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STATEMENT OF
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BEFORE THE
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
COMMITTEE ON GOVERNMENTAL AFFAIRS
ON
THE ADEQUACY OF LEGISLATION
AND REGULATIONS TO ADDRESS ABUSES
IN THE HOME HEALTH CARE INDUSTRY

Mr. Chairman and members of the Permanent Subcommittee, we are pleased to be here to present our views on the adequacy of present legislation and regulations to prevent profiteering in the home health care industry.

Our testimony today summarizes our April 24, 1981, report to the Permanent Subcommittee and, as requested, our views are provided in the context of the following five issues:

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

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

3. The effectiveness of oversight and administration by the Health Care Financing Administration.

4. The means by which disallowances can be recovered by the Federal Government without rendering insolvent bona fide home health agencies.

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

Overall, 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 the Health Care Financing Administration (HCFA) sufficient authority to address the Permanent 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 (HHS) establishing limits on Medicare reimbursement for home health agency (HHA) management and clerical costs.

Federal funding for home health services is provided under several legislative authorities; however, our comments relate primarily to the Medicare program. This program accounts for the bulk of Federal expenditures for home health services and its reimbursement principles have been adopted by many States in their Medicaid programs.

Medicare's Cost Reimbursement System

The first issue we will address is Medicare's cost reimbursement system. HHAs, like the other institutional providers (hospitals and nursing homes), are reimbursed retrospectively on the basis of their actual reasonable and allowable costs to provide patient care. 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. In our view, in addition to the open-ended nature of the system, several problems have emerged that apply not only to HHAs but also to other institutional providers paid under the same retrospective system.

One particular problem is the wide variation among HHAs in the cost of providing services. Under Medicare reimbursement principles, providers are paid the actual cost of providing quality care, however widely that cost might vary from provider to provider. This principle is subject to a limitation where a particular

provider's costs are "substantially out of line" with costs of other providers in the same area that are similar in size, scope of service, utilization, and other relevant factors. As discussed in our May 1979 report on Medicare's home health program, 1/ without a definition of what constituted "substantially out of line," Medicare 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 amended the Social Security Act to provide HHS 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 before the fact 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 and at our

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

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

HCFA believes that the cost data presently being reported by HHAs lack sufficient uniformity to make such limits meaningful. According to a HCFA official, HCFA is 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.

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.

Another problem with Medicare's cost reimbursement system is determining which costs are related to patient care and which are

not. The regulation governing this issue is very general and a number of problems have arisen with HHA costs. An example is whether certain HHA costs represent unallowable patient solicitation activities or whether they represent allowable costs of maintaining good relations with the medical community. We believe that, as long as the regulation is general, the instructions expanding on it 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 solution.

An additional problem with the reimbursement system is the application of the regulations for related organization transactions. The regulations governing transactions between providers and organizations considered to be related by ownership or control are designed to eliminate profits between the parties involved. The regulations, however, also provide for an exception 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.

A common complaint about the related organization regulation and guidelines 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 Medicare's 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 an improvement.

In related organization determinations, unless the provider is applying for an exception, the burden of proof 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. In practice, proving that parties are related, particularly through control, is very difficult and time-consuming. We believe, therefore, 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 agency and an organization that was instrumental in organizing the provider 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.

To overcome the problems with Medicare's cost reimbursement system, some have advocated that an alternative reimbursement system be established. A principal alternative reimbursement system 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. However, for HHAs the unit of service is a visit, which can vary significantly in duration including variations in traveling time. 1/

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.

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.

Effectiveness of Intermediary Audit Coverage

The second major area we will discuss is the effectiveness of intermediary 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 unallowable costs by reviewing a cost report without also field auditing the provider.

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.

HCFA Oversight

The question of how well HCFA monitors the program's administration is difficult to answer; however, we believe the agency has set up reasonable systems to fulfill this responsibility. Also, we have issued two reports since 1979 which touch on how well HCFA administers Medicare's home health program. One report we have already mentioned is our May 15, 1979, report which is entitled "Home Health Care Services--Tighter Fiscal Controls Needed" (HRD-79-17). The other report--a copy of which was forwarded to the Committee earlier--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.

Recovery of Overpayments

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 agency with 100-percent Medicare utilization would have great difficulty continuing operations if Medicare funding was interrupted. A nonprofit agency 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.

With regard to the recovery of overpayments from bankrupt or insolvent HHAs, for non-profit agencies the Government has two primary options:

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

--Demonstrate 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.

For proprietary agencies, recovery would be undertaken by the Government following the normal bankruptcy and contract law procedures.

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 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 agencies cannot repay and protect agencies from insolvency when they must repay identified overpayments.

Terminating Irresponsible HHAs

The last issue we will address is the means by which the Federal government can terminate irresponsible HHAs, and in summary, we

believe there is sufficient authority already on the books.

Under Medicare, for example, an HHA may be terminated for a number of reasons, including if it

--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, or

--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.

Under Medicaid, the States can establish the grounds for terminating providers but must terminate providers in those cases covered by Federal law.

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Mr. Chairman, this completes our prepared statement. We would be happy to answer any questions you or other members of the Permanent Subcommittee may have.