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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-203006

April 24, 1981

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The Honorable William V. Roth, Jr.
Chairman, Permanent Subcommittee on
Investigations
Committee on Governmental Affairs
United States Senate

RELEASED

Dear Mr. Chairman:

Subject: Response to the Senate Permanent Subcommittee on Investigations' Queries on Abuses in the Home Health Care Industry (HRD-81-84)

This report is in response to your April 14, 1981, request for our views on whether existing legislation and regulations are adequate to prevent profiteering in the home health industry under the federally financed health programs. As an example you mentioned situations in which individuals establish home health agencies (HHAs) and control them "off the books" through "front" people. These individuals then establish for-profit companies to provide the HHAs a variety of services at excessive cost to the financing programs.

In providing our assessment, we were to give specific comments on:

A. The effectiveness of the cost-reimbursement system or proposed alternatives.

B. The effectiveness of intermediary (Medicare paying agent) audit coverage.

C. The effectiveness of oversight and administration by the Health Care Financing Administration (HCFA).

D. The means by which disallowances can be recovered by the Federal Government without rendering insolvent the bona fide HHAs.

E. The means by which the Federal Government may terminate irresponsible HHAs from participation in federally funded home health programs.

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With two exceptions, we believe the existing legislation and regulations (including the new authorities provided by the Omnibus Reconciliation Act of 1980--Public Law 96-499) give HCFA sufficient authority to address the Subcommittee's concerns. The exceptions relate to

--the need for strengthening the regulations or related guidelines governing reimbursement in related organization situations and

--the desirability of the Department of Health and Human Services establishing limits on Medicare reimbursement for HHA management and clerical costs.

The related organization regulations are designed to eliminate profits between parties related by ownership and/or control, such as in the situation described in your letter. Concerning management and clerical costs, our prior work has identified excessive costs in these areas, and under section 223 of the Social Security Amendments of 1972, the Secretary of Health and Human Services has specific authority to establish reimbursement limits for such costs. Although, in line with our recommendation, the Department has established section 223 limits on total costs for home health visits, it has not done so for management and clerical costs.

HCFA believes that the cost data presently being reported by HHAs lack sufficient uniformity to make such limits meaningful. According to a HCFA official, they are trying to solve the data problem by implementing a uniform reporting system as required by the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142).

In addition, the 1982 budget may include significant reductions for audits made by Medicare intermediaries. Although this issue is not directly related to the question of regulatory or legislative change, significant budget cuts in this area can hamper the intermediaries' ability to assess compliance with existing legislation and regulations.

This report is based on work performed at HCFA headquarters in Baltimore, Maryland. Also, we relied heavily on various existing reports prepared by us and HCFA as well as a detailed analysis of existing laws and regulations. Because Medicare accounts for the bulk of Federal expenditures for HHA services, our comments relate primarily to this program. Also, many States have adopted Medicare reimbursement principles for their Medicaid programs. Our specific comments on each of the issues you raised are presented in enclosure I.

We did not obtain agency comments on this report because of the tight time constraints. Also, unless you publicly announce the report's contents earlier, no further distribution will be made until 30 days from its issue date. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Milton J. Socolar

Acting Comptroller General
of the United States

Enclosures - 2

RESPONSE TO THE SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS' QUERIES ON ABUSES IN THE HOME HEALTH CARE INDUSTRY

A. THE EFFECTIVENESS OF THE COST-REIMBURSEMENT SYSTEM OR PROPOSED ALTERNATIVES

Under Medicare, home health agencies (HHAs), like the other institutional providers (hospitals and nursing homes), are reimbursed retrospectively on the basis of their actual "reasonable" and allowable costs related to patient care (sections 1815(a) and 1861(v) of the Social Security Act). Thus, with few exceptions, the system is open ended, and it has been widely criticized as lacking incentives to providers to be efficient and minimize their costs. Under Medicaid, more and more States are using Medicare's cost-reimbursement system in response to criticisms that unrealistically low Medicaid payment rates had discouraged the use of home health services as a substitute for more costly long-term institutional care.

Despite the trends to more liberal reimbursement, annual Medicaid expenditures for home health services amount to about 1 percent of program payments, or about $250 million--with most of this in New York. In contrast, under Medicare, expenditures for home health services in 1981 are expected to amount to about 3 percent of benefit payments, or about $900 million.

In our view, in addition to the open-ended nature of the system, three problems have emerged that apply not only to HHAs but also to other institutional providers paid under the same retrospective system:

--Wide variations in the unit costs of similar services and the related problems in determining whether costs at the higher end of the range are reasonable.

