97TH CONGRESS
1st Session

SENATE

REPORT
No. 97-210

HOME HEALTH CARE FRAUD AND ABUSE

REPORT

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

MADE BY ITS

PERMANENT SUBCOMMMITTEE ON INVESTIGATIONS

OCTOBER 19, (legislative day, OCTOBER 14), 1981.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
84-877 O WASHINGTON: 1981

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Mr. ROTH, from the Committee on Governmental Affairs, submitted the following

REPORT

I. INTRODUCTION

In March, 1981, the Senate Permanent Subcommittee on Investigations (PSI) commenced an examination of the medicare home health program administered and funded by the Health Care Finance Administration (HCFA) in the Department of Health and Human Services (HHS). The primary focus of the subcommittee's review was a group of not-for-profit, tax exempt home health agencies and their subcontractors operating in the Chicago-metropolitan area. As a result of the investigation, made concomitantly with case studies by various organizations in other States, the subcommittee found the medicare home health program highly vulnerable to fraud, waste and abuse, providing an almost open-ended opportunity for unscrupulous operators to profit substantially at the expense of the taxpayer. These findings were the subject of PSI hearings held on May 13 and 14, 1981, which were presided over by Senator William V. Roth Jr., Chairman of the subcommittee.

This report details the evidence obtained during the course of the subcommittee's investigation, explains the medicare home health program and summarizes some of the recent government oversight and legislative initiatives which have been undertaken. The report also identifies the key problems with the current system of home health care delivery. It concludes with the subcommittee's recommendations and legislative proposals which are intended to eliminate many of the abusive practices uncovered during the investigation.

Senator Roth emphasized in his opening statement that the subcommittee's purpose in conducting these hearings was not to condemn the concept of home health care itself but rather to expose the various mechanisms by which one individual or small organization can control all aspects of the delivery of home health care services.[1] This report

[1] Opening Statement, William V. Roth, Jr., May 13, 1981 (hereinafter "Roth Statement").

is intended to further that goal of exposing—and eliminating—fraudulent practices in order to insure the continuance of the medicare home health care program as a viable alternative to institutional care for the aged and disabled.

A. THE MEDICARE HOME HEALTH PROGRAM

In 1965, Congress enacted title XVIII of the Social Security Act which authorized reimbursement for home health care services to medicare beneficiaries.[2] Prior to March 1977, the medicare home health program was administered by the Social Security Administration. Since then, HCFA has been responsible for operating the program, establishing policy and developing administrative guidelines. As of January 1, 1979, over 837,000 medicare beneficiaries had utilized home health care services,[3] and total medicare billings for these services in fiscal year 1980 was $750 million.[4]

Home health agencies are licensed (or otherwise legally sanctioned) public or private organizations which may operate either for profit (depending on State law)[5] or not-for-profit in which case the organization maintains a tax-exempt status. In accordance with a plan of treatment established and reviewed by the beneficiary's physician, home health agencies provide part-time skilled nursing and other therapeutic services, e.g., occupational, physical or speech therapy, to patients restricted to their homes. Proprietary (for-profit) agencies must provide all services directly.[6] A not-for-profit agency must provide at least one of these services through its own employees, but may contract outside agencies for the provision of additional services. Costs incurred by an outside agency which is owned or otherwise controlled by (or owns or otherwise controls) the not-for-profit agency, however, will not be recovered to the extent such costs exceed charges for comparable services, facilities or supplies furnished by a similar concern.[7]

The policies of an individual home health agency are determined by a group of professional personnel associated with the agency. This policymaking group must, by regulation, include one or more physicians and one or more nurses.[8] Federal regulations also require that skilled nursing services be delivered under the supervision of a registered nurse or physician who is available on the premises during operating hours.[9]

Upon receiving certification from a State health department (or comparable agency) that it has met all of the conditions of participation,[10] as well as any other State or local requirements, the home health agency enters into a provider agreement with HCFA and obtains a provider number. As of March 1981, there were 3,076

[2] Public Law 89-97 (1965), 42 USC 1395 et. seq.
[3] Hearing, p. 9.
[4] Hearing, p. 10. Overall, during fiscal year 1980, total home health care billings under medicare, along with billings under the Federal-State medicaid and title XX programs, which also provide for home health care services, exceeded $1 billion.
[5] Effective July 1, 1981, proprietary agencies no longer require a State license to operate. See Public Law 96-499.
[6] 42 CFR 405.1221(a).
[7] 42 CFR 405.427.
[8] 42 CFR 405.1201.
[9] 42 CFR 405.1221(d).
[10] 42 CFR 405.1201.

home health agencies participating in the medicare program, of which 534 were private, not-for-profit, tax-exempt agencies.[11]

Reimbursement to the home health agency is accomplished directly from HCFA or through fiscal intermediaries such as Blue/Cross Blue Shield. The responsibility of selecting a fiscal intermediary lies with the agency. The intermediaries make interim payments to the home health agencies, normally on a quarterly basis.

Home health agencies receive reimbursement for the cost of those services deemed necessary and proper, i.e., appropriate and helpful in developing and maintaining the operation of patient care.[12] Payments are based on the lesser of the reasonable costs of these services or customary charges to the general public for such services.[13] These charges are reflected on cost reports submitted by the home health agency annually to the intermediary. Cost reports list all direct and indirect expenses of the home health agency, including payments to subcontractors. These reports serve as the primary vehicle by which the intermediary determines reimbursement. First year reports are subject to full intermediary audits. Subsequent reports are each given desk audits with followup field audits as necessary. In 1980, there were 1,149 fiscal intermediary audits of home health agencies. In 1980, these audits cost $3.3 million, but resulted in recoveries of $13.5 million in disallowances, representing a four-to-one return.[14]

In those instances where disallowances are made after intermediary audit, the home health agency is required to remit the amount of the disallowances to the intermediary. Since the interim payments may be a nonprofit agency's only source of revenue, this remittance is often difficult for the provider to make. Cost disallowances are, however, fully appealable either through the administrative process, or once administrative remedies are exhausted, through the courts.[15] If an agency fails to take issue with a cost disallowance, or should the initial determination be upheld in subsequent proceedings, repayments are arranged either as lump-sum repayments, repayments over a period of months, or as offsets to future interim payments.

Intermediaries, similarly, are audited annually by HCFA and the intermediary audit materials used to audit home health agencies are reviewed for sufficiency.

Cases of suspected waste, fraud or abuse discovered by the intermediaries are referred through HCFA administrative channels to the Office of Inspector General in HHS for the purpose of instituting a full-scale investigation. In the past, the Office of Inspector General has also received information concerning suspected fraud from the Department of Justice, from former employees of the home health agencies and from its own internal services. Forty-eight referrals alleging fraud and abuse have been submitted to the Office of Inspector General since January 1977.[16] Three investigations originally undertaken by the Office of Inspector General have culminated in convictions; two currently are under grand jury investigation and

[11] Prepared Statement of Charles Morley, Chief Investigator (PSI) dated May 13, 1981, (hereinafter "Morley Statement").
[12] 42 CFR 405.451(b)(2).
[13] 42 CFR 405.451(a). Built into the reimbursement system, however, are variations for regional differences. 42 CFR 405.403-422.
[14] Hearing, p. 11.
[15] CFR 405.1801 et seq. In 1972, the Provider Reimbursement Review Board within HCFA was established as a forum for handling provider-intermediary disputes. See infra. p. 6.
[16] Hearing, p. 11.

fifteen are awaiting prosecutive opinion from the Department of Justice.[17]

Section 1866 of the Social Security Act authorizes HCFA to terminate a home health agency from participation in the program where, among other reasons, an agency representative knowingly and willfully makes any false statements or misrepresentations or an agency requests payment for items either substantially in excess of the actual cost incurred or in excess of a patient's needs.[18] Recent legislation also authorizes the termination or exclusion of providers from participation in the program if any of its agents, managing employees, or individuals associated with the provider, are convicted of a medicare related offense.[19] Failure to disclose such a situation is also grounds for termination.[20] Despite this authority, only four home health agencies or owner-operators have been involuntarily terminated or otherwise excluded from the program since its inception in 1965.[21]

B. RECENT CONGRESSIONAL REVIEW AND OTHER GOVERNMENTAL OVERSIGHT OF THE HOME HEALTH INDUSTRY

Since 1975, the delivery of home health services has been the target of more than a dozen congressional hearings. Many of these hearings involved case studies of fraud and abuse similar to the one undertaken by PSI in Chicago.[22] In addition, hearings have been held concerning not only the participation of proprietary agencies in the home health program,[23] but also legislative proposals eliminating restrictions on the receipt of medicare benefits [24] and the effect HCFA has had on small businesses operating in the home health field.[25] Indeed, PSI in 1978 issued a report on prepaid health plans and health maintenance organizations which touched upon some of the same issues involving fraud and abuse.[26]

In addition, the General Accounting Office (GAO), the Office of the Inspector General at HHS, the New York State Department of Audit and Control, HCFA, and the U.S. Department of Justice have all independently undertaken studies concerning fraud and

[17] Letter dated June 4, 1981, from Nathan Dick, Assistant Inspector General for Investigations, HHS, to PSI.

[18] 42 USC 1395cc(b)(2). For the identical reasons under section 1862 of the act, 42 USC 1395(y)(d)(1), HCFA may refuse payment to a participant in the Medicare program.

[19] 42 CFR 420.204; 42 USC 1320.

[20] 42 CFR 489.53(a)(1).

[21] Hearing, p. 124 HCFA officials concede that they have not effectively utilized their termination authority.

[22] Hearings on "A Study of Home Health Services Under Medicare" before the Subcommittee on Health and Oversight of the House Committee on Ways and Means, 94th Congress, 2d Session, No. 78-420 (September 1976); Staff of the Subcommittee on Federal Practices, Efficiency and Open Government of the Senate Committee on Government Operations, 94th Congress, 2d Session: Report on "Problems Associated with Home Health Care Agencies and Medicare Program in the State of Florida" No. 74-5990 (August 1976); Hearings on "Medicare and Medicaid Funds" before the Senate Special Committee on Aging in cooperation with the Subcommittees on Health and Oversight of the House Committee on Ways and Means, 95th Congress, 1st Session No. 86-072c and 87-469, pts. 8 and 9 (March 1977); Hearings on "Home Health Agencies" before the Subcommittee on Oversight of the House Committee on Ways and Means 95th Congress, 2d Session, No. 95-106 (August 1978); Field Hearings on "Abuse of Medicare Home Health Program" before the Senate Special Committee on Aging, 96th Congress, 1st Session No. 60-751-0, (August 1979); Hearings on "Medicare and Medicaid Fraud" before the Subcommittee on Health of the Senate Committee on Finance, 96th Congress, 1st Session, No. 69-849-0 (July 1980).

[23] Joint Hearings on "Proprietary Home Health Care" before the Subcommittee on Long-Term Care of the Senate Special Committee on Aging and the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging, 94th Congress, 1st Session, No. 70-652 (October 1975).

[24] Hearings on S. 421 and S. 489, "Medicare and Medicaid Home Health Benefits" before the Subcommittee on Health of the Senate Committee on Finance, 96th Congress, 1st Session, No. 43-611-0 (May 1979).

[25] Hearings on "Health Care" before the Senate Select Committee on Small Business, 96th Congress, 1st Session, No. 55-945, Part 1 and 2 (September 1979).

[26] Staff of the Permanent Subcommittee on Investigations of the Senate Committee on Governmental Affairs, 95th Congress, 2d Session, No. 29-010-0, Report on Prepaid Health Plans and Health Maintenance Organizations (April 1978).

abuse in the delivery of home health care services. The essence of their studies is as follows:

First, in response to a congressional request, GAO recently evaluated HCFA's proposed home health care cost reimbursement limits.[27]

In addition, on at least two separate occasions, GAO has called for stricter fiscal controls over the delivery of home health care services.[28] In the most recent of these reports, GAO cited a substantial number of fraudulent practices occurring in Florida and Louisiana based on an extensive investigation of several home health agencies located in those States. Specifically, GAO auditors found claims for undocumented costs or costs unrelated to patient care, noting in particular, costs incurred for a lavish trip to Europe for a home health operator and his wife for the sole purpose of observing European home health care programs. In addition, GAO investigators uncovered abuses in the relationship between home health agencies and their subcontractors, including the simultaneous use of provider facilities, the formation of subcontracts of excessive duration, and the formation of contracts between related organizations.

Second, after undertaking an investigation of its medicaid home health care program, not unlike GAO's medicare evaluation, the New York State Department of Audit and Control, Office of the Welfare Inspector General, identified a group of private home health agencies operating in Nassau County, New York which had made unconscionable profits from medicaid billings. Indeed, audits of seven out of twenty of these proprietary agencies revealed their owners had received a 4,000 percent return on their investment.[29]

Third, the Office of Inspector General in HHS has cited fraud and abuse in the delivery of home health care services in each of its annual reports for the years 1977–1980.[30]

Fourth, HCFA has addressed the problems concerning fraud and abuse in at least two instances worthy of note—required by law, the other self-initiated. In 1979, in accordance with section 18 of Public Law 95–147, HCFA submitted to Congress a report entitled "From Simple Idea to Complex Execution: Home Health Services under titles XVIII, XIX and XX," also known as the H.R. 3 report.[31] In addition to assessing the programs, in that report, HCFA officials both discussed the problems associated with home-delivered services and proposed changes in all facets of its administration designed to eliminate such problems.

During the same year, HCFA's Bureau of Quality Control (BQC) undertook an evaluation of the home health care program by conducting a validation review of selected agencies in Florida. The HCFA Task Force later extended its review to include agencies located in

[27] "Evaluation of the Health Care Financing Administrations Proposed Home Health Care Reimbursement Limits," GAO, HRD 80-84 (May 11, 1980).

[28] "Home Health Care Services—Tighter Fiscal Controls Needed," GAO, HRD 79-17 (May 15, 1979); "Health Costs Can Be Reduced By Millions of Dollars If Federal Agencies Fully Carry Out GAO Recommendations," GAO, HRD No. 80-6 (November 13, 1979).

[29] Press Release No. 511y8, New York State Department of Audit and Control, Office of Welfare Inspector General. See also the official Inspector General's Report entitled "An Examination of Medicaid Funded Personal Care Services, Nassau County, New, York (1978).

[30] Annual Reports 1977, 1978, 1979, 1980, Office of the Inspector General, Department of Health and Human Services.

[31] Section 18 of Public Law 95-146 called for the preparation of a report by HCFA which assessed the current status of the various home health care programs administered by the agency. The inadequacy of that report was made the target of a hearing on "Home Health Care Services for Older Americans: Planning for the Future: before the Senate Special Committee on Aging, 96th Congress, 1st Session, No. 50-227, (May 1979).

