
18 A. I participated in the audit of fiscal years 1987, 1988,
19 and 1989.
20 Q. What role did you play?
21 A. In 1987, I was processing audits for the Healthmaster
22 reports, which basically meant that I worked them up to the
23 point of determining whether they were audit criteria for
24 our office or not and then scoping audits and so on and so
25 forth, and basically maintained the process for the audit,

1 coming to the field, actually doing the audit, and then
2 wrapping up finalizations at the end of that -- after I was
3 back in the office.
4 So I had basic responsibilities from start to finish in
5 '87.
6 In '88, I was a supervisor of the audit, and it was
7 assigned to an auditor who worked for me. And basically, I
8 reviewed responsibilities with some analytical review during
9 that cost reporting year.
10 In 1989, I was limited supervisory review.
11 I participated in the audit in '87. It took several
12 different stints because it was a transfer from a previous
13 intermediary in '87, and we had difficulty getting files and
14 so on and so forth from the previous intermediary.
15 So we did a couple of stints on the '87 audit.
16 The '88 audit was a two-week audit of the home office.
17 And the '87 was an audit of the home office and, I want
18 to say, four or five providers.
19 And the '89 was an audit of the home office and two
20 providers, of which I came the last two days of
21 approximately a month or so audit to review.
22 Q. As to that last audit that you just mentioned, the '89
23 fiscal year audit --
24 A. Yes, sir.
25 Q. -- when was it actually conducted?

1 A. When was the audit conducted?
2 Q. Yes, sir.
3 A. When did you actually come up here to Augusta and
4 participate?
5 A. I came up in March for a pre-audit week. And I came up
6 at the last two days, two and a half days, of the audit,
7 which was in May.
8 Q. Who participated in that audit with you in May of 1991
9 at Healthmaster here in Augusta?
10 A. Brenda Chewning, Paul Auffant, and Loren Dyer, at
11 various times, not all at one time?
12 Q. Who was present that last week?
13 A. Paul Auffant, Loren Dyer, and myself. I was present for
14 part of the last week.
15 Q. What was your role that last week?
16 A. Supervisory review of the audit work papers.
17 Q. Mr. Voigt, you have before you the exhibit I handed to
18 you on the way to the stand?
19 A. Yes, sir.
20 Q. Government's Exhibit 4065. Is that your immunity
21 agreement which you entered into with the Government?
22 A. Yes, it is.
23 Q. Is it your understanding of that agreement that -- and
24 do you understand that the Government has agreed, according
25 to this document, 4065, not to prosecute you in the Southern

1 District of Georgia for allegedly having sexual relations
2 with a woman at the Radisson Hotel in Augusta, Georgia on or
3 about May 17, 1991?
4 A. That is my understanding, yes.
5 Q. Did you sign that along with your attorney?
6 A. Yes, I did.
7 Q. Tell these people over here, did anything unusual happen
8 on or about May 17, 1991, your last day here in Augusta,
9 Georgia?
10 A. Well, it was a very unusual day, one unlike I had ever
11 had before, I might add.
12 Q. Just start at the beginning and tell them what happened.
13 A. We had finished the audit the Thursday night before and
14 had exited, so we were not even planning on going to the
15 Healthmaster facility Friday, which had originally been
16 scheduled for the exit conference day.
17 The plans were -- because I had come in subsequent to
18 the auditors that were on-site and could not get on a plane
19 with -- the same flight that they were on because it was
20 booked, I had an early flight.
21 And we only had one rental car for various reasons.
22 And the plan was that Mr. Kelly would come to the hotel
23 and take Mr. Auffant and Mr. Dyer back to Healthmaster to
24 get the boxes of records that Mr. Dyer was in control of and
25 bring them back to the office at Aetna, Clearwater.

1 And Mr. Kelly would take them to the airplane.
2 Q. What do you mean by "Mr. Kelly"?
3 A. Dennis Kelly.
4 Q. The Defendant in this case?
5 A. Yes.
6 Q. The chief financial officer at Healthmaster?
7 A. Yes, sir.
8 Q. And which hotel or motel at Augusta were you three
9 auditors staying at?
10 A. I believe it was the Radisson.
11 Q. Well, what happened that morning?
12 A. I made several calls because Mr. Kelly was going to --
13 supposed to meet us earlier, and I was going to logistically
14 work out the situation where he would take Loren and Paul
15 and get the records and then take them to the airport.
16 And he didn't show up. It was like 9:00 o'clock or
17 something. And I called Healthmaster and various places
18 trying to find out if he was going to come because I was in
19 somewhat of a dilemma about leaving them there without any
20 transportation to the airport and picking up the records,
21 and so on and so forth.
22 I could not get in touch with him. But he did show up.
23 I'm not exactly sure of the time.
24 Q. Who showed up?
25 A. Dennis Kelly showed up.

1 Q. Where?
2 A. At my hotel room at the Radisson --
3 Q. What happened?
4 A. -- which was the scheduled meeting place for him to show
5 up.
6 Q. To pick up the two other auditors?
7 A. To coordinate the last day, yes, sir.
8 Q. Well, what happened when Dennis Kelly showed up at your
9 motel room that morning?
10 A. I called the other two auditors and told them to come
11 down to my room and we would logistically work out getting
12 the records; Dennis was there, you know.
13 They still had to check out of the hotel, and so on and
14 so forth.
15 Q. What else did you logistically work out? What happened?
16 A. Well, subsequent to that, there was a lady that showed
17 up at my room and -- of which I engaged in a sexual act
18 with.
19 Q. Well, let's start at the beginning and tell the jury how
20 this came about.
21 Who all was present in this room when this lady showed
22 up?
23 A. This -- my recollection is there was nobody present at
24 my room when she showed up. But there is an area that I
25 have somewhat difficulty in recalling whether they left

1 first or they left shortly after she got there.
2 I really don't remember which happened first. It would
3 have been -- you know, it would have been a very short
4 duration of time between the two. And I can't remember
5 whether they left first.
6 My recollection is nobody was there, but I'm not sure
7 that recollection is accurate.
8 Q. Do you recall where Mr. Kelly and the two auditors --
9 that is, Loren Dyer and Paul Auffant -- were when this woman
10 shows up at your motel room?
11 A. When they left, I assumed they went to their hotel rooms
12 to get their bags and check out.
13 Whether that happened when the lady showed up or after
14 the lady showed up, I have some difficulty with. I don't
15 remember. I don't remember well enough to say.
16 Q. Well, about how long was it after you -- you have
17 indicated Mr. Kelly and two other auditors might have left.
18 About how long a time lapse are talking about before
19 this woman shows up at your motel?
20 A. My recollection is it was a very short period of time,
21 you know, three, five minutes, something of that nature.
22 And I testified in the grand jury that a lady knocked on
23 the door or whatever. And I don't know whether my door was
24 opened. I don't know whether I had gone to put something in
25 the car or what had happened in that process.