--Problems in determining the allowability of costs claimed and their relationship to patient care.

--The application of Medicare's "related organization" rule, which basically requires that the reimbursable cost of goods or services furnished to a provider by a related organization be the lower of the actual cost to that organization or the price of comparable goods and services available elsewhere. Organizations generally are considered to be related if they are owned or controlled by the same person or persons.

Variations in costs

Under Medicare reimbursement principles, providers are to be reimbursed for the actual cost of providing quality care, however widely that cost might vary from provider to provider and from time to time for the same provider (42 CFR 405.451). This principle is subject to a limitation where a particular institution's costs are "substantially out of line" with costs of other institutions in the same area that are similar in size, scope of service, utilization, and other relevant factors.

As discussed in our May 1979 report to the Congress, 1/ without a definition of what constituted "substantially out of line," Medicare paying agents (intermediaries) found this provision to be virtually unadministrable in establishing upper limits on reimbursable costs--particularly on a retrospective basis.

Section 223 of the Social Security Amendments of 1972 (Public Law 92-603) amended section 1861(v)(1) of the act to provide the Department of Health and Human Services (HHS) 2/ with another vehicle for dealing with the problem of the wide variations in costs. Specifically, the law allowed the Secretary of HHS to establish limits:

> "* * * on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title."

Such reimbursement limits were to be established prospectively, and providers could charge beneficiaries for the difference between the section 223 limits and its rates following public notice by HHS that the particular provider would do so.

HHS initially established section 223 limits in 1974 for hospital inpatient general routine operating costs (42 CFR 405.460), and at our recommendation the use of the section 223 authority was expanded to cover the total cost of home health visits in 1979. We also recommended that, where feasible and appropriate, HHS establish section 223 reimbursement limits for individual home health care cost elements--such as management and clerical costs--because our work indicated that excessive overhead costs in the

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1/"Home Health Care Services--Tighter Fiscal Controls Needed" (HRD-79-17, May 15, 1979).

2/Then the Department of Health, Education, and Welfare.

form of administrative salaries and management consulting fees have been claimed and reimbursed by Medicare. To date, HHS has not adopted this recommendation.

The Health Care Financing Administration (HCFA) believes that the cost data presently being reported by HHAs lack sufficient uniformity to make such limits meaningful. According to a HCFA official, they are trying to solve the data problem by implementing a uniform reporting system as required by the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142).

Although we believe that existing legislative authority is adequate to implement our proposal, we note that, during the 96th Congress, S. 489 was introduced which would require limits for specific HHA line-item costs, such as transportation, administrative salaries, and fiscal and legal services. This bill was not enacted during that Congress, and in the absence of agency action on this issue, we would support similar legislative initiatives in this Congress.

Allowable costs related to patient care

Medicare principles of reimbursement for provider costs are contained in subpart D to part 405 of title 42 of the Code of Federal Regulations. These regulations include rather detailed rules for such specific elements of cost as interest expense (42 CFR 405.419), bad debts, charity and courtesy allowances (42 CFR 405.420), educational activities (42 CFR 405.421), and research costs (42 CFR 405.422).

In contrast, the regulation governing the costs related to patient care (42 CFR 405.451) is very general. Although disputes in interpreting this regulation have arisen involving all types of providers, its application has presented special problems in HHA reimbursement because of the competition involved in obtaining patients. A key feature of an HHA's operation is patient referrals from hospitals, doctors, and social workers. This has given rise to the use of full-time employees, described as hospital discharge planners or coordinators, whom we believe were engaged in identifying potential patients and soliciting referrals, which under the program instructions is not allowable for reimbursement.

Another problem is promotional gifts (pens, letter openers, etc.) that have been provided to doctors and other sources of patient referrals and charged to Medicare. Because the regulation (42 CFR 405.451(b)(2)) defines necessary and proper costs as "costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities," identifying and disallowing such promotional costs has been difficult. Although HCFA has issued various program instructions

to clarify the types of promotional activities that represent allowable costs, we believe that, as long as the regulation is general, the instructions will be difficult to implement or enforce. On the other hand, it has been argued that too rigidly drawn regulations facilitate the identification of "loopholes" and thus are equally difficult to enforce. We believe that currently this is a very "gray" area in which we can offer no easy solutions.

Costs to related organizations

The regulations governing transactions between providers and related organizations (including HHAs and "front" organizations) are embodied in 42 CFR 405.427. Also, implementing program instructions are contained in chapter 10 of Medicare's Provider Reimbursement Manual.

The underlying principle for transactions between related parties is as follows:

> "Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere."

Essentially, this provision is designed to eliminate profits for Medicare reimbursement purposes between parties considered to be related.

