MEDICARE HOME HEALTH AGENCIES: STILL NO SURETY AGAINST FRAUD AND ABUSE

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

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CONTENTS

Page

Hearing held on July 22, 1998 1

Statement of:

Schubert, Lynn M., president, Surety Association of America; Bill Koniers, senior vice president for business development, AMH Health Group, Inc., Connecticut; William A. Dombi, vice president for law, National Association for Home Care; Jayne F. Quinn, home care coordinator, York Hospital Home Care, York, ME; Steven Richard, CFO, Sun Home Health Service, Northumberland, PA; and Steve Schneider, CEO, VNA of Central New Jersey 55

Thompson, Penny, director, program integrity, Health Care Financing Administration; and George W. Grob, Deputy Inspector General, Department of Health and Human Services 5

Letters, statements, etc., submitted for the record by:

Dombi, William A., vice president for law, National Association for Home Care, prepared statement of 83

Grob, George W., Deputy Inspector General, Department of Health and Human Services, prepared statement of 20

Koniers, Bill, senior vice president for business development, AMH Health Group, Inc., Connecticut, prepared statement of 74

Quinn, Jayne F., home care coordinator, York Hospital Home Care, York, ME, prepared statement of 127

Richard, Steven, CFO, Sun Home Health Service, Northumberland, PA, prepared statement of 121

Schneider, Steve, CEO, VNA of Central New Jersey:

Information concerning interim payment system for Medicare 158

Prepared statement of 114

Schubert, Lynn M., president, Surety Association of America, prepared statement of 58

Thompson, Penny, director, program integrity, Health Care Financing Administration, prepared statement of 7

Towns, Hon. Edolphus, a Representative in Congress from the State of New York, letter dated April 15, 1998 35

MEDICARE HOME HEALTH AGENCIES: STILL NO SURETY AGAINST FRAUD AND ABUSE

WEDNESDAY, JULY 22, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2247, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Snowbarger, Pappas, Towns, Kucinich and Allen.

Also present: Representative Kanjorski.

Staff present: Lawrence J. Halloran, staff director and counsel; Marcia Sayer, professional staff member; Jesse S. Bushman, clerk; and Cherri Branson, minority counsel.

Mr. SHAYS. I would like to call this hearing to order and apologize for my arriving a bit late, and I would like to welcome our guests and witnesses.

Before issuing a driver's license, every State requires proof of financial responsibility in the form of auto insurance. Even the local video store requires a credit card number for every member to insure payment for late or lost videos. But to qualify as a Medicare home health provider today requires no financial guarantees of any kind. As a result, Medicare beneficiaries, and the Medicare program remain, vulnerable to billions of dollars of fraud, abuse and waste.

Medicare expenditures for home health have grown dramatically from less than $4 billion in 1990 to almost $18 billion last year. The Department of Health and Human Services [HHS] Inspector General [IG] estimates 20 to 40 percent of those payments may be improper. Easy money, and easy entry into the home health provider rolls, attract scam artists and fly by-night operators. The Health Care Financing Administration [HCFA] is unable to screen out or exclude problem providers before scarce Medicare dollars are irretrievably lost.

Last year, Congress and the administration took steps designed to strengthen a program relied upon by millions of the elderly and disabled for home health services. In the Balanced Budget Act, we directed HCFA to require home health agencies and durable medical equipment suppliers to obtain surety bonds "in an amount not less than $50,000." In September, the White House announced a 4-month moratorium on enrollment of any new Medicare home health agencies while HHS implemented the surety bond provi-

sions and other safeguards to bar unqualified and predatory providers.

But now, almost a full year later, we still face very troubling questions: Was the moratorium an effective antifraud tactic? What flaws in HCFA's implementation strategy resulted in the recent suspension of the surety requirement after 40 percent of home health agencies had obtained bonds? And what will HCFA do now to address the continuing vulnerability of Medicare home health and durable medical equipment payments?

To some, the moratorium was little more than HCFA's well-publicized admission the home health program was out of control. It indiscriminately harmed qualified and unqualified applicants alike, while the bad actors already in the program got 4 more months with additional legitimate competition.

Meanwhile, HCFA ventured clumsily into the complex field of surety bonds, issuing two versions of regulations still widely criticized as: beyond the statutory mandate; unrealistic under prevailing underwriting standards; and harmful to small and minority-owned businesses.