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Mississippi and California.[32] Based on an analysis of these agencies' fiscal year-end reports, the Bureau's auditors noted that in four agencies operating in Florida alone, costs totaling $387,000 had been disallowed, $233,000 of which were claimed as consultant fees paid by the four agencies to the same party. An additional $92,000 was disallowed for duties performed by nurse coordinators wholly unrelated to patient care, while $24,000 was disallowed for unauthorized expenses for meals, auto leasing and other miscellaneous items. Similar patterns of abuse were uncovered in BQC's review of home health agencies operating in California and Mississippi. Substantial disallowances consistently were attributed to excessive administrative salaries, prohibited related organization costs and undocumented or otherwise unauthorized claims.[33]

One final agency critique of the home health care program was set forth in a letter dated March 23, 1981 from the Chief of the Fraud Section, Criminal Division, Department of Justice to the Acting Inspector General in HHS.[34] In that correspondence, some of the major problems experienced by the division in prosecuting medicare fraud cases were outlined. In particular, the Department of Justice noted that HCFA regulations inadequately defined reasonable costs and costs related to patient care, and that current legislation failed to address recurring problems such as the allocation of the burden of proof in matters concerning the relatedness between home health agencies and their subcontracting agencies and the lack of certification of corporate records.

C. RECENT LEGISLATIVE AMENDMENTS

In partial response to the abuses uncovered by prior legislative or similar reviews of the home health care industry, the Social Security Act has been amended several times during the past 10 years. In 1972, Congress enacted Public Law 92–603 which created the Provider Reimbursement Review Board and excluded from payment any physician or individual practitioner who falsified records or submitted charges in excess of need or amount. This law also authorized HHS to establish cost reimbursement limits on the direct or indirect overall cost incurred for specific items or services. Subsequently, HHS did establish limits for the total cost of a home health visit, but, for the most part, has yet to establish cost caps for individual services such as home health aide services.[35]

Five years later, in 1977, Congress passed the "Medicare-Medicaid Anti-Fraud and abuse Amendments".[36] The provisions of this act, among other items, required mandatory disclosure of all persons having any ownership or control interest in the agency, established criminal penalties for defrauding medicare or medicaid programs and authorized the suspension of any physician or individual practitioner convicted of a medicare related offense. In addition, section 18 of the

[32] See generally, Home Health Agency Task Force Final Report, HCFA, October 1980. See also: HCFA Program Validation Report (California) No. 1–11–9006–07 (January 1931); HCFA Program Validation Report (Mississippi), No. 1–11–9002–07 and HCFA Program Validation Report (Florida), No. 1–11–3001–07 (March 1981).

[33] Specifically, in California, BQC auditors disallowed costs claimed by eight agencies in fiscal year 1978 totaling the sum of $557,992. Similarly, in Mississippi, BQC auditors disallowed one agency's claim for administrative salaries which amounted to the sum of $130,000 over a 2 year period.

[34] Hearing, Exhibit 10, p. 151.

[35] Statement of Gregory Ahart, GAO, dated May 14, 1981.

[36] Pub. Law 95–142.

act required HCFA to submit the H.R. 3 report to Congress mentioned previously in this report.

Finally, both the "Omnibus Reconciliation Act of 1980" [37] and the recently enacted "Omnibus Reconciliation Act of 1981" [38] include several provisions also designed to curtail fraud and abuse in the medicare program. Specifically, the provisions of the 1980 Reconciliation Act broaden HCFA's powers to exclude from the program not only physicians and practitioners, but any individual, including home health operators, convicted or otherwise associated with a person convicted of a medicare related offense. In addition, HCFA was given authority to establish bonding and escrow requirements for not-for-profit, tax-exempt agencies. Furthermore, under the 1980 act, providers no longer could recover costs related to subcontracts that exceed 5 years in duration or that are based on a percentage of home health agency revenues. Also, all subcontracts had to include a provision allowing GAO and HCFA access to the subcontractor's books and records.

In the 1981 Reconciliation Act, Congress has authorized HCFA to impose civil monetary penalties not to exceed $2,000 for each item or service against persons who submit fraudulent claims for reimbursement. In addition, under section 2144 of the act, in determining the amount of the payments that may be made with respect to services furnished by the home health agencies, the Secretary may not recognize as reasonable any such costs which exceed the 75th percentile of the cost. Previously, the Secretary could recognize as reasonable costs up to the 80th percentile.

D. THE CHICAGO INVESTIGATION

In March 1981, PSI staff met with members of the Better Government Association (BGA) [39] to discuss BGA's preliminary findings of fraud and abuse in the medicare home health program. Approximately 7 months earlier, the BGA undertook an investigation of the home health industry in three States: Illinois, California, and Mississippi. BGA investigators interviewed numerous home health agency employees, as well as employees of the fiscal intermediaries servicing those agencies, in each of these States. They reviewed various documents in the care and control of State and local authorities which were obtained through a Freedom of Information Act request; they also contacted Federal officials also believed to be investigating certain home health operators. Finally, in collaboration with NBC, television cameras filmed a conversation in a Las Vegas hotel room between an undercover BGA investigator posing as a potential home health investor and a home health operator who, during the meeting, described the means by which they could defraud the program of large sums of money.

[37] Pub. Law 95–499.

[38] Pub. Law 97–35.

[39] The BGA is a Chicago-based private watchdog organization dedicated to promoting a more efficient use of tax dollars. It is directed by J. Terrence Brunner who is assisted by Terry Norton, both former Department of Justice prosecutors. In addition to its headquarters in Chicago, BGA recently opened an office in Washington under the direction of Peter Manikas. Assigned to the BGA investigation of home health fraud and abuse were staff investigators Michael Lyons and Mindy Trossman.

Senator Percy, noting with interest that the case study undertaken by PSI centered in his own State of Illinois, commended Senator Roth for directing PSI's investigation and commented: "I have the fullest confidence in the Better Government Association and I applaud your (Chairman Roth) initiative in securing their (BGA) findings." (Words in parentheses added.) Hearing pp. 14–15.

Of particular interest to the subcommittee were the results of BGA's investigative efforts in the Chicago metropolitan area. There, BGA uncovered a home health agency operation conceived of and controlled by one individual, namely Michael Morrisroe. The Morrisroe operation ostensibly permitted five not-for-profit home health agencies to act as conduits for four profitmaking companies to which medicare funds could be channeled. Since the Government reimbursed these home health agencies on a cost basis, Morrisroe simply contracted out for his essential services, i.e., nurses aides and physical therapists, as well as technical consulting, at highly inflated costs. In fact, he controlled the suppliers who received these inflated payments. Morrisroe then passed the inflated costs through to the Government and received reimbursement. Limited by their lack of access to key financial documents, however, BGA staff was unable to determine the full extent of the profits realized from the Morrisroe scam.

To develop more fully the BGA's initial findings, PSI staff traveled to Chicago on several occasions. The staff met with BGA investigators assigned to the project and reviewed documents which had been obtained in the course of the earlier investigation. Among these documents were copies of the agencies' submitted, cost reports to the fiscal intermediary as well as their subcontracting agreements, certificates of incorporation and various letters of correspondence.

PSI staff next examined the books and records maintained by Blue Cross/Blue Shield (Chicago), the fiscal intermediary for the five home health agencies. With the full cooperation of intermediary officials, PSI arranged for Blue Cross auditors to prepare several charts and other materials demonstrating certain financial and other statistical data relating to the cost reimbursment experience of the five home health agencies.

PSI staff contacted former employees of the Morrisroe home health agencies. Several of them were interviewed, three of whom later testified at the hearing. The agencies' principals, including Morrisroe, declined to be interviewed and, through their respective attorneys, notified the subcommittee that they would assert their constitutional privilege in the event they were subpenaed and called to testify. This decision was based in part on an ongoing Federal grand jury investigation into alleged violations of the Internal Revenue Service Code by Morrisroe and some of the other agency principals in connection with the Chicago home health operation.[40]

As a consequence of these initial discussions and reviews, PSI staff learned the identity of several banks in Chicago and California with which the agencies and principals maintained their respective accounts. Based on this information, the subcommittee issued subpenas to several of these financial institutions, requesting copies of statements, checks, certificates of deposit and other relevant materials pertaining to the home health operation. In addition, a subpena was issued requesting work papers and copies of income tax returns in the possession of the accountant for many of the agencies and principals. Once in possession of these items, PSI staff conducted an in-depth financial analysis to determine the extent of profit realized by Morrisroe and the other principals.

[40] Hearing, pp. 29, 41–43.

To complete its investigation of the Chicago operation, PSI staff undertook two additional steps. It requested HCFA to prepare a utilization study comparing the total number of visits per patient made by other Chicago home health agencies to the total number made by the five Chicago home health agencies under investigation. Also, by letter dated April 14, 1981, Senator Roth solicited responses to five questions concerning the effectiveness of the home health program from various government officials and private concerns. Specifically, Senator Roth sought responses from GAO, BGA, HCFA, the National Association of Home Health Agencies (NAHHA) and the American Federation of Home Health Agencies (AFHHA). Members of each organization were asked for their views and comments on the viability of the retrospective cost reimbursement system, the effectiveness of intermediary audit coverage and the intensity of HCFA's program oversight and administration, along with their suggestions concerning the recovery of disallowances and the termination of irresponsible home health agencies. Based on the comprehensiveness of their individual responses, Senator Roth requested that a representative from each of these organizations testify before the subcommittee.

II. Details of the Evidence

A. The Morrisroe Operation

1. The Chicago Non-Profit Home Health Agencies and Their Profitmaking Subcontractors

In April 1976, Michael Morrisroe, an attorney, incorporated Southwest Home Health Agency as the first of his five 100% medicare funded non-profit home health agencies. One month later, he incorporated the Home Health Agency of Orland-Tinley Park. In September 1976, he established Midway Visiting Nurses Services, the Home Health Agency of Will/Cook County and the Home Health Agency of Oaklawn/Burbank.[41]

Northrad Management Corporation was the first of the four profitmaking companies controlled by Morrisroe, and clearly the largest Morrisroe moneymaker. Incorporated in Delaware on October 8, 1976 and licensed to do business in Illinois 10 days later, Northrad was established ostensibly to provide management and consulting services to the five home health agencies. Northrad charged each of the agencies approximately $12,400 as start-up costs and, thereafter billed them approximately $15,000 per month for consulting services.[42] While supposedly unable to operate since 1979 for its failure to pay a State franchise tax, Northrad has maintained a *de facto* existence through direct billings from Michael Morrisroe. Indeed, Morrisroe billed a number of the home health agencies for "legal fees" approaching $1,000 a month, as late as June 1980, according to Blue Cross records.[43]

Midwest Leasing Corporation, the second profitmaking subcontractor, was a subsidiary of Northrad. It leased office furniture to the Morrisroe-related agencies. In late 1977, Morrisroe sold Midwest to Stratford Leasing Company; however, the sales contract contained a leaseback clause, entitling Midwest to receive 50% of all receipts obtained from renewals of office furniture rented by the home health agencies from Stratford.[44]

The third profitmaking company, Oaklawn Physical Therapy associates, was incorporated in September 1977. Under the direction of Maureen Flannigan, a former physical therapist at Southwest Home Health Agency, Oaklawn provided physical therapy services to each of the five non-profit agencies.[45] When PSI investigators attempted to serve Ms. Flannigan with a subpena at Oaklawn's last known address, however, they found a telephone answering service.[46]

[41] Hearing, pp. 24-26.
[42] Hearing, p. 24.
[43] Hearing, p. 25, 29.
[44] Hearing, p. 28.
[45] Hearing, p. 35.
[46] Hearing, p. 66.

Incorporated in February, 1978 by Patricia Tinder, the former supervisor of nurses' aides at Will County Home Health Agency, Chicago Home Care (CHC) was the last of the four profitmaking companies. For approximately 1 year CHC furnished nurse aides to the home health agencies.[47] Its proprietary and deceptive character is best reflected by two salient facts: (1) its employees were none other than the nurses aides previously employed by the five home health agencies, and (2) the home health agencies billed medicare for nurses aides visits at a rate approximately 55% higher than when the aides were directly employed by the five home health agencies.[48] At the time of the hearings CHC was believed to be operating under the name of Harvey Home Care.[49]

2. Violation of the Related Organization Rule

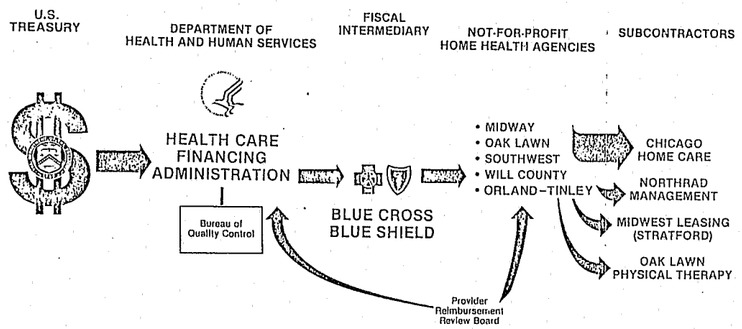
Federal medicare regulations provide that a home health agency may not recover as allowable costs profits realized by subcontractors who are related to the agency by common ownership or control. An exception is provided if the agency can demonstrate: (1) that the supplying party is a bona fide separate organization; (2) that a substantial part of its business is transacted with an organization not related to the home health agency; (3) that there is an open competitive market; and (4) that the services of supplies are those commonly obtained by the home health agency from other organizations and are not those ordinarily furnished directly to patients by the home health agency.[50] A subcontractor is considered to be related to the home health agency where the subcontractor is associated or affiliated or has control or is controlled by the home health agency.[51] Control is deemed to exist where an individual or an organization has the power, directly or indirectly, to influence significantly or direct the action or policies of the home health agency.