The regulations also provide for an exception to the above rule if all of four certain conditions are met to the intermediary's satisfaction. The conditions are that (1) the supplying party is a bona fide separate organization, (2) a substantial part of its business is transacted with organizations not related to the provider, (3) there is an open competitive market for the services or supplies in question, and (4) the services or supplies are those commonly obtained by the type of provider from other organizations and are not those ordinarily furnished directly to patients by that type of provider.

The regulations and manual instructions have changed little since November 1966 and June 1969, respectively; nonetheless, they have been the subject of considerable debate and controversy. A common complaint has been that many terms need to be defined more precisely; for example, "bona fide separate organization," "open, competitive market," and "control." At the same time, attempts to make the regulations more specific have been opposed because of concerns that more rigid regulations would arbitrarily hinder legitimate transactions.

On April 20, 1981, HCFA requested comments from us, and others, on a proposed change to the related organization provisions of the Provider Reimbursement Manual. Basically, the proposal clarifies many of the manual provisions and sets out more examples of what constitutes a related organization transaction. Our general reaction is that the proposed change is a significant improvement.

In related organization determinations, the burden of proof generally falls with the Medicare intermediary; that is, the intermediary must provide substantive evidence that the provider and party in question are related by common ownership or control. 1/ We believe that this burden of proof should be shifted to the provider when certain criteria are met. For example, if the administrator of an HHA (or hospital or skilled nursing facility) is related to a top officer of a supplying organization, the agency and the organization would be presumed to be related for Medicare reimbursement purposes. Another example would be subcontracts between an HHA and an organization that was instrumental in organizing it and/or getting it certified for Medicare participation. In such situations, therefore, the provider would be required to disclose such a relationship and demonstrate to the intermediary's satisfaction that such a relationship does not constitute a related organization arrangement under Medicare reimbursement principles.

Subcontracting abuses by HHAs

We believe that overall the provisions of the Medicare law and regulations provide sufficient authority to adequately control abusive subcontracting by HHAs, especially with the recent provisions added by Public Law 96-499, approved December 5, 1980.

Section 930(p) of Public Law 96-499 added to the Medicare law section 1861(v)(1)(H), which prohibits the Secretary from recognizing, as allowable costs, HHA costs related to subcontracts that are more than 5 years in duration or that base payments under the contract on a percentage of the HHA's revenues or claims for reimbursement. We have identified and reported on a number of instances in which contracts were excessively long and/or percentage of revenue type contracts between providers and both related and nonrelated organizations have resulted in inflated Medicare and Medicaid costs. We have recommended that percentage contracts be prohibited under both programs. We found problems with such

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1/Under the exception rule (42 CFR 405.427(d)), the burden of proof is on the provider that the four conditions are met.

contracts not only with HHAs, 1/ but also with nursing homes, 2/ hospitals, 3/ prepaid health plans, 4/ and Medicaid insuring agreements. 5/ The provision in Public Law 96-499 only covers HHAs.

Section 952 of Public Law 96-499 added section 1861(v)(1)(I), which requires Medicare providers to include in their subcontracts with others a provision giving HHS and us access to the subcontractor's books and records necessary to identify the nature and extent of the costs incurred by the provider under the subcontract. This provision should assure that the Government has available the books and records necessary to determine the reasonableness of costs associated with both arm's-length and non-arm's-length transactions.

Public Law 96-499 also gives the Secretary authority to establish bonding requirements for HHAs, which we believe will help HHS recover cost disallowances, including those attributable to subcontract abuses. This provision is discussed on page 10.

Alternative reimbursement mechanism

Besides proposals to establish tighter section 223 limits for HHAs, we are not aware of any proposals to change the Medicare reimbursement mechanisms for HHAs. A principal alternative reimbursement method for other types of providers is a prospective payment system, under which the rate of payment is established before the fact and retroactive adjustments generally are not made.

We believe a prospective system would be harder to use for HHAs because of the lack of a uniform unit of service on which to base the rate. For hospitals and nursing homes, a day of inpatient care is a common unit of service used in prospective payment systems. However, for HHAs the unit of service is a visit,

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1/See note 1, page 2.

2/"Problems in Auditing Medicaid Nursing Home Chains" (HRD-78-158, Jan. 9, 1979).

3/Report to the Administrator of HCFA on hospital management services contracts (June 30, 1980).

4/"Relationship Between Nonprofit Prepaid Health Plans With California Medicaid Contracts and For Profit Entities Affiliated With Them" (HRD-77-4, Nov. 1, 1976).