1 I can't recall the exact time I first saw her --
2 Q. Do you --
3 A. -- and the place where the other auditors were at that
4 point.
5 Q. Do you recall whether or not you were expecting somebody
6 to arrive, a woman?
7 A. No, sir, I was not.
8 Q. Did you know this woman was going to be provided to you
9 before she got there?
10 A. No, sir, I did not.
11 Q. Did you arrange for this woman to show up at your motel
12 room on that morning of May 17, 1991?
13 A. Did I arrange for it?
14 Q. Yes, sir.
15 A. No, sir, I did not.
16 Q. Do you know who did?
17 A. No, sir. I can speculate but --
18 MS. JONES: I object to any speculation, Your
19 Honor.
20 BY MR. GOOLSBY:
21 Q. Who was the last person you saw before that woman got
22 there?
23 A. It would have been Dennis Kelly, Paul Auffant, and Loren
24 Dyer. They left together.
25 Q. All right. Start at the beginning.

1 First of all, what did this woman like that showed up at
2 your motel room?
3 A. She was an attractive lady, mid-thirties, I guess,
4 brownish colored hair.
5 Q. Well, in that regard, let me show what has been marked
6 Government's Exhibit 4010A, a photograph of this woman here.
7 And we will have it on the TV screen here.
8 Do you recognize the woman shown in Government's Exhibit
9 4010A?
10 A. That appears to be the woman, yes.
11 Q. The woman that showed up at your motel room?
12 A. That appears to be.
13 Q. The woman you weren't expecting?
14 A. That's correct.
15 Q. What happened after that woman showed up at your motel
16 room? Was there any conversation?
17 A. Well, she informed me she was there to entertain me.
18 And my opinion of what that meant, if I may add it, was that
19 it was like a strip-o-gram or something that you would send
20 to a bachelor party or what have you.
21 You have to understand that this was the last year of
22 the audit that I was on at Healthmaster. I had audited them
23 three years in a row.
24 And I thought it was a way trying to go be funny or what
25 have you. I didn't know what it was.

1 Q. Were you married at the time?
2 A. Yes, sir.
3 Q. What happened next after you had this initial
4 conversation with this woman? Did she tell you what her
5 name was, for example?
6 A. I don't remember whether she did or didn't.
7 Q. Do you remember any name at all associated with this
8 woman on the screen?
9 A. I have heard the name subsequent, but I can't recall
10 whether she gave me a name at that point or not.
11 Q. Well, what happened next? Go ahead and tell these
12 people what happened.
13 A. She began to strip down to her underwear and approached
14 me and performed oral sex on me.
15 Q. Did you do anything else with this woman?
16 A. No. As far as sexually?
17 Q. Or otherwise?
18 A. After that process took place, I was rushed to catch a
19 plane. I basically gave her twenty dollars and said "bye,"
20 and I was gone.
21 Q. Where were you when this act of oral sex occurred?
22 A. In my hotel room.
23 Q. Where in your hotel room?
24 A. On the bed, I guess.
25 Q. Well, you guess or do you know, Mr. Voigt?

1 A. On the bed.

2 THE COURT: Do you feel it necessary to go into all

3 these details?

4 MR. GOOLSBY: Yes, sir. I want to test his

5 recollection about it.

6 THE COURT: Move along.

7 You want to test his recollection?

8 MR. GOOLSBY: Yes, sir, to see what he will admit

9 about it.

10 THE COURT: That's a new one.

11 MR. GOOLSBY: Judge, this is a new one.

12 THE WITNESS: I did -- it's not a situation I'm

13 happy about. I did wrong and I know that. I knew it the

14 minute after it took place.

15 And I admit to that action. You know, nobody is

16 responsible for that but myself.

17 BY MR. GOOLSBY:

18 Q. Were you offered any other gifts or gratuities while at

19 Healthmaster?

20 A. We were offered, you know, various things at one point

21 in time. I think I was offered Master's tickets and some

22 other things.

23 Q. Who offered you Master's tickets?

24 A. I think it would have been -- I think it was Dennis,

25 Mr. Kelly.

1 Q. Were you ever entertained with any meals or anything of
2 that sort?
3 A. Yes, sir, I was.
4 Q. What?
5 A. Well, we had gone out -- you know, I had been there
6 three years. And each year I had been out with them, I'm
7 sure, to a meal or two on each audit occasion.
8 Q. At whose house or where did it occur?
9 A. It didn't occur at anybody's house, usually at a
10 restaurant.
11 Q. Who paid for the meals?
12 A. Sometimes Mr. Kelly paid for the meals; some of them I
13 paid for.
14 Q. Were you offered the use of any condominiums or
15 automobiles while you were at Healthmaster?
16 A. I think there was some extension of that, yes.
17 Q. By whom?
18 A. I believe the auditors in '89 were offered something of
19 that nature. And I believe I was offered, you know, if I
20 wanted to take a vacation or something of that nature -- in
21 '88 I was offered something of that nature.
22 Q. By whom?
23 A. I don't know who the auditors were in '89.
24 Q. No, who offered to you?
25 A. I think Mrs. Garrison had stated that if I wanted to

1 take a vacation or something.
2 Q. At her condominium?
3 A. Um-hmm.
4 Q. Do you remember where that condo was?
5 MS. JONES: Your Honor, I object on relevancy.
6 None of these items are in this cases. None of the items he
7 is asking him about are charged in this case.
8 THE COURT: Overruled. Go ahead.
9 MR. GOOLSBY: I don't have any other questions.
10 Thank you.
11 THE COURT: All right, Ms. Jones.
12 CROSS EXAMINATION
13 BY MS. JONES:
14 Q. Mr. Voigt, I'm going to start out and ask you some
15 questions about your relationship with Mr. Dyer, in
16 particular, who was on this audit with you at Healthmaster
17 in May of '91.
18 A. Yes, ma'am.
19 Q. Since you were in Augusta -- here in Augusta in May of
20 '91, Mr. Dyer was fired from --
21 A. -- Aetna.
22 Q. -- Aetna, wasn't he?
23 A. That's correct.
24 Q. And you were his supervisor. You supervised him at the
25 time he was fired, didn't you?

1 A. That is correct.
2 Q. Tell the jury why he was fired.
3 A. He -- it had come to my attention when he worked with
4 Aetna that he had falsified some of his expense reports
5 claiming reimbursement on audits that had not actually
6 occurred.
7 And I brought this to the attention of the office
8 manager, who then addressed the situation with him. And
9 that action was the result of the conclusion of their
10 activity.
11 Q. In the final analysis, Mr. Dyer was fired from Aetna for
12 falsifying and stealing from the company, wasn't he?
13 A. I think the proper term was falsification of corporate
14 records.
15 Q. And you were involved in that process to some degree,
16 weren't you?
17 A. I reviewed the expense reports prior to them being
18 submitted to the secretary for review again and then the
19 reimbursement person over the expense reports.
20 Yes, I was the initial reviewer in that process. And I
21 was also involved -- I was the one who became aware, first,
22 that -- well, yes, first, that those items had been claimed
23 inappropriately.
24 Q. Isn't it fair to say that as a result of that, Mr. Dyer
25 became angry with you personally?