Investigative efforts enabled the subcommittee staff to trace the flow of medicare dollars from the U.S. Treasury to HCFA, from HCFA to Blue Cross, from the intermediary to the five home health agencies and lastly, from the agencies to the four profitmaking companies. This direct channeling of funds, reflected on Chart 1 prepared by PSI investigators and reproduced below,[52] demonstrates without exception an interconnection between the five non-profit home health agencies and their profitmaking subcontractors, falling squarely within the related organization prohibition set forth above. Indeed, at the hearing, this interrelatedness was characterized as follows:

> The essence of Mr. Morrisroe's strategy was simple and composed of four major components:
>
> Create the not-for-profit medicare-supported home health agencies, create for-profit service companies, sell the services to the agencies often at highly inflated prices, receive medicare dollars and, most importantly, conceal the relatedness

[47] Hearing, p. 35.
[48] Hearing, p. 45.
[49] Hearing, p. 35.
[50] 42 CFR 405.427(a).
[51] 42 CFR 405.427(b)(1).
[52] Hearing, p. 10.

between the agencies and the companies from the government.[53]



3. Relationship Among the Five Home Health Agencies

BGA investigator Michael Lyons testified that not only were the incorporators of Southwest Home Health Agency identical to the incorporators of the remaining agencies, but further that they were exclusively employees of the previously existing agencies.[54] Moreover, Tim Scanlon, a former Morrisroe employee at Southwest, testified concerning his discovery of a map of the Chicago metropolitan area in Southwest's storeroom just after the agency had opened on which five locations were pinpointed. When he inquired about the map's genesis, Mr. Scanlon was told that the designated areas had been selected by Morrisroe as the locations for the remaining four home health agencies to be opened subsequently.[55]

BGA staff also traced many of the personnel of each of the agencies, as well as the four profitmaking companies, to three Chicago families—the Ryans, the Krusiecs and the Flannigans—who would shift from one Morrisroe agency to another as the need arose.[56] The work history of Rose Gallagher and members of her family (the Krusiecs) served as one example of the family tree phenomenon. Ms. Gallagher began as a nurse for Southwest in 1976, became the administrator at Orland-Tinley for a short time and ultimately was the administrator at Will County. Her husband at one time was the director at Southwest while her parents, John and Marie Krusiec, were employees of Will

[53] Hearing, p. 24. Indeed, after carefully examining Chart 1, Senator Cohen commented:

> I find this all fascinating, disturbing, shocking, as a matter of fact. But I want to come back to my initial problem, what has been done about it, where are the leaks in the system, and what can we do to correct them? I know that is coming tomorrow. My initial question, as I look at the chart about Midway, Oaklawn, and Southwest, is why are they in existence, basically? Why do you have a not-for-profit home health care agency that doesn't provide any services and has to contract out? It seems to me the more you start contracting, subcontracting, getting your equipment and devices over here and buy your furniture from another company and you get your nurses from a third, you go on and on and on, you keep subcontracting, and then it becomes much more difficult to prevent the kind of fraud and abuse we have seen here.
>
> You are distorting the services and making it very difficult to track, certainly from a cost-accounting basis, where that money is going and why it is going there. I don't understand what functions these not-for-profit home health agencies are providing if they have to contract everything else out. Hearing, p. 53.

[54] Hearing, p. 23-25.
[55] Hearing, p. 59.
[56] Hearing, p. 23.

County. According to Mr. Lyons, Morrisroe firmly believed that the best way to insure the flow of medicare funds was to create a closely knit group of family and friends and to instill in them the fear of admitting any relationship to another agency in violation of medicare regulations.[57]

Further examples of an interrelationship among the five home health agencies were furnished by Jean Williams, a former administrator at Oaklawn Home Health Agency. Mrs. Williams, a registered nurse, described instances where she was instructed to shift patients from one agency to another as well as to cross-consult with other administrators, many of whom had little or no administrative experience.[58] Thus, by coordinating his control over and among these agencies, Morrisroe ultimately set the stage for their relationship with the four profitmaking subcontractors.

4. Interrelationship Between the Five Home Health Agencies and Their Four Profitmaking Subcontractors

At the direction of Mr. Morrisroe, each of the five home health agencies entered into exclusive contracts for the services provided by each of the four profitmaking contractors. They were given no choice.

According to Mr. Scanlon, Northrad literally was nothing more than a desk drawer at Southwest; it had no separate corporate location.[59] Its sole employee was Michael Morrisroe, although occasionally he requested part-time help which ultimately would be furnished by employees of his home health agencies.[60] Northrad's contract with each of the home health agencies provided that it would, inter alia, establish training programs, develop operational budgets and assist the agencies in creating public professional awareness of their existence. However, Mr. Lyons testified that in practice this consisted of nothing more than directions from Morrisroe to keep costs high [61] and pay certain subcontractors—Northrad, Chicago Home Care, Midwest Leasing and Oaklawn Physical Therapy (all Morrisroe controlled) on a priority basis along with sending agency personnel to train staff at other agencies and mass mailing of information concerning the agencies.[62] Further, since by the terms of the Northrad contract Morrisroe had full access to the agencies' books and records, he was able to remove or hide files before a Blue Cross/Blue Shield audit in order to disguise his real control.[63]

Chicago Home Care served as perhaps the most flagrant example of a controlled subcontractor. Although incorporated as a separate entity, its staff consisted entirely of home health aides who previously had been employed directly by the home health agencies at a lower cost to medicare. Moreover, Morrisroe installed as its "executive director" Patricia Tinder, a former welfare mother, clearly an appointment titular in nature. Mr. Scanlon testified that whenever he asked

[57] Hearing, p. 25.
[58] Hearing, pp. 62-64.
[59] Hearing, p. 60.
[60] Hearing, p. 28.
[61] Hearing, Exhibit 2, p. 31. To demonstrate the priority billing directions from Morrisroe, Mr. Lyons submitted for the record copies of five checks made payable to Chicago Home Care that were stamped paid one day prior to the date they were written.
[62] Hearing, p. 28.
[63] Hearing, p. 29.

Pat Tinder a question concerning the home health aides, she told him to ask Morrisroe. On at least one occasion when Scanlon heeded Pat Tinder's instruction, he saw Morrisroe cringe and admonish Tinder for associating him with the agency.[64]

Similarly, Mr. Scanlon stated that Maureen Flannigan, who had been a physical therapist for the five home health agencies prior to becoming the director of Oaklawn Physical Therapy, took her day-to-day instructions for operating the company from Morrisroe.[65]

5. Other Examples of Fraud and Abuse

In addition to describing the interrelationship between the agencies and their subcontractors, Jean Williams, Tim Scanlon and Carol Radatz, another former Morrisroe employee, as well as BGA investigator Lyons, all noted other specific instances of fraud and abuse.

The most egregious example cited was the destruction of subpenaed records. Mrs. Radatz testified that in 1979, while employed as a bookkeeper at Orland-Tinley Home Health Agency, FBI agents attempted to serve the agency with a subpena. Since agency employees previously had been instructed to refuse entrance to strangers, the agents slipped the subpena under the door. The office manager referred the subpena to Barbara Kedzior, the agency's executive director, who instructed the manager to wait by the telephone. Shortly thereafter, the office manager received a phone call from Morrisroe who requested that she describe the incident to him and read aloud the subpena. Mrs. Radatz further testified that she observed Mrs. Kedzior putting agency files into large garbage bags and then taking the identical bags home with her later that evening. Moreover, Mrs. Radatz stated that following the receipt of the grand jury subpena, Mrs. Kedzior instructed office personnel to shuffle and to confuse agency documents which previously had been maintained methodically.[66] Indeed, with respect to these instructions, Mrs. Radatz specifically recalls Mrs. Kedzior chuckling:

> Well, the FBI said we had to give them the records, but they didn't say what condition they had to be in.[67]

All of the employee witnesses recalled directions from Morrisroe to inflate costs through a variety of devices: Overbilling for vacation days, fabricating gas receipts, padding the payroll and leasing cars unnecessarily.[68] Mrs. Williams recalled in particular charging medicare for a $300 meal at a Washington, D.C. hotel during a trip to protest disallowances by members of the agencies and Morrisroe. The costs of the trip to Washington also were charged to medicare.[69]

In addition, Mrs. Williams recalled that Morrisroe suggested she obtain a "college" degree at medicare's expense from the University of Beverly Hills which she described as nothing more than a "paper mill." [70] Mrs. Williams also recalled that while bills from Northrad for

[64] Hearing, p. 59.
[65] Ibid.
[66] Hearing, p. 66. Mrs. Kedzior was one of the principals who notified the subcommittee, through her attorney, that she would invoke her fifth amendment rights in the event she was called to testify. See Hearing Exhibit 5, pp. 41-42.
[67] Hearing, p. 66.
[68] Hearing, pp. 66-68. Mr. Lyons also submitted for the record the affidavit of Catherine Couter Zito in which she alleges that she never worked for Oaklawn Physical Therapy although her name appears as one of the physical therapists on the initial State survey. See Hearing Exhibit 4, pp. 35-36.
[69] Hearing, p. 64.
[70] Ibid.

its services ran anywhere from $1,500 to $2,000 a month, its actual services consisted of nothing more than a daily social phone call from Morrisroe.[71]

Lastly, upon inquiry by Chairman Roth, Tim Scanlon testified concerning two other flagrant examples of fraudulent activities, both of which confirmed the control relationship between the agencies and their subcontractors. Specifically, Chairman Roth questioned as follows:

> Chairman ROTH. Earlier we had some testimony with respect to exhibit 3, the nurses' aide costs. There was testimony that the cost per visit was $10.73 in 1977 and this rose to $17.87 for each of the agencies. Are you familiar with this cost increase?
>
> Mr. SCANLON. There was a change at Southwest Community Home Health Agency concerning our delivering of home health aide services. We switched over from delivering in-house home health aides services to subcontracting for these services from Chicago Home Care, for home health. Blue Cross-Blue Shield questioned the cost-effectiveness of that move. Mr. Morrisroe directed me to make a cost comparison of in-home home health visits to contracted home health aide visits. When I told him that it was more cost effective to do it in-house, he said we don't want those figures, make it work, make it look as if it is more expensive to contract; that is, to have in-home service than to contract out when in fact it was not.
>
> Senator COHEN. You did that. Right?
>
> Mr. SCANLON. We did a study with Alexander Grant Co. and the accountant fixed it in such a way that it was less expensive to contract out for these services. However, we never submitted that study to Blue Cross-Blue Shield.
>
> Senator COHEN. Blue Cross-Blue Shield never saw that?
>
> Mr. SCANLON. They saw a variation of it but not that one.
>
> Senator COHEN. Did they reimburse based upon the contracting out?
>
> Mr. SCANLON. They reimbursed us based on the cost of contracting out for these services until such time as Blue Cross disallowed $3.83.
>
> Senator COHEN. I don't understand the timeframe. If they came to you and said we want a justification for the switch of services and then you had a justification prepared but never gave it to them, what happened?
>
> Mr. SCANLON. They didn't follow up until sometime later.
>
> Senator COHEN. That is the point I want to raise again, Mr. Chairman. The question is Blue Cross-Blue Shield has no incentive to really follow up since it is not their money either, is it?
>
> Mr. SCANLON. Blue Cross-Blue Shield was persistent in trying to follow up, but in this particular case we kept stalling, which was one of Mr. Morrisroe's tactics. In addition, a series of other events took place, so this problem got lost in the shuffle.

[71] Hearing, p. 63.

> Chairman ROTH. So the end result is that nothing really happened.
>
> Mr. SCANLON. $3.83 for the home health agencies was disallowed.
>
> Chairman ROTH. That was never recovered?
>
> Mr. SCANLON. That was never recovered.
>
> Chairman ROTH. Continuing with the operation of Chicago Home Care, we have seen evidence that the home health aide utilization rates was much higher in 1977 and 1978 than other agencies operating in the Chicago area, that these agencies billed 55 percent more home health aide beneficiaries than other agencies in the area.
>
> Do you have any explanation for this? Can you tell us what might account for this great utilization?
>
> Mr. SCANLON. Yes. I do. This is a long story. Chicago Home Care provided home health aide services to our patients. They were supposed to provide 1 to 2 hour visits depending on the orders of the doctor. However, the aides were actually staying in the homes about half an hour. Chicago Home Care would bill us for an hour visit, which was the standard visit. Usually it did not exceed an hour. We would bill Blue Cross-Blue Shield for an hour visit. Blue Cross-Blue Shield, our intermediary becomes suspicious, perhaps because our utilization was so high that we couldn't possibly be staying the whole hour. They instructed us to provide home health aide notes which would indicate the type of services provided by the home health aides and the length of their stay. Mr. Morrisroe instructed the people at Southwest Community Home Health Agency and Chicago Home Care to make up notes. He had the aides fill them out. It became apparent that an aide who could only do 7 visits in the day had done 15 or 10 that is, she wasn't spending a full hour. So Mr. Morrisroe then instructed me to have one of the secretaries Xerox a bunch of blank forms and he began to manipulate the forms in such a way that it looked as if an aide spent 7 visits a day instead of the 15. So in actuality we were being paid for 15 visits when we should have been paid for only 8.
>
> Chairman ROTH. How did he cover his tracks? In other words, did he use different names to cover these?
>
> Mr. SCANLON. He obtained their names from me. He started filling out the forms. He would check to see which days the aides were off and put down the days they actually made visits. Those aides who worked part time suddenly became full-time employees for purposes of these notes but not the payroll.
>
> Chairman ROTH. Was it generally known that this was the practice?
>
> Mr. SCANLON. This was the first time we provided the notes and it was the first time that it became a practice.
>
> Chairman ROTH. Did this practice become common knowledge?

Mr. SCANLON. It was known to me and shortly thereafter I resigned.[72]

More worthy of note, however, was Scanlon's explanation of the events surrounding the shift in 1978 from inhouse delivery of home health aide services to subcontracting for those services from Chicago Home Care. According to Scanlon, when Blue Cross questioned the cost effectiveness of this move, Morrisroe directed a cost comparison be made by Southwest's accountant. When Scanlon told Morrisroe that it was in fact more costly to contract out for the services, Morrisroe simply told him to make the figures "come out right." [73]

Orland-Tinley, Southwest, and Will County Home Health Agencies have filed for bankruptcy this year, due for the most part to a debt owed the Federal Government in excess of a quarter of a million dollars as a result of disallowances imposed by the intermediary, Blue Cross. Midway, as of April 1, 1980, owed the Federal Government $108,606.15.[74] However, it has been purchased by a home health agency operating on the north side of Chicago. Lastly, although Oaklawn is still technically operating, it is in dire financial straits. This financial situation can be directly attributed to Morrisroe's corporate structure calculated from the outset to defraud the government. The successful achievement of Morrisroe's operation, and the cynical philosophy behind it, were most eloquently summarized at the hearing by Tim Scanlon's closing remarks. In response to Senator Cohen's inquiry regarding the reason for his resignation from Southwest, Mr. Scanlon answered "Mike told me I was too idealistic for the business." [75]

B. FINANCIAL GAINS REALIZED FROM THE MORRISROE OPERATION

The subcommittee's financial analysis of the Morrisroe operation revealed a relatively unsophisticated but nonetheless successful methodology. With only a nominal initial investment, over a 3-year period, Morrisroe and the several other agency principals extracted nearly $1 million in medicare funds for their personal use. And, by ultimately investing those funds in a Caribbean company created ostensibly as a tax haven, Morrisroe and his associates suffered little, if any, tax consequences. To accomplish this, Morrisroe employed a variety of mechanisms, all of which, once again, can be directly attributed to his undetected ability to control the home health agencies and their subcontractors.[76]

1. Organizational Structure Put Funds Beyond The Government's Reach

As stated previously in this report, the five Morrisroe home health agencies were not-for profit, tax-exempt corporations. They had no significant assets and no retained earnings.[77] The interim medicare payments received from Blue Cross served as their sole source of revenue.