Surety in express of $50,000, up to 15 percent of prior year Medicare billings, was beyond the reach of some agencies, particularly nonprofits. In demanding bond coverage for overpayments, as well as losses to fraud and abuse, HCFA apparently failed to consider the effects of the new home health Interim Payment System [IPS] on providers. According to home health agencies, the IPS makes overpayment far more likely, while severely restricting the cash-flow needed to qualify for a bond to cover overpayments.

Still, almost 40,000 home health agencies obtained surety bond coverage before HCFA announced suspension of the implementation date, pending a General Accounting Office [GAO] study. Delayed implementation punishes those who complied and rewards those unwilling to incur the expense of a bond. Going forward, HCFA must reverse those incentives.

Our previous hearings and oversight reports on health care fraud concluded HCFA needs stronger tools and better management to keep problem providers out of Medicare. If properly managed, surety bonds could be such a tool. Today we ask HCFA, providers and insurers how that tool, and others, can be used to assure the financial responsibility of those who care for Medicare beneficiaries.

The bottom line: This is not just a financial issue. Unqualified providers affect the quality of care.

We welcome the testimony of our witnesses today as we continue to pursue oversight findings and recommendations to fight health care fraud and protect the quality of Medicare.

At this time, I recognize my partner in this committee, the ranking member, Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman, for holding this hearing today on home health care agencies and the proposed Federal bonding requirement. Recently, the Health Care Financing Administration decided to postpone the implementation of its surety bond rule, and this decision was met with relief by the industry, concern by regulators and confusion by everyone else. Hopefully, today we will clear up some of the confusion and discuss the role of surety bonds in combating fraud, waste and abuse.

Let me make it clear that I have always opposed bonding requirements and still do. In every industry in which they have been used, small and minority businesses have been adversely affected and excluded from the business that they are otherwise qualified to perform due to bonding.

Before we start this technical discussion on the advisability of the rule, we should first recall the reason that we required home health care services. Many of the 4 million people who rely on the system of home-based care providers would be hospitalized or receive care in an institutional setting if these services were not available. Home health care allows people with long-term illnesses to receive care at substantially lower cost than hospitalization or institutionalization.

By allowing people to return home and still receive the care they need, I believe that we provide not only a more sensible alternative but also a more cost-effective one. So before we start the discussion on the amount of money that we spend on health care, let's not forget the amount of money we are saving on hospital costs.

Under the Balanced Budget Act of 1997, Congress directed HCFA to have a surety bond rule in place by January 1, 1998. The statute required providers to obtain a bond as an antifraud screening device. Home health agencies which participate in Medicaid were required to obtain a bond in the amount of $50,000 or 15 percent of an annual Medicaid payment, whichever is greater. The regulation specified that HCFA would collect on the bond if the agency defaults from the program and has failed to repay Medicare or Medicaid. Without this new regulation, HCFA can recover any money it may be due.

After publication, the rule was changed several times. But it still suffered from one fundamental flaw. No one has yet shown a relationship between provider bonding and the reduction of fraud, waste or abuse. However, we do know that bonding requirements have always decreased the number of businesses in a field. That is a fact.

Mr. Chairman, we should not be fooled about the effect of these regulations. They will result in fewer businesses which will reduce the level of service to the elderly. I oppose any reduction in the level of care available for home-bound senior citizens.

I understand that we are here today to decide what should be done next. Let me make a few suggestions before we move forward.

It is my understanding that the GAO will undertake a report on bonding and home health care. I believe members of the subcommittee should meet with the GAO to determine the focus and direction of that study and assure that the Florida bonding experiment is carefully, carefully reviewed.

Second, in its future rule we should ask HCFA to carefully, carefully, carefully consider whether the bond requirement should apply to all providers or only those who have demonstrated some instability. Based on this kind of information, we can have a rule that really works for everyone. I think that is what we should be about.

On that note, Mr. Chairman, I am happy that you are holding this hearing; and I yield back.

Mr. SHAYS. I thank the gentleman very much.

I call on Mr. Pappas from New Jersey, one of the new members to the committee and a valued member.

Mr. PAPPAS. Thank you.

Ladies and gentlemen, welcome, and thank you for being here, and especially to the very last panelist, Steve Schneider, who is up from Monmouth County, NJ. His agency provides service to many of my constituents.

I think, Mr. Chairman, this hearing is necessary. As I have worked with Mr. Schneider and so many other home health care agencies for probably close to 15 years, I have been very impressed with the service that they provided, those that they help to keep from being institutionalized, and anything that we can do to facilitate their functioning and growth and ability to provide such a necessary service I believe will save U.S. tax dollars. It will delay people from being institutionalized, and that certainly has a quality-of-life value to it and a dollar-and-cents benefit as well.