1 A. I think that's an understatement. I have received some
2 phone calls at my house from Mr. Dyer.
3 Q. Tell the jury about those, please.
4 A. Subsequent to -- or prior to his being fired, he called
5 my house and would tell me, you know, basically how stupid
6 the manager of the office was, how incompetent other
7 auditors were, and so on and so forth; that he was smarter
8 than everybody else and just really kind of --
9 Q. Is it fair to say he was bitter towards you?
10 A. I think that's an understatement.
11 Q. Did he accuse you of all manner of things ultimately?
12 A. Yes, ma'am, he has.
13 Q. Did he accuse you of falsifying your expense records?
14 A. Yes, ma'am, he did.
15 Q. Did Aetna, as well as the Department of Health and Human
16 Services investigate those allegations?
17 A. Yes, ma'am, they did.
18 Q. And did they clear you of all of those charges?
19 A. Yes, ma'am, they did.
20 Q. And isn't it true that at no time during those
21 proceedings did Mr. Dyer ever accuse you or anyone of
22 anything in regards to this woman?
23 A. That is correct.
24 Q. And that was back in 1993, isn't it?
25 A. I'm not sure of the date, but that sounds fairly

1 accurate.
2 Q. Now, Mr. Voigt, you were not given immunity by the
3 Government until the second time that you went down for the
4 grand jury; isn't that correct?
5 A. That's correct.
6 Q. And the second time that you went down there, isn't it
7 true that the Government had a lady down there seated in a
8 room, and she -- they took you in there to look at her?
9 A. They did not take me in there to look at her. She was
10 seated in a room where I would have to pass by her.
11 Q. Did they point out her presence to you?
12 A. It was indicated that the lady was in the other room.
13 Q. Who indicated that to you?
14 A. It was indicated that the lady was in the other room
15 that would testify to the activity.
16 Q. Who indicated to you, though? Who was it? Was it one
17 of these agents?
18 A. I don't specifically remember which one, to tell you the
19 truth.
20 Q. But --
21 A. I was rather shaken during that day.
22 Q. -- it was one of the agents?
23 A. It was one of the agents that was there that day.
24 Q. And the agents told you that she was going to testify
25 that she engaged in this activity with you?

1 A. I don't know if that was the fullest extent of what they
2 said, but that was my understanding. Yes.
3 Q. That was your understanding.
4 Did they tell you that the lady they had down there had
5 told them that she didn't know Dennis Kelly?
6 A. No. I did not know that.
7 Q. Did they tell that you that the lady that they had down
8 there had told them that she didn't remember you?
9 A. No, they did not tell me that.
10 MR. GOOLSBY: Judge, objection to continued
11 hearsay.
12 THE COURT: Well, you brought the lady in here, so
13 I think they can talk about what she knew about it.
14 Go ahead.
15 But again, members of the jury, questions by
16 lawyers are not evidence. You will give them no evidentiary
17 weight.
18 Go ahead.
19 BY MS. JONES:
20 Q. They told you to the contrary, that the lady was there
21 and she was going to testify --
22 THE COURT: He already testified to that.
23 MS. JONES: I'm sorry.
24 THE COURT: All right. Did I not give you some
25 instructions on that?

1 MS. JONES: Yes, sir. I'm moving on.
2 BY MS. JONES:
3 Q. So then that Friday morning, isn't it true that
4 Mr. Kelly never told you that he was sending some lady to
5 your room; that's true?
6 A. To this day I don't know that as a fact, that he did.
7 Q. You don't know who sent her, do you?
8 A. That's correct.
9 Q. And you gave her some money after she was there, and you
10 left and went home.
11 A. I don't know the proper protocol for such an occurrence.
12 That was just the way I responded. I don't know why.
13 Q. Isn't it true that you didn't know until the morning you
14 went down before the grand jury that her name allegedly was
15 Kandace?
16 A. That might have been when I found out her name. I don't
17 know when I became aware of her name.
18 Q. Now, Mr. Voigt, you had been there that entire week with
19 Mr. Dyer and Mr. Auffant; isn't that true?
20 A. No, I came in later in the week. I think I came in on a
21 Tuesday evening, if my memory serves me correctly, and I was
22 there Wednesday, Thursday, and flew out Friday.
23 Q. Did you -- during the time that you were there with
24 Mr. Dyer and Mr. Auffant, did you take any taxi cabs to any
25 strip clubs?

1 A. Did I take a taxi cab?
2 Q. Yes. Did you call a taxi cab and go out with them?
3 A. No.
4 Q. Did you come back home in the wee hours of the morning
5 in a taxi cab with them from one of those burlesque lounges
6 and order in-room dining?
7 A. No, ma'am.
8 Q. You don't know anything about that?
9 A. No, that's the first I have heard that one.
10 Q. Mr. Voigt, did Mr. Dyer ever indicate to you that he had
11 telephoned this woman after he had returned back to Florida?
12 A. No.
13 Q. Or that he had any prior contact with her?
14 A. No, not that I'm aware of.
15 MS. JONES: Thank you. That's all.
16 THE COURT: Mr. Cochran.
17 MR. COCHRAN: No questions.
18 THE COURT: Any other questions?
19 MR. GOOLSBY: No, Your Honor.
20 THE COURT: You may stand down.
21 Call you next witness.
22 MR. GOOLSBY: Mr. Paul Auffant.
23 PAUL AUFFANT, GOVERNMENT'S WITNESS, PREVIOUSLY SWORN
24 THE CLERK: Please state your full name, spell your
25 last, state your residence and occupation?

1 THE WITNESS: My name is Paul Eugene Auffant,
2 A-U-F-F-A-N-T. I currently reside at 156 Laurel Hill Drive,
3 Prattville, Alabama. My occupation is finance, accounting
4 in the home health field.
5 DIRECT EXAMINATION
6 BY MR. GOOLSBY:
7 Q. Have you ever worked at Aetna?
8 A. Yes, sir.
9 Q. When?
10 A. Approximately -- and again the range of dates -- I know
11 my last day of work was March, 1992. And I believe I worked
12 there for two years. So that would be '89, '90 to 1992.
13 Q. Were you an auditor then?
14 A. Yes, sir.
15 Q. Did you ever participate in any audits of Healthmaster?
16 A. Yes, sir.
17 Q. When?
18 A. Again, the dates -- I will have to guess and say during
19 1991, the summer of 1991, I believe. I believe I was
20 engaged as a staff auditor for one particular fiscal year
21 ending.
22 Q. As to that audit which was conducted at Healthmaster in
23 1991, can you tell the jury whether or not you had a
24 traditional exit conference on the last day of that audit?
25 A. On the -- could you just elaborate a little on "the last

1 day"?
2 Q. Let me ask it this way: What happened the last day of
3 the audit?
4 A. The last date of field work, I believe, was Thursday
5 afternoon. The audit team, including myself, left for the
6 airport Friday around noon, I believe.
7 So I guess the last day of the audit, technically, would
8 have been Thursday afternoon.
9 Q. Did you do anything Thursday evening?
10 A. Yes. I participated with the audit manager and the
11 other staff auditor and Dennis Kelly. We met at a
12 restaurant in Augusta, had dinner.
13 My recollection is we then went to a sports bar. And
14 the period of time we stayed there, I'm not quite certain.
15 Q. Did you guys go anywhere else with Mr. Kelly that
16 Thursday evening?
17 A. I believe we also went to a topless bar for a brief
18 period of time prior to returning to our hotel.
19 Q. Who paid for all this entertainment?
20 A. My recollection is that the dinner was paid for by
21 individuals putting money into -- you know, like a pile of
22 money.
23 The drinks at the various locations were one person
24 would buy a round and another person would buy a round type
25 of thing. That's my recollection of that.