[72] Hearing pp. 60-61.
[73] Hearing, p. 60.
[74] Prepared statement of Michael Lyons (BGA), dated May 13, 1981, and conversations with HCFA officials by subcommittee staff subsequent to the hearing.
[75] Hearing, p. 67.
[76] Hearing, pp. 52-53.
[77] Hearing, pp. 11, 12, 43, 48 and 53.

These funds, however, would be passed to the Morrisroe subcontractors almost immediately after they submitted their bills to the home health agencies for payment. Yet, when Blue Cross later disallowed a substantial portion of these claims (see infra) the ultimate responsibility for reimbursing the intermediary lay with the non-profit health agency—not the subcontractor. Consequently, Morrisroe and his associates obtained large sums of money, secure in the knowledge they would never have to pay them back.[78]

2. Inflated and Fabricated Costs Increased Medicare Reimbursement

During its investigation the PSI staff uncovered various methods employed by Morrisroe which inflated agency costs, thereby increasing reimbursement or otherwise justifying the interim payments. Two of the more profitable of these methods used were (1) the maintenance of an extremely high total nurses aide visit per patient (utilization rate) and (2) the reliance on subcontracting agreements with Chicago Home Care for the provision of home health aides at inflated rates.

A. UTILIZATION RATE

Based on data received from HCFA staticians, PSI investigators prepared a chart which compared the total number of visits per patient made by other Chicago home health agencies to the total number made by the five Morrisroe agencies. This chart, reproduced below, reflects approximately a 55% higher utilization rate for the for the Morrisroe agencies.[79]

UTILIZATION RATE
VISITS BY NURSES AIDES PER BENEFICIARY

	1977	1978
AVERAGE VISITS-5 MORRISROE AGENCIES	30.9	33.2
AVERAGE VISITS-CHICAGO AREA AGENCIES	19.9	21.2
PERCENT DIFFERENCE	55%	56%

Consequently, the five agencies received far more medicare dollars per patient than the other Chicago home health agencies since they claimed a substantially greater number of visits.[80]

[78] Hearing, pp. 46-48, 56.
[79] Hearing, Chart 2, p. 44.
[80] Hearing, pp. 44-45.

B. SWITCH TO CHICAGO HOME CARE

The Morrisroe agencies initially provided nurses aide services in-home. Immediately after the creation of Chicago Home Care in February, 1978, all five home health agencies fired their staff nurses aides and advised them to seek employment with Chicago Home Care. Many, if not all, did.[81]

At the request of the subcommittee, Blue Cross auditors compared the cost incurred by the five home health agencies to deliver the nurses aide services in-house to the cost incurred by them after Chicago Home Care began to provide these same services. The results of this comparison are set forth below: [82]

NURSES AIDE COSTS

	1977 COST PER NURSES AIDE VISIT-5 HHA's	1978 COST PER NURSES AIDE VISIT-CHICAGO HOME CARE INC.	% INCREASE
SOUTHWEST	$10.73	$17.87	66%
ORLAND-TINLEY	$10.63	$17.87	68%
MIDWAY	$10.73	$17.87	66%
WILL CO.	$12.33	$17.87	45%
OAK LAWN-BURBANK	$12.32	$17.87	45%

As the chart indicates, it was significantly more expensive for the five agencies to enter into subcontracting agreements with Chicago Home Care. Moreover, testimony at the hearing confirmed Morrisroe's knowledge of this fact. As previously discussed in this report, Morrisroe instructed Mr. Scanlon, along with Southwest's accountant, to compare the cost of in-house delivery to the cost of subcontracting for these services. However, at the same time, Morrisroe instructed them to make sure the figures they derived would show that the use of Chicago Home Care would be less expensive than the agencies use of their own employees.[83]

The sole reason, therefore, for the formation of Chicago Home Care was to increase the charge for nurses aides and consequently, to receive additional medicare reimbursement.[84] This increase is particularly significant when viewed in the context of the unusually high utilization rate of the Morrisroe agencies as well as in light of the

[81] Hearing, pp. 30, 45 and 46.
[82] Hearing, Chart 3, p. 45.
[83] Hearing, p. 60.
[84] Hearing, p. 46.

evidence that the nurses aides actually earned less working for CHC than they had earned while employed by the individual agencies, and that CHC incurred few, if any, overhead expenses.[85]

Blue Cross ultimately determined that the five home health agencies were entitled to only $14.00 in reimbursement for these services provided by Chicago Home Care, thus disallowing $3.87 of the amount originally submitted.[86]

However, as a consequence of the organizational structure described above, the Federal Government to this day has been unable to recoup the amount disallowed—an amount equal to the sum of $231,000 or 17% of the total amount of $1,317,000 paid to the Chicago Home Care by the Morrisroe agencies during 1978 and 1979.

3. Other Intermediary Allowances

In addition to disallowing a portion of the amount claimed for nurses aide services, Blue Cross disallowed almost 30 other types of agency claims. The most significant of these disallowances were: (a) 83% of the amount paid by the agencies to Northrad for consultant services ($177,100 out of $212,741) and (b) almost all of the $100,000 paid by the agencies to Midwest Leasing.[87] The Northrad disallowance was based on the agencies' failure to substantiate the provision of services beyond Northrad's initial consultation with them. The Midwest Leasing disallowance was based on the unreasonableness of the rent charged for leasing office furniture.[88]

In addition, Blue Cross disallowed the sum of $83,242 out of the total amount of $692,820 (12%) claimed in costs incurred by Southwest generally during 1976.[89] Once again, however, these disallowances did not result in the recovery of medicare dollars which for the most part were beyond the Federal Government's reach since payment had already been obtained by the Morrisroe-controlled profitmaking subcontractors.[90]

4. Diverted Medicare Funds

During the course of PSI's investigation, it became apparent that funds which should have been returned to government coffers were diverted to Morrisroe's personal control. Specifically, during the period 1977–1980, the three prime contractors—Northrad, Chicago Home Care and Oaklawn—received a total of $1,866,689 in payments. As indicated below approximately 38% of these payments ($714,046) went directly to Morrisroe and other home health agencies principals while an additional sum of $247,069 was withdrawn from Southwest Will County Home Health Agency during the same period for a total withdrawal of $961,115.[91]

1. Chicago Home Care (Capitalized with $2,000).

Received $1,317,558 in medicare funds during 1978 and 1979.

[85] Hearing, pp. 44-46.
[86] Hearing, p. 46.
[87] Hearing, p. 46.
[88] Hearing, pp. 47–48.
[89] Hearing, pp. 48 and 56.
[90] Hearing, p. 47.
[91] Hearing, p. 49.

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Total of $354,352 (27%) withdrawn for personal use by: Michael Morrisroe, $25,000; Pat Tinder, $164,924; JoAnn Stevens $164,428.

2. Northrad Management Corporation (Capitalized with $5,000).
Received $212,741 in medicare funds during 1977–1979.
Total of $202,988 (95%) withdrawn for personal use by: Michael Morrisroe, $152,988; Northrad, $50,000 (invested in a Morrisroe partnership).

3. Oak Lawn Physical Therapy Associates (Capitalized with $1,000).
Received $336,390 in medicare funds during 1978–1980.
Total of $156,706 (47%) withdrawn for personal use by: Maureen Flanigan $156,706.

4. Southwest Community HHA.
Total of $60,000 withdrawn for personal use by: Michael Morrisroe, $50,000; Connie Kubicka, $10,000.

5. HHA of Will County.
Total of $187,069 withdrawn for personal use by: Rose Gallagher, $75,208; John and Marie Kruisek, $111,861.

Thus, with only $8,000 as an initial capital investment, four individuals withdrew $714,046 (38% of the medicare funds received by these companies). While in some cases, the amounts withdrawn represent administrative salary costs, they are far from the reasonable amounts for such services mandated by regulation. Moreover, in at least two instances, they represent compensation for individuals who otherwise maintained full-time jobs during this period.[92]

Of the total sum of $961,115 withdrawn by Morrisroe and the other principals, PSI investigators traced the sum of $511,115 to their respective bank accounts. None of these funds were ever reinvested in either the home health agencies or the subcontracting agencies. Some of the withdrawals were treated as loans (which were never repaid) or were withdrawn in the form of Certificates of Deposit. However, most of the withdrawals appeared as compensation on the corporate and individual tax returns, as well as the agencies books and records.[93]

The remaining sum of $450,000 was traced directly to a partnership known as Alternative Power Project. This project purportedly invested the funds in a Cayman Island tax shelter (see infra). According to the partnership tax return, the individuals listed below contributed the following amounts as their respective initial investment in the partnership:

Michael Morrisroe	$50, 000
Northrad Management Co	50, 000
Pat Tinder	105, 000
JoAnn Stevens	105, 000
Maureen Flanigan	65, 000
Rose Gallagher	40, 000
John Kruisec	25, 000
Connie Kubicka	10, 000
Total	450, 000

[92] Hearing, p. 50. These figures represent only the total number of withdrawals that could be ascertained from the books and records made available to the subcommittee. The actual amount potentially is much greater.
[93] Hearing, p. 52.

However, based on their financial analysis of the partnership's books and records, PSI investigators found that the actual individual investment in Alternative Power Project was derived as follows:

Date	Source of funds	These funds were used to buy	These certificates of deposit	Which were then invested in alternative power
Aug. 29, 1978	Oaklawn Physical Therapy check to Maureen Flanigan.	$15, 000		
Sept. 1, 1978	Bank check to Maureen Flanigan	50, 000		
Do	From Flanigan savings	10, 000		
Do	Cash in Chicago Home Care certificate of deposit.	25, 000		
Do	Bought certificate of deposit for Michael Morrisroe.		$100, 000	
Mar. 16 to Sept. 15, 1978	Chicago Home Care bought and "rolled over" 5 certificates of deposit.	[1] 210, 000		
Sept. 29, 1978	Northrad check	50, 000		
Do	Northrad check to Michael Morrisroe	50, 000		
Oct. 2, 1978	Maureen Flanigan check	5, 000		
Do	Oaklawn Physical Therapy check to Maureen Flanigan.	10, 000		
	Source unknown	25, 000		
Do	Purchase certificate of deposit for Michael Morrisroe.		350, 000	
Nov. 2, 1978	Certificate of deposit cashed and deposited in alternative power project's account.			$450, 000

[1] This amount was recorded on Chicago Home Care books and records as a $105,000 bonus to Pat Tinder and a $105,000 bonus to JoAnn Stevens. The $210,000 check was made payable to Ashland State Bank and was used as part of the purchase price of the certificate of deposit payable to Michael Morrisroe, dated Oct. 2, 1978. Neither Tinder nor Stevens ever saw any of these funds.

Again, it is worthy of note that as indicated on the chart above, on October 2, 1978, Morrisroe purchased a Certificate of Deposit in the sum of $450,000—the total amount contributed by the various individuals and entities to Alternative Power Project. The Certificate of Deposit subsequently was deposited in Alternative Power Project's account.

5. Tax Shelter Benefits Morrisroe and Associates in the Sum of $961,118 Tax Free

Moreover, in addition to withdrawing successfully from the agencies the amount of $961,118, Morrisroe and the other agency principals, with the aid of tax loopholes and bank secrecy laws, ultimately suffered little, if any, tax consequences.

A. INVESTMENT IN A CAYMAN ISLAND COMPANY

As stated above, the total cash investment by Morrisroe and his associates in Alternative Power Project was the sum of $450,000. Yet, the partners as a group deducted a total of $1,791,875 from their 1978 and 1979 Federal income tax returns. These deductions, representing almost a 400 percent return on their initial investment, was made possible by the following: (1) the inclusion of $900,000 in non-interest bearing unsecured notes as part of the initial investment in the partnership; (2) the subsequent investment in an amount equal to $500,000 by Cybrand Power Project and (3) the purported investment of partnership funds in Energy Engineering Company, as lessee, and Costa Rican Development Company, as lessor, whose stated purposes were to engage in oil exploration off the coast of Costa Rica.[94]

[94] See Section (7) infra.

A total of $1,400,000 out of the original $1,850,000 investment (the $900,000 in notes plus the $500,000 contributed by Cybrand) is highly questionable since this amount reflects money which can only be traced to "paper" indebtedness or, in light of the Cayman Island bank secrecy laws, could not be traced at all. In addition, the agreement entered into between the partnership and Cybrand, enabled the partners, rather than Cybrand, to deduct the $500,000 loss sustained by Cybrand from their personal tax returns.[95]

Cayman Island laws have hampered PSI's efforts to determine whether the funds invested in Costa Rican Development Company were used for oil exploration, and specifically for oil exploration in the Southwest Quadrant, Tract 6, Guanacaste Province, Costa Rica, as stated in the partnership agreements. (See infra). However, in this regard, the subcommittee did obtain some information concerning his company and the purported oil exploration.

By letter dated May 10, 1981, PSI staff contacted the Department of State, requesting information concerning ongoing exploration in the Guanacaste Province of Costa Rica. The State Department cabled that (1) the only oil exploration activity ongoing in Costa Rica was and is that being undertaken by Pemex, the Mexican State Oil Company; (2) that it was unable to confirm the existence of the Costa Rican Development Company; and (3) that no oil exploration is taking place in Guanacaste, but is occurring in other areas of Costa Rica[96] Indeed, the spokesman for the American Embassy in San Jose further commented as follows:

> (2) FYI: Volcanic geology of most of Guanacaste is such that no one in his right mind would seek oil/gas deposits there. [97]

Consequently, due to the bank secrecy laws in the Cayman Islands, the IRS in connection with the grand jury investigation discussed previously, most likely will be unable to trace the original sum of $450,000 invested in Energy Engineering beyond the documented fact that the company negotiated the checks at a Cayman Island bank..[98]

B. THE REMAINING SUM OF $511,115

PSI has not traced the additional sum of $511,115 that had been withdrawn from the Morrisroe agencies. However, by letter dated June 4, 1981, Chairman Roth advised the Attorney General concerning the results of PSI's investigation and furnished the Assistant United States Attorney assigned to the Morrisroe grand jury proceeding with all the pertinent financial material amassed during the course of the investigation.[99] It is hoped that this information will facilitate a complete exposure of the financial aspect of the Morrisroe operation.

6. Partnership and Other Documents

To more fully explain some of the references made to the legal documents examined by the subcommittee staff and introduced

[95] Cybrand shared only in the profits of the company and not the losses. This agreement is the key feature of a tax shelter. See section 7, infra, for a full analysis of the agreements.
[96] Hearing, Exhibit 7, p. 52.
[97] Ibid.
[98] Hearing, p. 51.
[99] Hearing, p. 52.

at the hearing relating to the Morrisroe partnership (Alternative Power Project) and its oil drilling venture,[100] this section will summarize the documents' contents and point out some of their peculiarities.