5/"Medicaid Insurance Contracts--Problems in Procuring, Administering, and Monitoring" (HRD-77-106, Jan. 23, 1978).

which can vary in duration between the various types of visits, including variations in traveling time. 1/

Also, establishing prospective rates on a per-visit basis (or on a patient served basis) could be subject to manipulation and would give HHAs incentives that could lower the quality of care provided. For example, to maximize revenues, HHAs would have an incentive to decrease the duration of visits in order to increase the total number of visits. A decrease in the length of visits in turn could compromise the quality of care provided.

B. THE EFFECTIVENESS OF INTERMEDIARY AUDIT COVERAGE

A good measure of the effectiveness of intermediary audits is their cost/benefit ratio; that is, the relationship between the cost of the audit and the savings or disallowances resulting from it. While HCFA does not specifically monitor the cost/benefit of HHA audits, over the last few years the cost/benefit ratio for all types of Medicare providers (hospitals, skilled nursing facilities, and HHAs) has been about $4 saved for every $1 spent.

Although the effectiveness of intermediary audits is an important issue, an equally important and recurring issue is the adequacy of audit coverage. To minimize Medicare administrative costs, many provider cost reports are settled or accepted without field audits. For example, for provider cost reporting years ended in 1978, about 60 percent of the HHA cost reports were settled without a field audit. A major concern with settling cost reports without such an audit is that providers can be reimbursed for significant unallowable costs. It is difficult to identify such unallowable costs by reviewing a cost report without also field auditing the provider.

An example of the potential shortcomings of not field auditing is demonstrated by a January 1981 HCFA Bureau of Quality Control report on eight large HHAs in southern California. The cost years audited by the Bureau for six of the HHAs had been settled by the intermediaries without the benefit of field audits, and for these agencies, the Bureau recommended 2/ overall cost

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1/Although this unit of service is used in establishing section 223 limits, such limits are the maximum amount to be considered reasonable and thus are not the sole basis for payment.

2/The Bureau's recommendations are not necessarily final. Intermediaries are responsible for making final determinations, which are also subject to appeal by providers.

adjustments of $366,319. Most of the adjustments involved related organization transactions ($121,901) and salary adjustments ($97,551). The recommended related organization adjustments involved transactions for rent, durable medical equipment, accounting and billing services, and consultation. The salary adjustments involved unreasonable salary costs and the lack of documentation to show that the salaries claimed were in fact paid.

Adjustments of the magnitude listed above are not likely to be representative of the level of unallowable costs that could be identified at other agencies; however, they do demonstrate the potential benefits of field audits and the potential risks of settling cost reports without such audits.

For fiscal year 1982, significant cuts in the HCFA budget for intermediary audits are under consideration. On March 12, 1981, HCFA told intermediary representatives that plans were being considered to reduce the 1982 budget for provider field audits by $19 million, about a 67-percent reduction over the fiscal year 1981 funding level. We believe cuts of this magnitude could hamper the intermediaries' ability to assess compliance with existing legislation and regulations.

C. THE EFFECTIVENESS OF OVERSIGHT AND ADMINISTRATION BY HCFA

The operation of the Medicare program is highly decentralized; day-to-day program responsibility is delegated under contract to Blue Cross and Blue Shield plans and commercial insurance companies (intermediaries and carriers) located throughout the country. HCFA's role largely involves providing national policy direction to the program and assuring that its contractors perform as required.

HCFA oversees the program's administration in several ways. Ten regional offices are responsible for monitoring the performance of the contractors in their regions, and many contractors have on-site HCFA representatives. Also, all contractors are required to routinely provide information on various aspects of program operations, including the cost and timeliness of claims processing, the timeliness and results of provider audits, the disposition of beneficiary inquiries, and the amount of and reasons for claim denials. Finally, HCFA is to formally evaluate each of its contractors annually. These evaluations cover the principal aspects of their operations, such as claims processing, beneficiary services, and fiscal administration.

How well HCFA monitors the program's administration is difficult to say; however, we believe the agency has set up reasonable systems to fulfill this responsibility. We have issued two reports since 1979 which touch on how HCFA administers Medicare's home health program. Your letter noted one of them: "Home Health Care Services--Tighter Fiscal Controls Needed" (HRD-79-17, May 15, 1979). Another report (copy enclosed) discusses our evaluation of HCFA's 1980 proposed home health care limits established under section 223 of the Social Security Amendments of 1972. The report (HRD-80-84, May 8, 1980) points out various problems with the data base and methodology used to develop the limits.