1 Q. Did Mr. Kelly participate in that?
2 A. Yes, sir.
3 Q. Did anything unusual happen the next morning, that
4 Friday morning?
5 A. Could you be a little more specific, "unusual" --
6 Q. Let me show you a photograph, 4010A.
7 Does that refresh your recollection?
8 A. Yes, sir. I was just trying to word the answer
9 correctly.
10 Q. What happened that morning? Just start at the beginning
11 and tell the jury what happened.
12 A. I received a phone call about -- probably about 8:00
13 a.m. from Glen Voigt. And I was to meet in Glen's room.
14 I met in Glen's room. And I believe Loren Dyer was
15 there also.
16 At some point in time Dennis Kelly stuck his head into
17 the hotel room door. I don't recall the exact
18 conversations.
19 One of Dennis Kelly's friends, that particular woman,
20 who did not go into the hotel room we were in. She was in
21 another hotel room at the time.
22 And basically, we each went to that particular hotel
23 room separately. That's basically the layout of the events.
24 Q. Who arranged for this woman to be there?
25 A. Specifically, I was never told that a certain individual

1 arranged it. My assumption was Dennis Kelly --
2 MS. JONES: I object to assumptions, Your Honor.
3 THE COURT: The objection is sustained.
4 BY MR. GOOLSBY:
5 Q. Well, did you have any discussions with Mr. Kelly about
6 this woman in the other room? Did the subject come up while
7 Mr. Kelly was there?
8 A. The subject had come up during the week. I recall
9 comments being made.
10 Q. By whom?
11 A. I'm trying to think of the specifics.
12 Q. Did Mr. Kelly ever give you any indication that a woman
13 would be there at the hotel?
14 MS. JONES: Your Honor, I object to this leading on
15 this critical point.
16 THE COURT: He is not leading. The objection is
17 overruled.
18 THE WITNESS: Dennis Kelly never specifically told
19 me individually that a woman would meet me.
20 Basically, during the week -- my recollection is --
21 that at one point in time Dennis Kelly -- I witnessed Dennis
22 Kelly using his car phone to call a lady friend of his, the
23 assumption being that she was a lady friend of his that
24 really was not elaborated on, but we all made the same
25 assumption.

1 Q. What assumption is that?
2 MS. JONES: I object to any assumptions, Your
3 Honor.
4 BY MR. GOOLSBY:
5 Q. All right. Do you recall what Mr. Kelly said when he
6 called this lady friend on his car phone?
7 A. At that I particular time he wasn't able to get through.
8 But my recollection is that he did it as a joke. We
9 were standing by his car had been in his car, and he pressed
10 the button and tried to call her. And she didn't answer the
11 phone.
12 And that was the -- I recall that particular incident
13 that related to that woman.
14 Q. All right. Let's go back to that Friday morning.
15 Did you ever enter a motel room at the Radisson Inn
16 Suites that morning with this woman?
17 A. Yes.
18 Q. Who's motel room was it?
19 A. She had another hotel room that she had -- she was in,
20 and I didn't have any further information on whether she had
21 checked in, et cetera.
22 Q. Do you recall where Mr. Kelly and the other auditors
23 were before you went into that motel room with the woman?
24 A. Glen Voight and Loren Dyer were in Glen Voigt's room.
25 Dennis Kelly, I don't believe, stayed in the room. He

1 stuck his head in and then left. So he was not actually in
2 Glen Voigt's room.
3 Q. Well, do you recall what Mr. Kelly said when he stuck
4 his head in the room before you went into the room with the
5 woman?
6 A. That I don't recall.
7 Q. What happened in the room with the woman, between you
8 and the woman?
9 A. Basically, we had physical relations, very brief. And
10 that was the sum total of what happened in the room.
11 Q. Did she -- did you have oral sex with this woman? Did
12 she provide that service to you?
13 A. Yes.
14 Q. What happened after this occurred?
15 A. I returned to Glen Voigt's room.
16 Q. Who was there?
17 A. Glen Voight, I believe, was in the room. I believe
18 Loren Dyer had vacated, and I don't recall the exact
19 specifics of who was in the room at that time.
20 But Glen Voight was in the room, is my recollection,
21 when I returned.
22 Q. Where was Mr. Kelly at that point?
23 A. Mr. Kelly was not in the room at that point.
24 Q. He left?
25 A. Yeah. I'm uncertain as to where he was at that point.

1 Q. Were you ever offered any gifts or gratuities while at
2 Healthmaster?
3 A. At one point in time, we were offered T-shirts. At
4 another point in time, we were offered -- due to the audit
5 workload, we had to stay over the weekend. And we were
6 offered to use, I believe, their condominium in Hilton Head.
7 The condominium in Hilton Head -- we had laughed about
8 it and obviously called -- Glen Voigt at that point in time
9 was actually in Tampa at the office. And we obviously -- we
10 had no intention of taking them up on that. We did notify
11 Glen.
12 The T-shirts, I'm uncertain as to whether we ever ended
13 up with a T-shirt or not.
14 Those are the two instances that I recall.
15 Q. Who offered it?
16 A. Again, no one offered it to me directly. I recall at
17 one point in time it being discussed. And there might have
18 been a pile of T-shirts on the audit table.
19 I don't recall exactly who offered.
20 MR. GOOLSBY: All right, sir. No further
21 questions.
22 THE COURT: All right, Ms. Jones.
23 CROSS EXAMINATION
24 BY MS. JONES:
25 Q. Mr. Auffant, I'm Celeste Jones. I represent Mr. Kelly.

1 You had had your exit conference and the adjustments on
2 the cost report had been made on Thursday evening before you
3 all went to dinner.
4 A. After Thursday afternoon, I did not touch my work papers
5 again.
6 Q. Ever?
7 A. They were packed up.
8 Q. Earlier in the week, while you had been in Augusta
9 there, you all were staying at the Radisson Inn; isn't that
10 correct?
11 A. We stayed at two different hotels, and I can't recall
12 which one we stayed at that week. But the Radisson was one
13 of the hotels. I just can't recall specifically.
14 Q. One evening earlier in the week, did you go with Loren
15 Dyer in a taxi cab to a club called the Disco Lounge?
16 A. `I recall if -- I don't recall the taxi cab ride, per se.
17 I do recall on one other occasion, we did go to that
18 particular location which was the same one I mentioned
19 earlier.
20 Q. I would like to show you Defendant's Exhibit 47, if you
21 would review that please.
22 That is the bill for Mr. Dyer's room at the Radisson Inn
23 for the period of time May the 5th through May the 17, 1991.
24 That's when you were there doing this audit, isn't it?
25 A. That's my recollection.