A. OIL, GAS AND RELATED SUBSTANCE AGREEMENT

In the lease agreement between the Alternative Power Project (lessee) and Costa Rican Development Company (lessor), the Costa Rican Development Company is never identified in detail. As noted above, the Department of State has advised that the company does not currently exist in Costa Rica and has never engaged in oil explortion in Guanacaste Province.

An even more troublesome aspect of this agreement is the fact that the lessor does not appear to have any legitimate interest in the land it is leasing to Alternative Power Project. Since the State owns all oil and gas rights, only it can enter into the arrangement called for in this agreement.[101]

The description of the real estate is inadequate since the Agreement merely refers to the "Southwest quadrant of Tract 6, area as follows: 880 acres (more or less) of marshland running into the ocean and offshore." The reference to the "Southwest quadrant of Tract 6" has even greater significance as reflected by the State Department's finding that there is *no* "Southwest quadrant of Tract 6." [102]

The agreement does not specify whether there is an obligation on the part of the lessee to deliver only in kind, whether the "one-eighth part" referred to at p. 1 of the agreement is a royalty, and what arrangement should be made if the lessor cannot take and store or transport the oil.

Much of the agreement appears to be extracted from standard form domestic U.S. oil and gas leases. It is understood that this language is seldom used for projects outside of the United States. One reason for this is the peculiarities of foreign law. Yet this agreement makes no reference to the Costa Rican Constitution, or Costa Rican Law pertaining to ownership of hydrocarbon.

The agreement also discusses the "estate of either party" as if a corporation could leave an estate.

B. CONTRACT BETWEEN LESSEE AND ONE AGREEING TO DEVELOP LEASE

This contract contains several strange features. For example, who or what is the entity referred to as "Energy Engineering Developing Company?" The Contract also variously refers to this entity as the "developer" and the "company."

The contract is drafted in a way which, if read literally, would mean that the developer/company would receive no crude oil for 9 years commencing January 1, 1979. Yet, elsewhere in the contract, the company receives 100% of all gas produced. This right is con-

[100] Hearing, Exhibit 6, p. 51.
[101] Under Costa Rican law, ownership of petroleum, hydrocarbons and other minerals is reserved to the state. Law 14 of June 16, 1936 (Coleccion de Leyes y Decretos I 1936 62 (Ed. Official, San Jose, Impreuta Nacional, 1937)), amending Article 73 and Law 33 of June 28, 1937 (Conleccion de Leyes y Decretos 1937 (Ed. Oficial, San Jose, 1939)) amending article 73 and 3 of the December 7, 1871 charter; Section II, Powers of Congress, Article 82 N15, 1946 Constitution and Article 121 N14, 1949 Constitution.
[102] Hearing, Exhibit 7, p. 52.

tingent upon the ability of the company to secure contracts from the lessor. Presumably, Maureen Flanagan signed the "Contract" for Alternative Power Project (lessee), as she did the Oil, Gas and Related Substance Agreement, although this is not specified. In the contract, however, an indecipherable signature stands for the "director" who presumably is signing here for Energy Engineering Development Company and who presumably signed the Oil, Gas and Related Substance Agreement for Costa Rican Development Company (lessor).

C. INTERNATIONAL DAYWORK DRILLING AGREEMENT

In this agreement, the contractor, Energy Engineering Development Company, is to furnish a "drilling vessel." At no time is the "vessel" identified by name, type, or capacity. Generally, oil and gas contracts include such information. In addition, the same peculiarities arise with respect to the signatures on this agreement.

D. AGREEMENT CONCERNING ADDITIONAL DAYWORK DRILLING SERVICES

In this agreement Energy Engineering Development Company (EEC) commits itself to provide numerous items and services. For this EEC is to be paid $40,000. It appears extremely likely that, should EEC actually incur the costs itemized in this agreement, those costs would greatly exceed $40,000. Hence, this agreement appears to be an additional vehicle simply designed to move money between entities and individuals.

E. EXPLORATION AND RESEARCH AGREEMENT

In this agreement Alternative Power Project commits itself to pay $500,000 to Energy Engineering Development Company (EEC) in 1978, and an additional $500,000 in 1979. Alternative Power Project also agrees to keep secret a process allegedly known as Mineral Liquification Quenching (MLQ) and, in the event of a breach of this commitment, to pay $1.5 million to EEC as liquidated damages. Is there such a process as MLQ? The subcommittee staff was unable to ascertain.

The agreement sets no standards of conduct for EEC for which it is to receive the $1 million. Nor does it specify what personnel EEC will provide, what expertise EEC will provide, or in what manner EEC will account to Alternative Power Project for funds.

F. MANAGER'S CONDITIONAL OPTION TO BUY LEASE INTEREST

This arrangement is found to be most peculiar. In it, Energy Engineering Development Company has the option to purchase one-half of the leasehold interest of Alternative Power Project. In the meantime, however, APP has already paid huge sums to EEC and commits itself to pay an additional $90,000 according to this "option."

There is no explanation as to what would happen to EEC's rights under the previously discussed "Contract Between Lessee and One Agreeing to Develop Lease" if EEC should exercise this option. In the management agreement EEC already has the right to 5%

of the crude oil and all of the gas. Again, this option appears to be an off-hand attempt at creating a document which would serve as a pretext for transferring funds between parties.

7. Conclusion

Charles Morley, Chief Investigator (PSI), perhaps best summarized the financial aspect of the Morrisroe operation when he stated at the hearing:

> . . . By escalating their charges, by somehow having a very high utilization rate, they (the home health agencies) managed to increase to a maximum the amount they could pull out of medicare. Certain individuals we have discussed here bled those companies for 27% to 95% right off the top. They put 47 percent of this into a tax haven and therefore insured that the amounts they withdrew and the amounts they will be earning for years to come will be tax-free. . .
> . . . These individuals with very little capital, only a moderate amount of ingenuity and really not much sophistication walked away with a million dollars of taxpayers' funds tax-free [103]

[103] Hearing, pp. 52-53.

III. Organizational Views of Problem Areas Affecting the Home Health Care

A. Problem Areas

The subcommittee inquiry into home health care fraud and abuse included an attempt to identify systemic problems and to elicit potential solutions to such problems from concerned organizations. Accordingly, as stated previously in section I of this report, the chairman of the subcommittee requested written comments from the following organizations: the General Accounting Office (GAO), the Better Government Association (BGA), Blue Cross/Blue Shield, the National Association of Home Health Agencies (NAHHA), the American Federation of Home Health Agencies (AFHHA), and the Health Care Finance Administration (HCFA) of the Department of Health and Human Services.[104] These organizations were asked to provide viewpoints and recommendations on the following areas:

1. The effectiveness of the cost reimbursement system or proposed alternatives;
2. The effectiveness of intermediary audit coverage;
3. The effectiveness of oversight and administration of HCFA; and
4. The means by which the Federal Government may terminate irresponsible home health agencies.

Consideration of these organizational recommendations, and related issues, was provided during the subcommittee hearings at which time representatives of GAO, BGA, NAHHA, AFHHA and HCFA[105] offered their testimony. In addition, several organizations submitted written comments or reports to the subcommittee after its hearings. At least one of these reports[106] submitted by the BGA, with assistance from the Center for the Study of Welfare Policy, University of Chicago, contained a detailed review of key issues and is reprinted, in part, at Appendix I.

1. The Effectiveness of the Cost Reimbursement System or Proposed Alternatives

Organizational representatives expressed unanimous concern over the effectiveness of the current system of retrospective cost reimburse-

[104] Letter of April 14, 1981, from Senator William V. Roth, Jr. to:
a. The Honorable Milton J. Socolar, Acting Comptroller General, General Accounting Office.
b. Mr. Terrence Brunner, Executive Director, Better Government Association.
c. Mr. Dan Gregorio, Director of Procedure, Blue Cross/Blue Shield.
d. Mr. William Halamandaris, Executive Director, National Association of Home Health Agencies.
e. Frank H. Case, Esq., Attorney for American Federation of Home Health Agencies.
f. Dr. Carolyne K. Davis, Administrator, Health Care Finance Administration, Department of Health and Human Services.

[105] The individuals representing these organizations at the hearing were as follows:
GAO—Mr. Gregory Ahart, Director, Human Resource Division.
BGA—Mr. Peter Manikas, Legislative Counsel.
NAHHA—Mr. Hadley Hall, President.
AFFHA—Mr. Ronald Reck, President.
HCFA—Dr. Paul Willging, Deputy Administrator, Health Care Finance Administration.

[106] Among others, organizational position papers were received from the Community Home Health Services of Philadelphia and the Home Medical Services of California.

ment. GAO, for example, characterized it as a system which is "open-ended . . . and lacking incentives to providers to be efficient and minimize their costs." [107] GAO further noted the following additional problems:

> (1) [Another] 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.[108]
>
> (2) 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.[109]
>
> (3) 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* 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 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.[110]

AFHHA,[111] NAHHA [112] and BGA [113] generally agreed with GAO's assessments on the lack of clarity over the terms "reasonable costs" and "related organizations." [114] A specific recommendation made by GAO concerning regulations with respect to the "relatedness" principle involves the shifting of the burden from the intermediary to the

[107] Hearing, p. 110.
[108] Hearing, p. 110-111.
[109] Hearing, p. 111.
[110] Hearing, P. 111-112.
[111] Hearing, p. 74.
[112] Hearing, pp. 115-116.
[113] Hearing, pp. 75-76.
[114] Hearing, pp. 111-112.

home health agency to disclose the relationship between the home health agency and its subcontractors.[115]

As the overseer of the retrospective cost reimbursement system involved in the home health care program HCFA reflected its concern over the effectiveness of this system by establishing a task force which in its 1980 report [116] recommended modification of the existing system. Dr. Willging, Deputy Administrator of HCFA, indicated in his subcommittee testimony, however, that HCFA was considering a "competitive" system as an alternative to the current retrospective mechanism [117] and not necessarily a "prospective" cost reimbursement system which would establish target rates or predetermined rates which would govern the amount of reimbursement provided to a home health agency over the course of the ensuing year of operation.[118] AFHHA characterized a "prospective" cost reimbursement system as one which, in its opinion "would reward business efficiency . . . enhance the quality in the system . . . eliminate . . . bureaucracy and reduce costs . . . [119]. Under the AFHHA proposal, retroactive adjustments would not generally be made thereby virtually eliminating the current "disallowance" procedure with its appeal rights to the PRRB.

Under a similar "prospective" proposal, NAHHA made the following suggestion:

> NAHHA recommends a prospective reimbursement system be developed. One way this could be approached is with the establishment of a target rate—based on total cost per patient or spell of illness—capturing the agencies' past cost experience multiplied by the units of service. Alternately, the agencies could be requested to prepare and submit a budget—in essence a negotiated rate—which would serve as the basis for reimbursement. In either event, the essential ingredients are that reimbursement be at the rate target which would define cost to the program and expectations to the provider. Costs exceeding the target would not be reimbursed unless warranted by exceptional circumstances. Services delivered at a cost below the target by increased efficiency should be rewarded by allowing the agency to keep a portion of that savings. Retroactive judgments should be eliminated. The reams of regulations spun out of "reasonable cost" could be discarded. The current incentives for running up costs and "front" arrangements of concern to the subcommittee would be eliminated.[120]

HCFA however, has contended that a "prospective" system with predetermined unit costs would be difficult to implement due to the disparity in the types of care required by individual patients.[121] GAO similarly suggests that prospective rates "could be subject to manipulation and could give agencies incentives that would lower the quality of care." [122] It was further represented by Dr. Willging of HCFA that

[115] Hearing, p. 112.
[116] Supra, p. 6, footnote 32.
[117] By letter dated August 10, 1981 from Patricia Hirsch Feinstein, Director, Office of Legislation and Policy to Carolyn Herman, Assistant Counsel (PSI), HCFA stated in connection with Dr. Willging's testimony concerning the use of a comprehensive strategy that the Secretary of HHS has established a task force charged with exploring various approaches to increasing competition in the health field generally, among which are (1) tax changes (2) multiple choice of health plans (3) Medicare and Medicaid (4) plan qualification and (5) cross-cutting issues.
[118] Hearing, p. 122.
[119] Hearing, p. 119.
[120] Hearing, p. 115.
[121] Hearing, p. 122.
[122] Hearing, p. 112.

the "Secretary (of HHS) has previously suggested that an administration bill for a competitive strategy will be submitted to the Congress this year" [123] but that "in the interim, however . . . we can tighten up the [retrospective] reimbursement mechanisms we currently have".[124] One such specific mechanism involves the establishment by HCFA of cost guidelines which should be facilitated by a new cost reporting system implemented in October, 1980 for home health agencies.[125]

The need for injection of "competition" into the health care industry was generally endorsed by organization representatives of NAHHA [126] and the BGA [127] as well as Blue Cross, one of the largest intermediaries in the home health field. Blue Cross' proposal, however, injects competitive incentives into a "prospective" type system. Their position is as follows:

> As you requested, we respectfully present a cost-based (and audited) incentive reimbursement concept, for possible experimentation, which may curtail abuse and foster cost containment for home agencies.
>
> After a careful evaluation, it is our considered judgment that this program has the potential to:
>
> Minimize tendencies toward fraud and abuse;
> Provide financial incentives to achieve efficient performance;
> Save medicare significant dollars;
> Spread risk and encourage competition.
>
> We feel that an incentive program would be supported by the Home Health Agency Industry as well as the Health Care Finance Administration.
>
> Any consideration toward an alternative reimbursement approach, we believe, must be simple, easily understood, and conceptually sound.

INCENTIVE PROPOSAL

THE BASIC DESIGN

1. Establish a Target Fixed Rate:

The audited "reasonable cost" of participating HHAs would be used to compute the average cost per common unit.

[123] Supra, footnote 118.
[124] Hearing, p. 122.
[125] Hearing, pp. 122-123.
[126] Hearing, p. 102.
[127] Hearing, p. 105, 107. In addition, at the request of the subcommittee, the Better Government Association (BGA) prepared a report entitled, "Home Health Care and other In-Home Services: Issues, Problems, and Options for Reform." Included in that report, for which the subcommittee commends the BGA, is a list of potential pros and cons of a prospective budgeting system for home health care services. The following is a brief summary of these findings:

A. Pros

1. Prospective budgeting would eliminate uncertainty caused by retrospective payment denials.
2. Prospective budgeting could have a positive impact on quality of care because agencies would have a limited but known resource which they would be encouraged to use most efficiently.
3. Prospective budgeting would reduce wide variations of cost by encouraging efficiency in operation and preventing inflation of costs where providers have a monopoly on services.
4. Prospective budgeting might lead to an emphasis on preventive care and maintenance of health.