D. THE MEANS BY WHICH DISALLOWANCES CAN BE RECOVERED BY THE FEDERAL GOVERNMENT WITHOUT RENDERING INSOLVENT THE BONA FIDE HHAs

The Medicare program can recover overpayments from HHAs in three basic ways:

--By a lump-sum payment from the HHA at the time of the cost report settlement.

--Through a repayment schedule under which the HHA makes periodic payments until the overpayment is repaid.

--Through offset by reduction or suspension of future payments for services rendered to program beneficiaries until the overpayment has been recaptured.

These methods of recovering overpayments assume that the HHA has or can obtain the funds necessary to make the repayments or can continue to operate at reduced revenue levels. We believe that it is unreasonable to assume that nonprofit HHAs with a high proportion of Medicare utilization will have the reserves necessary to repay significant overpayments or the ability to continue to operate if their Medicare payments are reduced substantially below the level of their costs.

The primary options available to the Government to collect overpayments from bankrupt or insolvent nonprofit HHAs are:

--Attaching the HHA's assets, which are normally of nominal value (e.g., office furniture and equipment).

--Demonstrating that the directors and/or officers of the corporation abused its tax-exempt status for their personal enrichment--which enables the Government to proceed against the assets of the directors and/or officers involved.

The ability to recoup overpayments from a proprietary HHA would depend on the HHA's financial condition. Recovery from insolvent proprietary HHAs would be undertaken by the Government following the normal bankruptcy and contract law procedures.

In our view, the ability to collect overpayments from HHAs, particularly nonprofits, depends heavily on the extent of their reliance on the Medicare program for revenues. A nonprofit HHA with 100-percent Medicare utilization would have great difficulty continuing operations if Medicare funding was interrupted. A nonprofit HHA that received revenues from other sources and/or received philanthropic support might have less difficulty. A proprietary chain that is part of a diversified corporation might encounter little difficulty.

A recently enacted provision of the Omnibus Reconciliation Act of 1980 could decrease the likelihood of an HHA becoming insolvent when it has to repay overpayments. Section 930(n) of the act added to the Medicare law section 1861(o)(7), which authorizes the Secretary of HHS to require HHAs to be bonded or to establish escrow accounts to protect the Government's financial interest. When this provision is implemented through regulation, it could both protect the Government from losses resulting from overpayments that HHAs cannot repay and protect HHAs from insolvency when they must repay identified overpayments.

E. THE MEANS BY WHICH THE FEDERAL GOVERNMENT CAN TERMINATE IRRESPONSIBLE HHAs FROM PARTICIPATION IN FEDERAL PROGRAMS

Several authorities are available to the Government to terminate irresponsible HHAs.

Under the Social Security Act, providers, including HHAs, are required to disclose to HHS the identity of any person who has an ownership or controlling interest in the provider or who is an agent or managing employee of the provider and has been convicted of a criminal offense against any of the three programs (section 1126). HHS or the applicable State agency can preclude or terminate program participation by the provider if such an individual is associated with it (42 CFR 420.204). Failure to disclose such situations is grounds for termination (42 CFR 489.53(a)(1)).

Providers, including HHAs, are also required to disclose to HHS, and to the States for Medicaid and title XX purposes, information on persons with ownership in or control over them (section 1124). If an HHA fails to disclose this information, it can be terminated (42 CFR 420.206(c)).

Furthermore, providers, including HHAs, are required to disclose upon request information on the ownership of a subcontractor with which the provider had business transactions aggregating $25,000 (during the previous 12 months) and any significant transactions between the provider and any wholly owned supplier or other subcontractor during the 5-year period ending on the date of the request (section 1866(b)). Failure to disclose this information is grounds for termination (42 CFR 489.53(a)(9)).

Under Medicare (42 CFR 489.53), an HHA may also be terminated if it

--is not in substantial compliance with the requirements of the Medicare law or regulations or its provider agreement with Medicare,

--does not meet the Medicare conditions of participation for HHAs,

--fails to provide information to HHS necessary to determine if payments are or were due under Medicare and the amount of the payment due,

--refuses to permit HHS or its agents to examine its financial or other records necessary to verify information furnished as a basis for Medicare payments,

--knowingly and willfully makes or causes to be made any false statement or misrepresentation of a material fact in an application or request for payment under Medicare,

--submits or causes to be submitted requests for payment under Medicare of amounts for items and services substantially in excess of the costs incurred by it in providing such items or services,

--furnishes items or services that HHS has determined to be substantially in excess of the needs of individuals or of a quality below professionally recognized standards of health care, or

--fails to comply with the civil rights requirements contained in the regulations.

Under Medicaid, the States can establish the grounds for terminating providers (except for those required by Federal law discussed at the beginning of this section).