1 Q. And on that bill, there is a local call on May the 7th
2 to a phone number 722-9925 and another one 722-7717.
3 And that call was made -- those two calls were made at
4 11:04 and 11:07 p.m. respectively.
5 Do you see that?
6 A. Yes, ma'am.
7 Q. Were you in Mr. Dyer's room when he called the Augusta
8 Cab Company or do you recognize those numbers as being to
9 the Augusta Cab Company?
10 A. I do not recognize the numbers. I don't recall ever
11 being in a room with Loren Dyer when he called a cab
12 company.
13 Q. Were you with Mr. Dyer or did you go to his room at any
14 time -- and if you look on that bill -- to watch any of the
15 VidCom Six moves, such as the one on May the 5th shown at
16 1:30 a.m.?
17 A. No, ma'am. I associated with the audit staff and the
18 provider staff only -- other than the times that I have
19 mentioned -- during the audit and during the group outings
20 and not with any individual.
21 We went to our rooms -- or I went back to my room.
22 Q. Did you engage in any late night dining with Mr. Dyer,
23 particularly on the evening that is shown on the bill as
24 being the two calls on May the 7th, the after-hours dining?
25 Do you recall that?

1 A. My recollection is that I attended the after-hours
2 dining with groups of people and not with Loren Dyer
3 individually by himself. So --
4 Q. Isn't it true, Mr. Auffant, that earlier in the week you
5 and Mr. Dyer -- or Mr. Dyer had called a cab and you all had
6 gone down to these clubs and stayed until late wee hours of
7 the morning and come back and had after-hours dining?
8 A. I recall Mr. Dyer on several occasions asking me if I
9 would accompany him to these clubs. And I did not accompany
10 him by himself to these clubs.
11 My attendance at these clubs was solely with Glen Voight
12 and whoever that particular group happened to be, and never
13 with Loren Dyer by himself.
14 Q. But you were aware that Mr. Dyer was going to these
15 clubs and he was inviting you to go along.
16 A. Yes, ma'am.
17 Q. Are you aware that currently Mr. Dyer is working for
18 ABC?
19 A. Yes, ma'am.
20 Q. And that is Healthmaster's chief competitor, isn't it?
21 A. I'm not sure of the statistical comparisons. They are a
22 major competitor, yes.
23 MS. JONES: Thank you, sir. That's all I have.
24 THE COURT: Mr. Cochran, do you have anything?
25 MR. COCHRAN: No, sir.

1 THE COURT: Any redirect?
2 MR. GOOLSBY: Not Your Honor.
3 THE COURT: You may stand down.
4 And we will take a short break.
5 (Recess at 2:55 p.m. until 3:07 p.m.; jury present)
6 THE CLERK: Please state your full name, spell your
7 last, state your residence and occupation.
8 LOREN DYER, GOVERNMENT'S WITNESS, PREVIOUSLY SWORN
9 THE WITNESS: My name is Loren Morgan Dyer. The
10 last name is spelled D-Y-E-R. I live at 107 Fiddler's Bend
11 in Brunswick, Georgia. And I'm an accountant.
12 THE COURT: For whom?
13 THE WITNESS: For First American Health Care.
14 THE COURT: Do you want to use that microphone
15 there?
16 THE WITNESS: Should I hold it?
17 THE COURT: Yes, just hold it in your hand.
18 Go ahead.
19 DIRECT EXAMINATION
20 BY MR. GOOLSBY:
21 Q. Have you ever worked for Aetna Life Insurance Company?
22 A. Yes, I have.
23 Q. When? About when?
24 A. About late 1990 to early 1992.
25 Q. What was your position at Aetna?

1 A. I started out as an analyst and then moved up to a
2 senior analyst.
3 Q. While working at Aetna, did you ever participate in any
4 audits at Healthmaster here in Augusta?
5 A. Yes, I did.
6 Q. Did you participate in the 1991 calendar year audit
7 regarding the 1989 fiscal year audit?
8 A. Yes, I did.
9 Q. Did that audit occur in May of 1991?
10 A. Part of that audit occurred in May of 1991, yes.
11 Q. Which part?
12 A. I believe it was nearing the end of the audit.
13 Q. You've indicated that you have changed employment.
14 Would you please briefly go ahead and explain to the
15 jury the circumstances about why you left Aetna?
16 A. I had done some traveling on two separate audits at
17 Aetna. And on my team, it was a common practice to claim
18 meals, meal expenses, that we had not actually incurred.
19 I was aware that there were other situations where
20 expenses had been padded; expenses claimed were not true
21 expenses.
22 And a teammate on my team suggested to me that I ride
23 with him to both of these audits and that we both claim
24 mileage so we could make some extra money on those audits.
25 Q. Who suggested this?

1 A. A man by the name of Roland Cleneay. I discussed it
2 with my boss, which was Glen Voigt, and he said to go ahead
3 and do it.
4 So I did it. And later that was used as grounds for
5 termination.
6 Q. Did you, in fact, submit false expense vouchers?
7 A. Yes, I did.
8 Q. Did you ever pay that money back?
9 A. Yes, I did.
10 Q. Let's jump back to the audit which you participated in
11 in May of '91 at Healthmaster.
12 Who all participated in that audit with you?
13 A. During that audit, there were auditors on-site,
14 including Glen Voight, Brenda Chewning, Paul Auffant, and
15 me.
16 Q. All right. Let's jump ahead to the last day of that
17 audit, on or about Friday, May 17th 1991.
18 Did anything unusual happen to you at the Radisson Inn
19 Suites here in Augusta?
20 A. Well, the last day of the audit would have been
21 May 17th. And I was sleeping in my room, and I received a
22 telephone call. It was roughly 9:00 a.m. in the morning.
23 And we were sleeping late that morning.
24 Glen Voigt, myself, and Dennis Kelly, and Mr. Auffant
25 had been out very late the night prior to that. And so we

1 were sleeping late.
2 The phone call came in from Glen Voigt, and he
3 instructed me to get up, get dressed, and to come down to
4 his room within ten or fifteen minutes, which I did.
5 When I got to Mr. Voigt's room, I knocked on the door
6 and went inside. And shortly thereafter, Mr. Auffant also
7 came in.
8 And Mr. Voigt explained to me that Dennis Kelly had some
9 entertainment for us and that he would be there shortly.
10 I think we waited there in Glen's room for just a few
11 minutes, and Mr. Kelly came in and told us that that girl,
12 who I know as Kandi, would be coming by shortly.
13 Q. What happened then?
14 A. We waited just a few minutes. And I thought it was
15 probably going to be a stripper or something of that sort.
16 And Kandi did come in. And Mr. Kelly told me and Paul
17 that we would go back to my hotel room and Kandi was going
18 to stay in Glen's room.
19 Q. What did you do?
20 A. At that point I went ahead and went with Mr. Kelly, and
21 I believe Paul also, back to my room. And there we waited
22 ten or fifteen minutes until a call came in that I assume
23 was from Kandi. And --
24 Q. What answered the telephone call?
25 A. Mr. Kelly did.