B. Cons

1. Potentially cumbersome arrangements would have to be developed in the event of underestimation or overestimation of costs by the intermediary. If costs are underestimated, beneficiaries requiring services may not receive them.
2. It is possble that in a prospective budgeting system costs would not be constrained because of a program commitment to providing the best possible quality of care.
3. Fiscal budgets may be inconsistent with the concept of entitlement. These budgets may prove inadequate for financing services to all those elderly and disabled.

The target rate might be set somewhere between the average "reasonable cost" (after audit)[128] and the "cap" (223 limits). The target rate should be adjusted for inflation.

Adjusted for geographic location and/or other major variables such as HHA size (visit or case volume), "hospital-based" versus "free-standing", etc.

Reimbursement might be established on a common unit i.e., per visit. Case mix could be considered or studied during a per visit experimental approach.

2. Share

After a thorough audit and determination of "reasonable cost", the difference between the target rate and the reasonable actual costs will be compared:

If the target is exceeded	*If actual "reasonable cost" is under target*
Medicare reimbursement in whole, or in part, covers the loss up to a designated "cap" (223 limits).	Medicare shares with provider: for example a percentage such as 50% of the gain. This would give the provider additional funds for community service. . . .

> Our proposal, while cost-based, is designed to modify today's system by spreading risk. Incentives for cost containment are provided by the recognition of and sharing in the cost saving achieved by the Home Health Agency.
>
> The success of such an experiment would be dependent upon an improved and clear definition of covered and medically necessary HHA services, as the provider must be fully aware of the rules, if risk is to be properly assumed.
>
> This proposal, under the current law, would require a medicare waiver for cost reimbursement to cover the incentive of "target rate".[129]

2. The Effectiveness of Intermediary Audit Coverage

While there has been a general recognition that intermediary audits provide the first line of defense against excessive and inflated costs, concerns have been raised that budgetary reductions may be made in the amount of money provided to intermediaries for "field" audits, i.e. audits which involve a detailed examination of home health agency records and supporting documentation, including, with the passage of the Reconciliation Act of 1980, the books and records of subcontractors providing key services to agencies. GAO noted that on May 52, 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 magni-

[128] Adjusted for inflation.
[129] Hearing, Exhibit 9, p. 149.

tude could hamper the intermediaries' ability to assess compliance with existing legislation and regulations.[130]

Given the fact that in 1978 about 60 percent of cost reports were settled without field audits, this reduced level of audits would provide little fraud deterrence in view of the extreme unlikeliness of audit detection. Such a reduction is also particularly significant in view of HCFA information that intermediary audits return $4 for every $1 expended, and that under refined targeting procedures, such audits can reasonably be expected to return $8 to $10 for every $1 expended.[131]

With respect to the overall quality and consistency of intermediary audit coverage, both NAHHA and AFHHA noted concerns over the frequency and uniformity of such audits.[132] HCFA has indicated, however, that several activities are underway to address this concern. These include:

(a) The institution of a Home Health Agency Cost Report Evaluation Program (HHA–CREP) to measure the quality of intermediaries' actions in reviewing, adjusting and settling home health agency cost reports;

(b) Designation of regional intermediaries for freestanding agencies. Consolidating the home health workload under fewer intermediaries will create an environment which can provide greater assurance of accurate payment determinations to home health agencies. The designated regional intermediaries will be able to concentrate and focus their resources better on the special claims processing and audit problems posed by home health agencies;

(c) Instructions to part A fiscal intermediaries which will require them to rank their HHAs based on utilization of services and provider costs. The intermediary will then perform an onsite review of medical records for: providers who do not have favorable waiver presumption, and all new providers. (The implementation of the new instructions is planned during the October–December 1981 quarter.)[133]

A related problem attributed to intermediaries in general has been the failure of intermediaries to timely notify home health agencies of changes in regulations. Furthermore, the BGA observation that patients are ill-informed as to their options or entitlements under home health care programs was underscored by NAHHA testimony which further noted that the Federal Government does not provide patients with a copy of the bill that has been paid on their behalf or with information as to how to seek alternative home health agencies when the quality of care becomes suspect.[134]

3. The Effectiveness of Oversight and Administration by HCFA

Perhaps the most substantial criticism concerning the effectiveness of HCFA, the Federal administrator of the home health program, focuses on the alleged failure of HCFA to formulate reliable and specific regulations. Not only was this a criticism levied by NAHHA [135]

[130] Hearing, p. 112.
[131] Hearing, p. 146.
[132] Hearing, pp. 73, 120.
[133] Hearings, pp. 142, 143.
[134] Hearings, p. 118.
[135] Hearing, p. 90.

and AFHHA,[136] as representatives of the industry, but, perhaps even more notably, this same criticism was also raised by the Department of Justice.[137] In summary, the Department of Justice letter to the Acting Inspector General at HHS on this point [138] reflects its assessment of how regulatory vagueness has created obstacles to the effective criminal prosecution of home health agency operators engaged in excessive cost practices. The relevant excerpts from that letter are as follows:

> [B]ased on our experience . . . , we have serious concerns regarding the regulatory scheme governing private, non-profit 100 percent medicare patient organizations. Specifically, we are concerned about the opportunities for fraud and abuse that the current regulatory scheme presents and the resulting difficulty the government has in proving criminal intent and successfully prosecuting individuals who have engaged in various forms of fraud and abuse. We would like to submit, for your consideration, our perception of the most significant problems in the existing regulatory scheme and some possible solution to these problems.
>
> PROBLEMS
>
> As you may know, a home health agency (hereinafter HHA) is defined in the medicare legislation as a private, non-profit organization primarily engaged in providing skilled nursing and/or other therapeutic services which are supervised by a physician or registered nurse. 42 U.S.C. § 1395(o). Operational costs of the HHA are reimbursable if "reasonable" and "related to the care of beneficiaries." 42 C.F.R. 405.451. A major difficulty in prosecuting violators of existing laws and regulations is establishing that costs, submitted for reimbursement, were not "reasonable" or not "related to the care of beneficiaries." Some of the major causes of this difficulty, which also provide, in the first instance, major opportunities for fraud, are discussed below.
>
> 1. Composition of Board of Directors
>
> There are currently no regulations governing the composition of an HHA's board of directors. Consequently, HHAs can become family operations permitting the owners to place members of their family, who have no connection to, or expertise in, the health care industry, on the board. This enables family members to take liberal advantage of "perks"—frequent, first-class air travel from far and distant places, telephone, lavish entertainment, etc. for frequent "board meetings"—all reimbursed as a business expense.
>
> 2. Salaries of Owners/Operators
>
> General regional guidelines have been published for a limited number of areas listing approved salary ranges for

[136] Hearing, p. 117.
[137] Hearing, p. 120.
[138] Hearing, Exhibit 10, p. 151.

operators of various health entities, including HHAs, by the number of patients served. The salary guidelines are not mandatory, do not contain regional cost ceilings, and, at best, are persuasive without force and effect of law. This permits owners/operators to exercise broad latitude when fixing their annual salaries. Not only is it difficult to prove the salary "unreasonable" in a civil proceeding but the chance that an excessive salary could become the subject of a criminal proceeding is practically impossible. Our investigation uncovered owners/operators receiving salary increases which were made retroactive to the date of a prior salary increase. There is nothing in the regulatory scheme which specifically prohibits such action and, with family directors on the board, approval is guaranteed.

3. General Business Expenses

There are no regulations to govern general corporate expenses. The only applicable statutory standard is whether the expense is reasonable. Thus, without a cost ceiling, the following corporate expenditures have served to inflate the cost of health care:

(a) Lavish entertainment of the medical community and/or local community leadership;

(b) Luxury cars provided to high-ranking members of HHA staff (other than board members) at the expense of the program; and

(c) First-class and/or frequent travel to national industry conferences coupled with first-class accommodations in the conference city.

4. Other Types of Costs

Our investigations have shown other costs that HHA owners/operators allege to be "related to patient care" which are susceptible to abuse. Again, there are no regulations which invoke a ceiling on costs or directly prohibit these activities. We have seen similar abuses by other providers of medicare services, but in the investigation we conducted, the following practices clearly and unnecessarily inflated the cost of home health services:

(a) Office space rental in luxury buildings coupled with lavish decorating expenditures for improvements of office conditions, including wallpapering, expensive carpeting, installation of private showers and wet bars;

(b) Loans and capital advancements of HHA operating funds for personal expenses of owners/operators or their business associates which are characterized by owners as investments on behalf of the corporation; and

(c) Payment of handsome fees to consultants (who may be friends or former employees) without adequate proof of need for or performance under the consulting contract.

5. Accounting Procedures

As previously noted, many HHAs are wholly funded by the medicare program. Final audit of the annual medicare Cost Report ordinarily occurs approximately 1 year after its submission to the intermediary for final adjustment. If the audit disallows certain expenses, there is only one way the medicare program can recoup the money: Reduce the reimbursement rate in the current fiscal year.

It has been our experience that HHAs included large accruals for anticipated computerization, uniform expense, and staff pay increases in the first quarter of the fiscal year in order to generate cash flow. In most instances, there is little, if any proof the HHA intends to pay out the funds claimed as accruals. In fact, the HHA may deliberately create a phony accrual to ensure cash flow during the year. If the accrual is not paid out, the HHA is in an overpaid status for the year. There may be no potential criminal prosecution if the yearend cost report does not reflect the phony accrual expense, but the HHA has had the use of the cash during the year and the medicare program has no really effective way of recouping the overpayment. The added cash is many times picked up by directors in the form of a bonus or advancement of capital. By the time medicare disallows the accrual, it is 2 years from the original disbursement under the program. The disallowance may only be recouped by reducing the reimbursement rate in the year that it is disallowed. Thus to avoid bankruptcy and/or serious disruption of the provision of health care, the government will attempt to reduce the reimbursement rate to permit the agency to continue while reimbursing the government over a period of years. This creates a situation where the government is never fully reimbursed and the HHA feels compelled to create new accruals to cover the reduction in operating capital. The "accruals," if not paid out, will ultimately become the source of a future disallowance for which the government will again not receive full reimbursement.

During the subcommittee hearings, HCFA countered the general criticism of regulatory vagueness by noting that its 1980 Task Force Report [139] identified several improvements which Dr. Willging represented in his subcommittee testimony to be "either already completed or now underway." [140] These measures included:

Revised guidelines for intermediary use in judging the acceptability of management contracts;

Clearer delineation of reimbursement rules for "nurse coordinators" who assist in establishing the treatment plan, but who were sometimes engaged in what might be termed patient solicitation;

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[139] Supra, p. 6, footnote 32.
[140] Hearing, p. 142.

Development of initial guidelines for assisting in the determination of "reasonable" HHA owner and administrator salaries.[141]

The BGA raised another criticism of HCFA oversight in the form of an observation that:

> Oversight responsibility concerning HHAs is seriously fragmented. HCFA, State and local governmental agencies as well as private fiscal intermediaries each share the responsibility of monitoring provider performance. They also each exercise considerable discretion in determining how their oversight responsibility will be undertaken.
>
> In short, as a result of this fragmentation, it is difficult to hold any single entity accountable for how providers perform. To whom for example, should beneficiaries complain if they are dissatisfied with a HHA's services: to the HHA, the intermediary, the State Department or public health or HCFA?
>
> In fact, the question seems almost academic because many beneficiaries do not know what agency is providing the service, what services they are eligible for, or how they came to be enrolled in the program. A 1978 Inspector General report indicates that program beneficiaries who are elderly, disabled and sometimes disoriented have little knowledge of their entitlements nor do they know who to contact when problems arise. That report states:
>
> > Patients seldom know what services are available and accept the services provided as a windfall without further inquiry. Most patients (75 percent) could not remember how they came to know about the home health services they were receiving.
> >
> > The Inspector Generals finding is wholly consistent with the BGA's discussions with beneficiaries in Mississippi and elsewhere. The BGA found, for example, that some home health recipients believed that they would lose their medicare or medicaid eligibility if they switched from one provider to another. The potential for abuse that might result from such misunderstanding is clear.
>
> We believe that the lack of institutional accountability should be considered a major problem area and urge the committee to examine this problem in detail.[142]

4. The Means By Which the Federal Government Terminate Home Health Agencies

Beyond the sanctions that are provided by various Federal criminal statutes, it has been long recognized by Congress that remedies are necessary to permit the termination or exclusion of providers who engage in fraud or abuse. As discussed briefly in section I of this report, such remedies have been made available to HCFA.

Specifically, Section 1862(d) of the Social Security Act authorizes the Secretary of Health and Human Services to exclude from medicare reimbursement any home health provider, who has:

[141] Hearing, p. 142.
[142] Hearing, p. 77.

> (a) Knowingly and willfully made or caused to be made any false statement or misrepresentation of a material fact in a request for payment under medicare or for use in determining the right to payment under medicare;
>
> (b) Furnished items or services that are substantially in excess of the beneficiary's needs or of a quality that does not meet professionally recognized standards of health care; or
>
> (c) Submitted or caused to be submitted bills or requests for payment containing charges (or costs) that are substantially in excess of its customary charges (or costs).

Similarly, under section 1866(b)(2) of the Social Security Act, the Department of Health and Human Services may terminate a provider agreement if it determines that the provider committed any of the offenses cited in (a) through (c) above.

In addition, under the Reconciliation Act of 1980, the Secretary's administrative sanction authority was broadened. Effective December 5, 1980, any owner or operator of a home health agency who was convicted of a title XVIII, XIX, or XX related offense is subject to an immediate exclusion from reimbursement under these programs.

Moreover, under the authority contained in Section 1866(a)(3) of the Social Security Act, the Secretary now may refuse to enter into a provider agreement with a home health agency if any owner or operator of the agency has been convicted of a criminal offense related to participation in the medicaid or medicare programs.