1 Q. What happened?

2 A. Mr. Kelly told me to go ahead and go down to Glen

3 Voigt's room.

4 When I got to Glen Voigt's room and knocked, the door

5 opened up and Mr. Kelly -- I'm sorry -- Mr. Voigt came out.

6 And he was fixing his tie, putting on his coat. And he said

7 to me that he would meet me back in the office.

8 Q. What happened then?

9 A. I was going to ask Mr. Voigt what exactly was going on,

10 but he turned and left. And -- because he had an earlier

11 flight than I did.

12 And I -- he took my rental car. I don't know if I had

13 given him the keys prior to that or if I gave them to him

14 then. But he took my rental car and went ahead and left.

15 So I went into his room and closed door. And I asked

16 Kandi, I said, "What exactly is going on here?" And she

17 said to me anything that I wanted.

18 Q. Go ahead and tell the jury what happened then.

19 A. Well, I was very nervous. But I stood there and looked

20 at her. And she finally started telling me things to do, to

21 go ahead and take off my coat, take off my shirt, and take

22 off my shoes, which I did.

23 And she continued to do that also so that we --

24 Q. Did she undress as well; is that what you mean?

25 A. Yes.

1 THE COURT: Do you have to grovel any more at this?
2 MR. GOOLSBY: Well, Your Honor, it's a part of the
3 proof of Counts 33 through 35.
4 THE COURT: I see. I thought you had already
5 developed it somewhat.
6 All right. Go ahead.
7 BY MR. GOOLSBY:
8 Q. What happened then?
9 Let me just ask you this: Did you engage in oral sex or
10 attempt to engage in that activity with Kandi at that time?
11 A. I did not, no.
12 Q. Did she attempt to do that with you?
13 A. It's possible. I was -- ended up laying on the edge or
14 the corner of the bed staring at the ceiling. I know she
15 did take out a condom and started to try to put that on me.
16 I don't think she did anything else. But in a few
17 seconds I decided that I was not going to be able to do
18 anything or go through with anything.
19 So I went ahead and got up and told her, "I can't do
20 anything here. Nothing is going to happen." And I told her
21 to put her clothes back on.
22 I got dressed, and we decided that we would just wait
23 for about ten or fifteen minutes, and then I would go ahead
24 and leave.
25 Q. And what happened after you waited there with Kandi for

1 a while?
2 A. After I waited, she went ahead and called what I assumed
3 was my room and told Mr. Kelly that I was on my way back.
4 And as I was returning to my room, I passed Mr. Auffant
5 on the way to Glen Voigt's room.
6 Q. You indicated that this happened on Friday morning.
7 What had happened exactly the night before that Thursday
8 night?
9 A. As I recall, we -- there were several times that we were
10 out to dinner, to bars, to the discotheque.
11 But if I am correct, this time we began with dinner at
12 the French Market Grille. We had many drinks.
13 We then, through the course of that evening, ended up, I
14 believe, at Chevie's or Chevy's and also at a sports bar
15 called the Proud Lion or something to that effect.
16 And then we proceeded on to the Discotheque Lounge.
17 Q. What is "we"? Who all participated in those activities
18 that Thursday evening?
19 A. On that evening, as I recall, it was Paul Auffant, Glen
20 Voight, Mr. Kelly, and me.
21 Q. Who drove that Thursday evening?
22 A. Dennis Kelly did.
23 Q. What kind of car did he have?
24 A. It was a Mercedes.
25 Q. Did Mr. Kelly provide you transportation back to your

1 motel that evening --
2 A. Yes, he did.
3 Q. -- at the end of the evening?
4 A. Yes.
5 Q. Had you ever heard the name Kandi before you met her
6 that Friday morning?
7 A. I had heard that name sometime before the 17th. I was
8 in a similar situation, a dinner situation, an evening with
9 Mr. Kelly and Mr. Auffant. And we were in his car.
10 And he -- we had been out drinking. And he told me that
11 there was a girl he wanted us to meet. And he picked up his
12 cellular phone. And he had an automatic speed dial, and hit
13 the speed dial number and called.
14 And as he was waiting for a response, he told us it was
15 a girl named Kandi. And I don't remember the details, but I
16 understood that she was a prostitute.
17 But he could not get an answer. So when he hung back
18 up, I said, "That's fine. We can't do anything like that
19 anyway."
20 Q. Were you offered any other gifts or gratuities while you
21 were at Healthmaster?
22 A. We were offered the use of a company vehicle while we
23 were on-site.
24 Q. By whom?
25 A. By Dennis Kelly.

1 We were offered the use of a Hilton Head condominium
2 over the weekend.
3 We were offered Healthmaster services in getting us
4 Master's tickets for the upcoming season.
5 We were offered other items such as golf shirts,
6 wallets, pens, umbrellas.
7 Q. Who was your on-site supervisor during this particular
8 audit?
9 A. It varied depending on who was on-site. My team boss
10 was Glen Voigt.
11 While I was on-site, I was always the lowest ranking
12 person there. So it would either have been Mr. Auffant or
13 Ms. Chewning.
14 Q. Did Mr. Voigt ever give you any instructions about how
15 to handle related parties of Healthmaster?
16 A. He did.
17 Q. What?
18 A. He instructed me that we were not going to audit those
19 companies, that we were doing to strictly deal with what had
20 been represented to us as the Medicare costs.
21 So we were not going to audit those companies.
22 Q. You have already indicated as to what happened that
23 Friday morning.
24 Does Aetna usually have an exit conference, that is, a
25 final meeting, with representatives of the health care

1 provider at the conclusion of an audit to go over any
2 adjustments?
3 A. Yes.
4 Q. Do you also prepare any notes or memoranda showing what
5 occurred during such an exit conference?
6 A. Yes. There should be a summary prepared explaining what
7 was said and what was mentioned in that conversation.
8 Q. Well, how did you hand that -- that is, how did you
9 prepare a memorandum on this occasion if no traditional exit
10 conference occurred?
11 A. Well, I went to my boss, which was Mr. Voigt, and I said
12 since we had no exit conversation I didn't know what to do.
13 And he instructed me to take the prior year's work paper
14 that had been written up and make the appropriate changes
15 and use it as a guide to fabricate a work paper for that
16 year.
17 Q. Did you do that?
18 A. Yes, I did.
19 MR. GOOLSBY: Thank you. No further questions.
20 THE COURT: All right, Ms. Jones.
21 MS. JONES: Thank you, Your Honor.
22 Your Honor, I would like to get two of the
23 Government's exhibits, 410 and 411, if I could, please.
24 MR. GOOLSBY: 4010.
25 MS. JONES: 4010 and 4011.

1 CROSS EXAMINATION
2 BY MS. JONES:
3 Q. Mr. Dyer, you are currently working for ABC Health Care,
4 aren't you -- or First American?
5 A. Yes, First American Health Care.
6 Q. When you were fired at Aetna, what were you making?
7 What was your salary?
8 A. It was between 27 and $28,000.
9 Q. And what is your salary now at First American, ABC?
10 A. Well, when I started I was making 35.
11 Q. What is your salary now?
12 A. 50,200.
13 Q. All right. And you were fired from Aetna for
14 dishonesty, weren't you?
15 A. I was fired for falsification of company records.
16 Q. Okay. Falsification of company records.
17 But the company records that you falsified was a
18 business report. If you look at those documents that I
19 handed you, you will see your personnel file.
20 Would you like for me to help you?
21 A. Please.
22 Q. All right, sir. Here.
23 On February the 19th, 1992, you were terminated from
24 Aetna for falsification of company records. And the records
25 that you falsified were expense reports so that Aetna would

1 pay you money, reimbursement for expenses that you really
2 didn't incur; isn't that right?
3 A. Yes.
4 Q. And you testified on your direct examination that
5 somebody working there, a fellow by the name of Roland
6 Cleneay told you that it would be all right to do, so you
7 did it because he told you to.
8 A. No. I discussed it with him and Mr. Voigt.
9 Q. Okay. So your testimony is that two people at Aetna
10 told you that you should give a false cost report and that
11 would be all right, and that's why you did it.
12 That's your testimony isn't it?
13 A. Basically.
14 Q. You're a grown man?
15 A. Yes.
16 Q. How old are you?
17 A. I'm twenty-seven.
18 Q. Twenty-seven years old. Do you know right from wrong.
19 A. I would hope so.
20 Q. Well, you weren't able to recognize it then, were you?
21 You turned in a false cost report, didn't you?
22 A. I did submit these statements.
23 Q. You submitted false statements, didn't you?
24 THE COURT: He has said that about three times.
25 MS. JONES: Thank you, Your Honor.

1 THE COURT: You made that point. Go ahead.
2 BY MS. JONES:
3 Q. After that, you went to work for ABC, First American,
4 didn't you?
5 A. Yes, I did.
6 Q. And you went with ABC and filed a series of charges
7 against Aetna alleging that Aetna gave Healthmaster
8 favorable treatment and unfavorable treatment to ABC; you
9 did that, didn't you?
10 A. No, I don't remember doing that, filing charges.
11 Q. You don't recall going to a hearing where you testified
12 concerning ABC's challenges against Aetna?
13 A. I'm sorry. To a hearing?
14 Q. With the Department of Health and Human Services, a
15 review?
16 A. There was a point that I did meet with HCFA, yes.
17 Q. And HCFA reviewed those allegations, didn't they?
18 A. That is what I have been told, yes.
19 Q. Before you is Defendant Kelly's Exhibit Number 43, which
20 is the report of Dale Kendricks, the branch chief of the
21 Department of Health and Human Services.
22 Do you see that, sir?
23 A. Yes, I do.
24 Q. Do you see that in the second paragraph where it states,
25 "The majority of ABC's complaints was based on information

1 they received from Loren Dyer, a former Aetna employee."
2 Do you see that?
3 A. Yes, in the first sentence of the second paragraph?
4 Q. Yes, sir. That's what it says, isn't it?
5 A. Yes, it does.
6 Q. On the second page -- turn to the second page of the
7 report -- Mr. Kendricks, the gentleman with the Department
8 of Health and Human Services, under his conclusions, he
9 concluded that you were not a credible witness, didn't he?
10 A. I think that's what he says here, yes.
11 Q. He directly says, "I do not believe that Loren Dyer is a
12 credible witness."
13 A. Yes, that's what is written here.
14 Q. And then lists out one, two, three, four, five, six,
15 seven different reasons for that. And he documents them in
16 this report, doesn't he, sir?
17 A. I think that is what he's trying to do, yes.
18 Q. And then on the third page of this report at paragraph
19 number two on page three, he concludes that there is no
20 evidence that Aetna's 1989 Healthmaster audit was improper.
21 Isn't that correct? Isn't that what he concluded?
22 A. Yeah. That's what he's saying here, yes.
23 Q. In fact, you went to this hearing before the Department
24 of Health and Human Services on or about June the 3rd, 1993.
25 And I will hand you a copy of that transcript and see if

1 that refreshes your recollection.
2 A. I've seen this transcript.
3 Q. Isn't the date correct, June, 1993?
4 A. As I recall, that's right. Yes.
5 Q. All right, sir. And at no point and no where included
6 in that transcript of record is there any allegation
7 concerning a prostitute, is there?
8 A. No, I don't think there is.
9 Q. Thank you.
10 THE COURT: I suppose they were grateful for that.
11 MS. JONES: Yes, sir. I'm sure they were.
12 BY MS. JONES:
13 Q. And it wasn't, Mr. Dyer, until sometime in 1994 that you
14 raised this allegation concerning this prostitute?
15 I have a copy of your affidavit if you want to see the
16 date.
17 A. Yes, please.
18 Yes, I think that's right.
19 Q. It was about a year later.
20 And, in fact, when ABC took this information -- you
21 provided this information to the Government, didn't you,
22 while you were employed at ABC?
23 A. Yes, I did.
24 Q. Yes you did.
25 And you took them a copy of this Government's exhibit,

1 and you told them that that was Kandi's phone number that
2 was listed on that card, didn't you?
3 A. No, I didn't.
4 Q. You did not?
5 A. No.
6 Q. All right, sir.
7 Do you recognize this?
8 A. No.
9 Q. Did you not also take them, sir, a copy of your personal
10 phone bill?
11 And I will hand you a copy of it that has been marked as
12 Government's Exhibit 4010D.
13 A. Yes. These are three different pages of three different
14 bills of my phone bills.
15 Q. And there is highlighting on some of the phone numbers
16 on there, aren't they?
17 A. Some of the phone numbers are highlighted.
18 Q. And didn't you testify and tell the Government that
19 after you got back home in Florida, you attempted to call
20 Kandi?
21 A. I had discussed what had occurred with Mr. Voigt who was
22 my supervisor. He was concerned about what Mr. Kelly's
23 intentions were and was trying --
24 THE COURT: Did you call this woman?
25 THE WITNESS: I did.

1 THE COURT: That was her question.
2 MS. JONES: Thank you, Your Honor.
3 BY MS. JONES:
4 Q. And those were the phone bills indicating and showing
5 where you called her?
6 A. Yes.
7 Q. Thank you.
8 And if you, please, would you publish the phone number
9 in Waynesboro, Georgia?
10 A. Would you like me to read that?
11 Q. Yes, sir.
12 A. It is area code 404, 554-6065.
13 Q. Thank you, sir.
14 And these calls were made after you had been up here at
15 Healthmaster in September -- in August and in September?
16 A. I believe so, yes.
17 Q. Now during the time that you were here in 1991 at this
18 audit at Healthmaster, you stayed at the Radisson hotel,
19 didn't you?
20 A. During part of that audit, yes.
21 Q. If you would please, Mr. Dyer, come around here. I want
22 to ask you a few questions about your hotel bill -- if you
23 would step around here, please?
24 THE WITNESS: Do I, Your Honor?
25 THE COURT: Yes, you may stand down.