While the necessary statutory sanctions have been provided to HHS, the instances of their implementation are minimal. Indeed, Dr. Willging of HCFA reported in his testimony that "in the entire history of the program, we have only excluded four HHAs or owner operators." [143] Dr. Willging further noted that this was not a "laudible track record" and that his staff has been instructed to increase the emphasis on the implementation of these remedies.[144]

With respect to the five Morrisroe home health agencies in the Chicago area, Dr. Willging acknowledged, in response to questioning by Senator Roth, that, despite an awareness of abuse and possible fraud on the part of these five Chicago agencies which led to a criminal referral to the Department of Justice in 1978, nothing was done to terminate these agencies as medicare providers.[145] Dr. Willging noted that, while certain actions were taken against these agencies, i.e. reductions in payments and increased audits, there was other corrective action, such as termination or exclusion, that should have been taken against the five agencies in question.[146]

Subsequent to the hearings, subcommittee staff inquired of HCFA what exclusionary actions, if any, had been taken with respect to the two remaining Morrisroe agencies which had not filed for bankruptcy. By letter dated August 10, 1981, HCFA officials advised subcommittee staff that on July 30, 1981, Blue Cross/Blue Shield had been notified officially to suspend all medicare payments to the two remaining agencies, namely, Midway Home Health Agency and Oaklawn Home Health Agency. It is worthy of note that this HCFA directive to the intermediary does not prevent irresponsible individuals associated with these agencies from participating in the medicare program at a subsequent time with another agency.[147]

[143] Hearing, p. 124.
[144] Ibid.
[145] Hearing, pp. 125–126.
[146] Hearing, p. 126.
[147] Supra, fn. 118.

B. SUMMARY OF HCFA INITIATIVES DESIGNED TO ELIMINATE PROBLEM AREAS IN THE CURRENT DELIVERY OF HOME HEALTH CARE SERVICES

Listed below are the major HCFA initiatives, some of which have been referenced above, which are designed to curtail several of the abuses revealed at the hearing. Those initiatives which already have been implemented by HCFA include the following:

1. the establishment of cost guidelines, facilitated by a new cost reporting system implemented in October 1980 for home health agencies; [148]

2. the institution of a Home Health Agency Cost Report Evaluation Program (HHA-CREP) to measure the quality of intermediaries' actions in reviewing, adjusting and settling home health agency cost reports; [149]

3. the preparation of instructions to part A fiscal intermediaries which will require them to rank home health agencies based on utilization of services and provider costs; [150]

4. the revision of guidelines for intermediary use in judging acceptance of management contracts and the purchase of other administrative support services; [151]

5. the development of initial guidelines for assisting in the determination of reasonable home health owner and administrative salaries; [152]

6. the establishment of a Contractor Performance Evaluation Program (CPEP) which requires HCFA staff to review at least annually the intermediaries' ability to detect fraud and abuse through the claims and the cost report settlement process.[153]

In addition to these initiatives, HCFA intends to undertake the following measures to remedy the problem areas outlined above. It should be noted that some of these additional measures are a direct consequence of recent statutory power granted HCFA.[154] Other measures are a result of HCFA's Task Force's own evaluation of its programs:

1. the development of proposed instructions to implement Section 930 of Public Law 96-499 which will prohibit reimbursement for costs incurred by home health agencies for contracted services where a contract is entered into for a period exceeding 5 years or where payment by the home health agency to the contracting organization is based on a percentage arrangement; [155]

2. the designation of regional intermediaries for free-standing agencies; [156]

3. the creation of reimbursement rules for nurse coordinators; [157]

4. a review of certification procedures to make them more stringent; [158]

[145] HCFA response to letter dated April 14, 1981 from Senator Roth to Carolyne Davis, Administrator, HCFA, p. 3.
[149] Supra, fn. 132.
[150] Ibid. By letter dated August 10, 1981, HCFA officials notified subcommittee staff that in September, 1981, it plans to issue these instructions to be used by the fiscal intermediaries during the October-December 1981 quarter.
[151] Supra, fn. 141. By letter dated August 10, 1981, HCFA notified subcommittee staff that final instructions have been approved and are proceeding through the printing and publication stage.
[152] Supra, fn. 141.
[153] HCFA response to a letter dated April 2, 1981 from Senator Roth to the Honorable Richard Schweiker, Secretary, HHS.
[154] Supra, Section IB.
[155] HCFA response to letter dated April 14, 1981 from Senator Roth to HCFA. By letter dated August 10, 1981, HCFA advised subcommittee staff that draft implementing instructions have been circulated among respesentatives of the home health industry, intermediaries and other parties for comments.
[156] Supra, fn. 133.
[157] Supra, fn. 141.
[158] HCFA response to a letter dated April 2, 1981 from Senator Roth to the Honorable Richard Schweiker, Secretary, HHS, p. 7.

5. the preparation of national fiscal audit instructions for intermediaries. The instructions are intended to provide for the type and scope of home health agency fiscal audits HCFA expects of intermediaries to undertake to assure proper program reimbursement of home health agencies; [159]

6. the preparation of regulations which will provide access to the books and records of subcontractors for services to providers which cost $10,000 or more over a 12-month period in order to verify the nature and extent of the costs of the services. These regulations will affect all appropriate contracts entered into after December 5, 1980; [160]

7. the establishment of bonding and escrow requirements for home health agencies which receive all of or a substantial portion of their income from the medicare program to assure the availability of funds to repay overpayments; [161]

8. the prohibition of a physician who has an ownership interest or other financial or contractual relationship with a home health agency from certifying the need for care or establishing the plan of treatment for medicare beneficiaries of the home health agency.[162]

C. CONCLUSION

Chairman Roth, at the conclusion of the hearings, aptly summarized the systemic problems in the delivery of medicare home health care services as follows:

> I . . . want to underscore that we recognize that undoubtedly the vast majority of providers are conscientious public providers. We do not mean to infer from what we have said that all of them are of the type we discussed today. But I have to re-emphasize that I see nowhere in the system the kind of controls and checkpoints that I think are necessary if we are going to maintain reasonable costs unless you are able to create an environment of real competition. Do the latter and provide quality services. I think that is highly desirable. But I do urge the Department and HCFA move as expeditiously as possible. It is not a time for slow action.[163]

[159] Ibid.
[160] Statement of Paul R. Willging, Deputy Administrator, HCFA, dated May 14, 1981, pp. 14-18.
[161] Ibid. By letter dated August 10, 1981, HCFA officials advised subcommittee staff that preliminary draft regulations have been received from industry and now are being reviewed by HCFA staff.
[162] Statement of Paul R. Willging. According to Dr. Willging this provision is included in a regulation recodification package that is nearly ready for the Administration's signature.
[163] Hearing, p. 149.

IV. Subcommittee Findings and Recommendations

1. *The subcommittee finds that the current retrospective cost reimbursement system, as it applies to not-for-profit agencies, lends itself to fraud, waste and abuse. It provides no incentive for home health agencies to contain costs. It offers no viable mechanism by which the government can recoup overpayments. It enables unscrupulous operators, such as Morrisroe, to profit substantially at the expense of the taxpayer.*

The subcommittee believes that the adoption of a prospective system may be one means of eliminating many of the abuses uncovered during the course of its investigation. Specifically, it will force the home health agencies to be cost-efficient in order to meet the target rate. It will place the burden of recouping overpayments which the home health agencies make to its subcontractors on the home health agency and not the government. It will make unscrupulous operators think twice before entering the home health care industry.

According to HCFA officials, in response to a specific subcommittee inquiry, the adoption of a prospective system would require a statutory change. Specifically, by letter dated August 10, 1981, HCFA advised the staff of PSI as follows:

Q. Does the statute require retrospective reimbursement to home health agencies or has HCFA simply used this method as a discretionary act of the Secretary?

A. Section 1861(v) of the Social Security Act is the basis for reasonable cost reimbursement under medicare. It is a very general authority and leaves great discretion to the Secretary in establishing by regulation the methods of determining reasonable cost reimbursement. However, section 1861(v) does provide that reasonable cost shall be—

"the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services,"

It further requires the Secretary to—

"provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."

Therefore, the current medicare reimbursement system is one of retrospective payment for reasonable cost incurred and a change to prospective reimbursement would require a change in the law.

In view of the position of HCFA, the subcommittee recommends that the Senate Finance Committee hold hearings to determine specifically the feasibility of establishing a prospective cost reimbursement system which would incorporate target rates or predetermined rates governing the amount of reimbursement provided over the course of the ensuing year to a home health agency.

Under even the current reimbursement system the subcommittee recommends that HCFA implement the following steps to curtail fraud and abuse:

a. HCFA should inject a competitive strategy into the system by requiring home health agencies to accept bids from responsible subcontractors for all contracts in excess of $10,000. Ultimate acceptance would be subject to the approval of HCFA.

By instituting a system of competitive bidding, HCFA should experience a decrease in the number of contracts between related organizations. Such a competitive strategy also will require subcontractors to demonstrate fully their costs prior to the provision of their services, resulting in greater efficiency and cost-containment.

b. HCFA should phase in a competitive bidding strategy for the award of claims processing contracts. Under this plan HCFA would be permitted to contract with any public or private organization for claims processing functions. Currently, under Part A of the medicare statute, providers nominate organizations to process claims. Under Part B, the Secretary directly selects the carriers. Medicare pays both Part A and Part B contractors on the basis of their costs. Competitive bidding is not required under either Part A or Part B.[164]

By phasing in competitive bidding for fiscal intermediaries, greater incentives for efficiency and economy should result at the intermediary level. Indeed, HCFA estimates that such bidding would save $23 million in 1982 and about $120 million a year by 1985.[165]

c. HCFA should expedite its promulgation of bonding regulations so that a viable mechanism will exist to enable the government to recoup overpayments. The subcommittee further recommends that such regulations specifically require bonding for all agencies in their first 5 years of operation as well as for those agencies who, based on their previous records, reflect continued irresponsible or unethical management.

d. Regulations defining terms of art such as "related organizations," "costs related to patient care," "necessary and proper costs" and "reasonable costs" are unduly vague and should be further refined. In addition, the burden of proof concerning the nonrelatedness of subcontracting organizations and home health agencies should be placed on the home health agency. Specific disclosure and certification also should be required.

The subcommittee believes that by eliminating regulatory vagueness and requiring greater accountability, HCFA can prevent home health agencies from being reimbursed for costs unrelated to patient care, inflated costs and excessive costs.

2. *The subcommittee finds that intermediary audits provide the first line of defense against excessive and inflated costs.*

The subcommittee recommends that HCFA reconsider any intention to reduce its budget for intermediary audits of home health agencies. The home health care program has grown four-fold in the past 5 years. Audit oversight of that program must keep pace with its growth.

[164] HHS Fact Sheet, May 18, 1981, p. 3. Although competitive bidding among claims processors was one of the proposed legislative changes in the Administration's Health Care Financing Amendments of 1981, according to HCFA officials, it was not one of the proposals considered in connection with the 1981 Reconciliation Bill.

[165] Ibid.

3. *The subcommittee finds that intermediaries in general fail to timely notify home health agencies of changes in regulations. The subcommittee further finds that patients tend to be ill-informed as to their options or entitlements under the home health care prog ns.*

The subcommittee recommends that the intermediaries be made more accountable to the home health agencies. The subcommittee further recommends that the consumer be educated concerning the availability and variety of home health care services. Also beneficiaries should be provided with a copy of the bill that has been paid on their behalf.

4. *The subcommittee finds that HCFA has failed to make adequate use of the authority provided it to terminate home health agencies or otherwise preclude individuals from participation in the home health care program. Indeed HCFA's own Task Force uncovered numerous agencies which were and are engaging in practices violative of the termination provisions. Yet, HCFA concedes that since the program's inception, it has terminated only four owner operators from it.*

In light of this track record, the subcommittee makes the following recommendations:

a. HCFA should issue written instruction and guidelines directing agency officials to pursue aggressively those situations warranting termination or exclusion.

b. The Inspector General of HHS should include in his annual report to Congress the number of termination or exclusion actions initiated by HCFA.

c. Requirements for program participation should be strengthened to prevent entrepreneurs with little or no experience in the health field from exploiting the system for personal financial gain. In particular, all administrators should demonstrate substantial experience in the home health field before they are permitted to participate in the program.

d. The regulation which requires home health agencies to provide only one essential service should be amended to provide that home health agencies be required to provide at least two essential services directly through its own employees, one of which is nursing service. This recommendation should prevent home health agencies from becoming brokerage houses.

Conclusion

The subcommittee requests that HCFA review the several findings and recommendations enumerated above and submit a report to the subcommittee no later than 90 days after the date of publication of this report which sets forth in detail its evaulation of the subcommittee proposals. The subcommittee further requests HCFA to include in its report a timetable for the implementation of the various measures listed on pages 40–41 of this report and any other contemplated means by which fraud and abuse in home health care can be reduced. Finally, it is requested that KCFA provide the subcommittee with ongoing status reports on the type of action taken against the five Morrisroe agencies, whether such action be administrative, civil or criminal in nature.

The following Senators, who were Members of the Permanent Subcommittee on Investigations at the time of the hearings, have approved this report.

William V. Roth, Jr.	Henry M. Jackson
Charles H. Percy	Lawton Chiles
John C. Danforth	Sam Nunn
William S. Cohen	John Glenn
Warren B. Rudman	Jim Sasser

The Members of the Committee on Governmental Affairs, except those who were members of the Senate Permanent Subcommittee on Investigations at the time of the hearings, did not sit in on the hearings on which the above report was prepared. Under these circumstances, they have taken no part in the preparation and submission of the report except to authorize its filing as a report made by the subcommittee.

APPENDIX

Excerpts From Report of the Better Government Association With Assistance From the Center for the Study of Welfare Policy, University of Chicago (June 1981) Entitled "Home Health Care and Other In-home Services: Issues, Problems, and Options for Reform"

INTERIM REFORMS

The need to address the problems of cost containment, accountability and quality of care involved in providing in-home services is growing increasingly acute. Although in-home services still constitute a relatively small proportion of the Medicare and Medicaid budget, in absolute terms in-home expenditures amount to over $1 billion annually and are growing rapidly. In-home and community-based programs are expected to continue to expand throughout the next decade as they attempt to meet the needs of a growing elderly and chronically disabled population.

Clearly fundamental reforms are needed to improve the effectiveness and efficiency of in-home programs. These reforms should focus on developing alternative methods of financing in-home health and supportive services. Several such reform proposals have been made and they are briefly discussed in the following pages.

However, within the context of the present payment mechanism there are several interim reforms that should be considered.

1. To better control costs and prevent fraud and abuse:

   Increase the number of field audits focusing on those HHAs which spend a specified percentage of their income (e.g. over 5 percent) on certain ancillary services such as management, consulting and legal services;

   Prohibit Medicare payments for all promotional gifts to doctors, hospital personnel and others who supply HHAs with services;

   Explore the use of the civil section of the False Claims Act to recapture misappropriated Medicare funds;

   Provide for a coordinated auditing program of in-home services delivered under Titles XVIII, XIX and XX. The purpose of this reform is to identify duplicate billings for services rendered under different programs. The problem relates primarily to services under Titles XIX and XX whose in-home personal services overlays are sometimes indistinguishable from one another;

   Review Medicare regulations to determine if such terms as "related organizations" and "costs related to patient care" can be more precisely defined.

2. To increase program accountability:

   The Medicare program's Conditions of Participation for home health agencies should be strengthened to increase the ties

between HHAs and the local community. HHA advisory boards should not be dominated by agency personnel and should include more members from local community groups;

HCFA or appropriate State agencies should contract with citizens groups who have experience with serving elderly and disabled persons to monitor HHA performance and file reports which would be available for public inspection.

3. To improve service delivery and the quality of care

HCFA or appropriate State agencies should implement a program for interviewing program beneficiaries to better assess the quality of care;

A central source should collect and distribute information on the availability of in-home services to better inform potential clients concerning their options for long-term care;

Medicare's Conditions of Participation could be upgraded to strengthen the requirements for in-service training for home health aides and other personnel. This should not include licensure or pre-certification requirements which might only lead to over-professionalization and increased costs.

LONG TERM REFORMS

There are, of course, a wide range of alternatives available to policymakers for restructuring the home health program. Several administrative options exist concerning critical decisions such as who should provide the care delivered, what range of services should be provided and how those services should be financed.

Home health providers, for example, can (and do) include government, non-profit, proprietary and voluntary (such as VNAs) agencies. In addition to these provider agencies, channeling agencies similar to Health Maintenance Organizations (HMOs) can also be used to coordinate the activities of the various service providers.

Payment for home health services can be made on an open-ended or fixed-budget basis. The payer can be a third party such as the government, a private fiscal agent or the individual receiving the benefit. A co-payment method or consumer subsidy (for example, vouchers) can also be used. With respect to the payment mechanism, providers can be paid for their charges (the amount billed), actual costs incurred, through negotiated rates, on the basis of a fee schedule or on the basis of pre-determined rates similar to insurance premiums. A discussion of all of these options is well beyond the scope of this report. However, the range of administrative options available and how they each might affect other program considerations, such as the quality of care provided, should be kept in mind as reform efforts are undertaken.

Several reform objectives have been outlined in this report. The following discusses various long-term proposals designed to accomplish these objectives. While some of these proposals are untested, we believe they offer promising alternatives to present home health policies.

1. Cost containment

There are three general ways in which the amount of payment for in-home services can be contrained: (1) budgetary controls can

be placed on providers, on the program as a whole, or both to limit the resources allocated to in-home services; (2) program requirements can be manipulated to reduce services, limit eligibility or control utilization; (3) policies that increase price competition between providers can reduce program costs.

Three specific approaches to cost containment are considered below: prospective budgeting, implementing utilization controls and enhancing price competition through the use of vouchers. These approaches emphasize increasing the efficiency of service providers rather than reducing benefit levels. We believe they should be considered before other policies that are designed to reduce services are implemented.

Prospective budgeting

HCFA has already indicated its intention to specifically examine prospective-based systems as an alternative to retrospective cost reimbursement. There is widespread dissatisfaction with the current payment mechanism, particularly in terms of its inability to control escalating costs, and prospective budgeting appears to have several potential advantages.

First, under a prospective system rates would be negotiated in advance. Providers would therefore know what amount of funds would be available for the coming rate year. Prospectivity would, of course, eliminate the uncertainty caused by possible retrospective payment denials which can impose a severe financial hardship on providers.

A prospective-based system might also have a positive impact on the quality of care provided. Since providers would be faced with limited but known resources, they could be encouraged to use those resources most efficiently by devising a treatment plan and timetable for each client. They would also have sufficient flexibility to formulate a treatment plan that integrated a variety of services to suit a patient's needs.

Prospective budgeting might also lead to placing greater emphasis on preventive care and the maintenance of health. Providers would be financially discouraged from performing expensive crisis intervention treatments and encouraged to undertake relatively inexpensive preventive approaches to health care.

The principal advantage of prospective budgeting is, of course, that it would compel providers to operate more efficiently. A preestablished ceiling could also reduce the wide variations in costs that providers now experience and providers would not be able to inflate costs where they have a virtual monopoly on services.

There are, however, several potential problems with prospective budgeting that require careful consideration. Contingency arrangements, for example, would have to be developed for returning or alternatively allocating additional funds if the need for services is either overestimated or underestimated. And, if budgets are set too low without sufficient administrative flexibility to subsequently modify them, persons who need and are eligible for services may not be able to receive them.

There is evidence that where prospective budgeting has been used in other aspects of the health care system costs have not necessarily

been constrained. In Canada, for example, provincial governments approve hospital budgets, yet expenditures for hospital services there have risen at a rate comparable to the rate in the United States. According to one analysis, the Canadian experience is due largely to the tendency of government officials to continue to reimburse providers on the basis of the total costs incurred because of their commitment to providing the highest quality of care achievable.

More fundamentally, it may be that fixed budgets are inconsistent with the concept of "entitlement." If viewed as an entitlement program, home health care should be available to persons who meet the eligibility requirements as a legal right. Fixed budgets, of course, may prove inadequate for financing services to all those eligible to receive them. One way this problem may be averted is if public policies generate a sufficient supply of providing agencies and if government agencies, such as State or local departments of public health are able to take up the slack.

Prospective budgeting is certainly no panacea for controlling the rapidly rising costs of home health care but it does appear to offer an improvement over the present system. However imperfect, prospective budgeting at least offers a mechanism potentially capable of constraining costs. The present payment method, retrospective cost reimbursement, does not appear to be even potentially capable of preventing skyrocketing cost increases.

Utilization controls

To control the use of home health care resources, the responsibility for determining the amount, type and duration of services could be shifted from service providers to others, such as independent case managers who are not affiliated with the home health agency.

The excessive costs of home health care often result from providers choosing to perform expensive, often superflous and inappropriate services. Enabling independent agents to control utilization can substantially reduce the cost accruing from the provision of unnecessary services since independent case managers would have no vested interest in escalating service costs. Case managers could also assist in developing economical treatment plans specifically tailored to a client's needs.

It could, of course, be argued that home health agencies, like hospitals, should be allowed to control the use of their own resources. However, there are several notable differences between hospitals and HHAs. Hospitals, for example, have well established internal review mechanisms designed to prevent overutilization. External review, such as that provided by Professional Standards Review Organizations (PSROs), provide a similar check on hospital use.

Additionally, it should be noted that HHAs do not routinely have to make emergency decisions regarding the provision of acute care, when time for outside intervention to determine the appropriateness of use is severely limited. Consequently, independent case managers appear to be both an effective and appropriate means of controlling home health utilization.

Vouchers [1]

[1] The use of vouchers is also discussed, infra, in terms of improving quality of care.

The cost of providing home health care may also be controlled by generating price competition among service providing agencies through the use of vouchers placed in the hands of clients.

Because vouchers are a form of consumer (rather than producer) subsidy, the potential client would be able to select the providing agency that offers services that best meet the individual client's needs. Since the value of the voucher is limited, the purchases would have an incentive to select the agency that provided the best mix of services at the lowest price so that the value of the voucher would be maximized.

Unlike prospective budgeting and utilization controls discussed above, vouchers have the advantage of relying on the marketplace to allocate price (within the upper limit of the voucher), thereby reducing the complex regulator structure needed to monitor provider activities. Some regulatory activity would of course still be needed to ensure quality of care by licensing provider agencies and otherwise monitoring provider performance.

There are, potentially, some serious drawbacks to a voucher system for home health care. Can clients be expected to have access to information concerning provider agencies which would allow them to act as rational consumers? There is presently little information available regarding what agencies exist and what services they provide. Futhermore, the problem may be exacerbated due to the clients' physical or mental disability which could prevent him or her from obtaining needed information.

Additionally, if vouchers are issued to a large number of persons simultaneously, for example to all individuals over the age of 65, demand for services may increase rapidly driving up prices where supply is low, at least until other providers enter the marketplace to pick up the deficit in supply.

On the other hand, while the proliferation of providers might hold down costs, it could also increase service fragmentation and create substantial problems for monitoring the quality of care provided.

Nevertheless, while these problems and others are substantial, they do not appear to be insurmountable (some responses to these problems are discussed later in this report under the section dealing with quality of care). In any case, the potential advantages to the use of consumer subsidies such as vouchers in restraining costs deserve careful consideration.

II. Increasing program accountability

Despite a growing amount of evidence concerning provider financial abuse and problems relating to a lack of client knowledge concerning the home health care program's operations, little attention has been devoted to ensuring that either clients or government officials have the ability to monitor the services actually delivered by provider agencies. To the extent that this issue has been examined, it is usually discussed in terms of the fiscal intermediaries' role. Therefore the following focuses on alternative means by which provider performance can be monitored.

Community involvement

Citizens groups, as well as program beneficiaries, can perform important functions relating to improving program accountability. Vol-

unteer groups have proliferated throughout the Nation voicing concerns on behalf of the elderly and disabled. These groups might be used, on a contractual basis, to audit home health visits to assess the clients' perspective on the care provided as well as to determine and report on whether the services paid for are delivered and if the services appear to be of adequate quality.

These community-based monitoring activities might either replace or supplement more formal evaluations. The reports of these groups should also be available for public inspection so that potential clients will receive the benefit of an independent assessment of the agencies' operations.

As mentioned earlier, the home health care program's Conditions of Participation could also be enhanced to increase representation on agency boards by the family members of clients served by the agency or other community representatives. Presently, agency boards are often dominated by professional service-providers and by home health agency officials themselves. These boards can be used to provide at least a limited check on HHA operations and make them more accountable to those they serve.

Case management

Case managers can serve important functions in both improving accountability and the quality of home health services. The contribution of a case manager to improving the quality of services will be discussed in more detail in the next section. Here we seek to underscore the importance of assigning a single individual or a team in a specific area to monitor home health care clients.

Given the fragmentation of current accountability structures, it is not surprising that clients frequently receive inappropriate care and disappear amidst a vast and confusing array of services. Many of these inadequacies stem from the absence of a single, identifiable individual or agency responsible for monitoring clients. Case managers can assume responsibility for tracking home health care clients and insure the delivery of appropriate services in preferred environments. Ultimate accountability for a small group of clients would rest with case managers. They could be trained and located in several possible organizations, including State and local agencies as well as with community groups.

III. Quality of care

While there is evidence that home health care clients are generally satisfied with the quality of care provided by HHAs, there is also reason to believe that various measures could be undertaken to improve the program's operations with respect to service delivery. The following discusses several possible reforms relating to increasing HHA ties with the community it serves and enhancing the autonomy of the clients (that is, increasing their control over the amount and nature of the services provided).

Community-based services

The increasing professionalization of the home health industry has several drawbacks for the clients it serves. Agency officials understandably want to improve service delivery by requiring that agency personnel be certified and otherwise credentialed. Additionally,

professional organizations seek wage protection by lobbying for more stringent standards concerning who is allowed to deliver home health services. However, discussions with clients and client organizations suggest that this increasing professionalization may limit the utility of the services provided. For example, many individuals are reluctant to accept the help of unknown professionals for such personal needs as bathing and dressing. Members of particular racial and ethnic communities may be uncomfortable with agency personnel who are unaware of the clients' religious beliefs and cultural habits. Moreover, language barriers may prevent individuals from effectively communicating with agency personnel concerning the client's particular needs.

Consequently, encouraging the development of agencies with strong community ties, such as some federally funded Community Action Agencies, could have several advantages. Personnel from these agencies would be more likely to observe similar cultural norms and traditions as the clients and would perhaps have a greater familiarity with the clients' needs. Therefore, clients might well be more willing to seek help with their personal needs associated with disability and aging.

Another benefit related to community-based in-home programs concerns local job creation. Community-based agencies often have ties to and greater knowledge of low income persons in need of employment. Many individuals currently receiving public assistance can with proper training be employed in human service capacities (often referred to as double social utility). AFDC mothers can provide services to the homebound elderly. Tax credits or other subsidies could also be provided to families who provide for a severely impaired or disabled person. Additionally, a small amount of targeted seed money could help mobilize a local community's response to providing in-home services to disabled elderly persons.

Enhancing client autonomy

Several revisions in the home health program could be made to increase clients' influence concerning the services provided. As stated previously, a report by HHS has indicated that clients often have little knowledge regarding what services are available and tend to accept the services provided with little questioning. The report indicated, for example, that 75 percent of the patients interviewed could not remember how they learned of the services they were receiving. Consequently, clients tend to seek and receive those services that are most prominently advertised, convenient or easiest for providers to deliver. As a result, provider agencies exercise considerable discretion in determining the benefits the client receives.

To increase the choices available to clients, tax credits could be used to channel funds directly to supporting families. This subsidy would allow families with disabled elderly persons to undertake greater responsibility for providing needed care and helping to postpone or prevent institutionalization. Additionally, services provided by a family member might be more effectively administered. Such a subsidy would also allow for greater flexibility in purchasing services such as respite care, day care or crisis intervention. Alternatively, a tax credit could be used to enable supporting relatives to pay for daily in-home care, freeing them for employment.

A tax credit might also reduce the dependence of a family supporting an elderly individual on existing service delivery systems that are inadequate, poorly coordinated or inaccessible. The simplicity of a tax credit, in contrast to other forms of public assistance, also makes this approach appealing.

Tax credits, however, have obvious shortcomings. There would be no guarantee that the credit will be used to provide services and misuses of the credit will be difficult, if not impossible, to monitor or control. Perhaps more importantly, a tax credit may offer a financial incentive for an elderly relative or friend to care for a home health client when no personal incentive for providing that care exists.

Vouchers also offer advantages related to increasing client choice. Under a voucher system the value of the voucher could vary according to the degree of impairment. For example, the maximum value of the voucher could be set at the cost of nursing home care if the was severely impaired. Less disabled persons would receive vouchers of decreasing value according to an assessment of the services the individual needed. Someone other than the provider, such as a case manager under the auspices of a State or local agency, could be responsible for assessing the degree of disability.

A voucher system could greatly increase a client's ability to choose within prescribed services as well as increase the range of services available. Under such a system, community-based providers who seek to provide only selected services, such as homemaker services, could do so under Medicare without establishing an agency also capable of providing skilled nursing care. Community-based providers could become a viable competitor to formal providers who, because of lack of competition, have kept prices artificially high.

CONCLUSION

Since Congress enacted the Medicare and Medicaid programs in 1965, home health services have helped millions of elderly disabled citizens receive needed care while remaining in their homes. In many cases, home health benefits have proven to be an effective lower cost alternative to institutionalization. And in-home services will become even more important in the years to come as the elderly become a larger percentage of the Nation's total population.

Yet disturbing trends in the home health program's development are apparent. Federal expenditures for home health services have quadrupled during the past 5 years. Moreover, expenditures can be expected to continue to rise rapidly as the Medicare program's most costly providers—individually operated non-profit and proprietary agencies—conduct an increasing proportion of all home health visits.

Despite repeated attempts to combat provider misconduct, problems concerning fraud and abuse persist. The growth of profitmaking management firms which assist in establishing Home Health Agencies and then sell them questionable services at inflated costs is of special concern.

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