1 BY MS. JONES:
2 Q. During the week when you were here, from May the 5th to
3 May the 17th, 1991 -- this is you, Loren Dyer, right?
4 A. Yes.
5 Q. And you were working for the Medicare Division of Aetna.
6 A. Yes.
7 Q. And you were here from May the 5th of 1991 through May
8 the 17th, 1991 at the Radisson Suites in Augusta.
9 A. I believe that's right. Yes.
10 Q. And are during the this time --
11 THE COURT: And please speak loudly enough so that
12 court reporter --
13 THE MARSHAL: Also, the jury can't see.
14 BY MS. JONES:
15 Q. You were at room number 418, weren't you?
16 A. I don't specifically recall 418.
17 Q. Would you dispute this bill?
18 A. No.
19 Q. Thank you. During the time you were here, you ordered
20 some in-room movies, didn't you?
21 A. I don't recall specifically, but it's possible. Yes.
22 Q. And, in fact, you ordered a movie from VidCom Six at
23 1:30 a.m. on May the 5th?
24 A. That appears to be the case, yes.
25 Q. And that's an adult movie, isn't it?

1 A. It probably was.
2 Q. And nobody was in your room making you order that movie,
3 were they?
4 A. Not that I recall, no.
5 Q. And also on May the 7th, you called two Augusta cab
6 companies, didn't you?
7 A. I don't know what those numbers are.
8 Q. Well, think. Do you remember calling a cab to come pick
9 you up in room 418 and take you down to the Discotheque
10 Lounge?
11 A. I do remember that, yes.
12 Q. And you called them at 11:04 in the evening, didn't you?
13 2104 military time.
14 A. Yes.
15 Q. At 11:04 in the evening.
16 A. I won't dispute that.
17 MR. KOHLER: 9:00.
18 MS. JONES: 9:00. Excuse me. Thank you.
19 BY MS. JONES:
20 Q. And you went to the Discotheque Lounge, didn't you?
21 A. I do recall that, yes.
22 Q. And nobody made you go down there, did they?
23 A. No.
24 Q. Nobody made you call these people that carried you down
25 there?

1 A. Not that I recall.
2 Q. When you got back that evening, you had dining room --
3 after-hours dining to the tune of $44, didn't you?
4 A. That appears to be the case, yes.
5 Q. You weren't by yourself, were you?
6 A. I was by myself as I recall.
7 Q. You were by yourself; that's your testimony?
8 A. Yes.
9 Q. Is it your testimony, sir, that on that evening when you
10 ordered in-room dining when you were by yourself, that you
11 had three turkey club sandwiches and one shrimp cocktail?
12 A. I don't know. I don't recall the specifics.
13 Q. Well, that's the meal ticket and that's your signature,
14 isn't it?
15 A. That appears to be my signature, yes.
16 Q. You're in room 418, weren't you?
17 A. I don't recall specifically 418, but that appears to be
18 the case.
19 Q. You weren't by yourself, were you?
20 A. I don't recall each one of those nights who was with me.
21 Q. Thank you, sir, you can have a seat.
22 Mr. Dyer, ABC, when you went to work for them, were very
23 upset about the disallowances that they had been receiving,
24 weren't they?
25 A. I don't really know how they felt when I went to work

1 for them.
2 Q. All right, sir. You haven't been made aware at any
3 point in time about their displeasure at the disallowances
4 on their cost reports?
5 A. In general.
6 Q. And, in fact, right now today, you are making twice as
7 much money there as you were making when you were working at
8 Aetna, but you're still an auditor, aren't you?
9 A. No, I'm not.
10 Q. What are you?
11 A. I am intermediary audit and reimbursement.
12 Q. You were doing intermediary reimbursement audit work at
13 Aetna, weren't you, the same kind of work?
14 A. Only part of it.
15 Q. You're filling out the cost report at ABC, and at Aetna
16 you were reviewing it and auditing it, right?
17 A. No.
18 Q. You're not doing the same kind of work?
19 A. No.
20 Q. What is different?
21 A. I do a lot more analytical and problem solving type
22 work.
23 Q. Okay. So you do problem solving work at ABC now.
24 A. By that type of work, I mean finding documentation,
25 research, those sorts of things.

1 Q. And your testimony in this case is -- and ABC is well
2 aware of it. In fact, they have their attorney here, don't
3 they?
4 A. Yes.
5 Q. So they know what you're testifying to here in this
6 courtroom, don't they?
7 A. I believe so.
8 Q. And it's true, isn't it, sir, that on that Friday, on
9 the 17th of May, when Kandi came to that motel room, it was
10 because you contacted her and you called her, and you had
11 had seen her earlier in the week when you had been out at
12 those lounges?
13 THE COURT: Wait a minute. Take it one at a time.
14 MS. JONES: All right, sir.
15 BY MS. JONES:
16 Q. Isn't it true that it wasn't Dennis Kelly that called
17 Kandi; it was you?
18 A. No, that's not true.
19 Q. And isn't it true, sir, that you had met her earlier in
20 the week when you were going to those clubs?
21 A. No, that's not true.
22 Q. And isn't it true that you continued to contact her
23 after you left here as indicated on your phone bills?
24 A. I called her phone number.
25 MS. JONES: That's all I have. Thank you, Your

1 Honor.

2 THE COURT: How about it, Mr. Cochran?

3 MR. COCHRAN: No, sir.

4 THE COURT: Do you have anything else?

5 MR. GOOLSBY: Judge, could we look at their chart

6 for just a minute?

7 THE COURT: Yes.

8 MS. JONES: Help yourself.

9 REDIRECT EXAMINATION

10 BY MR. GOOLSBY:

11 Q. Mr. Dyer, rather than show you the chart, let me just

12 hand up to you the original exhibit marked 4009A which has

13 been admitted as the Radisson Inn Suites motel room bill.

14 Would you look --

15 MR. GOOLSBY: If I might hand it up?

16 THE COURT: Yes.

17 BY MR. GOOLSBY:

18 Q. Would you look at the middle of that bill for May 7.

19 A. Yes.

20 Q. Was the cost of $44 for the room or for room service, as

21 Ms. Jones suggested?

22 A. It appears to be the room charge. It's repetitive.

23 THE COURT: Is that for the room?

24 MS. JONES: He's correct, Your Honor. I misspoke

25 myself. I'm sorry.

1 THE COURT: I should say you did. That is
2 reprehensible.
3 MS. JONES: It was $20 for the room service.
4 THE COURT: Anyhow, that is reprehensible.
5 MS. JONES: I'm sorry, Your Honor. I didn't mean
6 to.
7 THE COURT: Anything else of the witness?
8 MR. GOOLSBY: No, Your Honor.
9 * * * * * * * * * * * * * *
10
11
12
13 CERTIFICATION
14
15 I certify that the foregoing is a true and correct
16 transcript of the stenographic record of the above-mentioned
17 matter.
18
19 Norma Hatfield — August 17, 1995
20 Norma Hatfield, Court Reporter — Date
21
22
23
24
25

ISBN 0-16-055733-X