Mr. SHAYS. Thank you.

Another new member of the committee and also very valued is Mr. Allen from Maine.

Mr. ALLEN. Thank you, Mr. Chairman, for holding these hearings today.

Last year, Congress took an aggressive action in the Balanced Budget Act to deal with the rapid growth and perceived fraud and abuse in Medicare's home health benefit. We share the goal of weeding out fraud and abuse in the system.

Clearly, the rapid rate of growth of the home care industry raises questions about how the system is managed. However, we must be careful not to equate rapid growth with fraud and abuse. We must be careful not to enact policies which harm reputable, cost-effective home health agencies and, ultimately, put patients at risk.

Our population is aging; all of us are aging. Finding ways to care for our aging population, to give them comfort and a high quality of life should be our goal. It seems that the home health industry is answering that call. Many States like Maine are making the conscious decision to care for people in their homes rather than in an institutional setting.

Again, Mr. Chairman, thank you for providing this hearing today to examine a particular measure for fighting fraud and abuse in the home health care industry, the surety bond.

I am pleased for the second panel you have selected a constituent of mine from Maine, Ms. Quinn, to testify. I am certain that she will provide us with valuable insight as we work through this issue.

I look forward to hearing from all of the panelists today and discussing how we can weed out fraud and abuse without making cuts at the expense of our most vulnerable population, our home-bound seniors.

Mr. SHAYS. I have a little housekeeping business first.

I ask unanimous consent that all members of the subcommittee be permitted to place any opening statements in the record and, without objection, so ordered, and that the record remain open for 3 days for that purpose and, without objection, so ordered. And I ask further unanimous consent that all witnesses be permitted to

include their written statements in the record, and, without objection, so ordered.

At this time, I recognize our first panel: Penny Thompson, director of program integrity, Health Care Financing Administration. You have been in office 2 months?

Ms. THOMPSON. Yes.

Mr. SHAYS. And also George Grob, Deputy Inspector General, Department of Health and Human Services.

As you know, we swear in all witnesses when they testify, so if you would stand and raise your right hand.

[Witnesses sworn.]

Mr. SHAYS. For the record, our witnesses have responded in the affirmative; and I would like to say, to give you some guidance, we request your statements be 5 minutes. It is important for our first panel to be able to put on the record what needs to be put on, so we allow you to go up to 10 minutes. So you will see the green light go on and then a red light and then we will turn it to green for a second round. If you can finish between 5 and 10. The second panel we would like to keep their testimony as close to 5 minutes as possible, except for the gentleman from Connecticut.

STATEMENTS OF PENNY THOMPSON, DIRECTOR, PROGRAM INTEGRITY, HEALTH CARE FINANCING ADMINISTRATION; AND GEORGE W. GROB, DEPUTY INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. THOMPSON. Chairman Shays, subcommittee members, thank you for giving us the opportunity to describe our efforts to protect the integrity of the Medicare home health benefit and implement the BBA provisions requiring home health agencies to obtain surety bonds.

The home health benefit is essential to millions of Medicare beneficiaries. Unfortunately, this benefit has also been subject to widespread waste, fraud and abuse and unsustainable growth. Until this year, home health agencies had to meet few standards to participate in Medicare. The bond requirement is one of several steps to raise the bar for home health agencies.

Because of the problems documented by the HHS IG, we declared a moratorium on new home health agencies entering the program last fall. The moratorium helped turned the tide of unsustainable growth. The moratorium also sent a message to the industry that we are serious about stopping waste, fraud and abuse.

During the moratorium, we developed the bond regulation, doubled the number of home health cost audits and increased medical review of claims. We have also established new minimum capitalization requirements for new agencies to ensure that we have enough funds on hand to operate responsibly.

We instituted a new requirement that agencies treat 10 patients at least before they are allowed to enter the Medicare program. We look at the care they provide before they are allowed into the program.

We have increased survey frequency for problem agencies. We now have authority to exclude providers who have been convicted of health-related fraud. We can require new agencies to disclose re-

lated-party ownership so we can determine whether any principals have a history of questionable practices.

We have proposed new regulations which require agencies to use a standardized system to assess patient needs and improve quality of care. Home health agencies are now held to higher financial and quality of care standards both before and after they are allowed to enter the Medicare program.

Surety bonds use a private sector mechanism to screen agencies that provide care to Medicare's home-bound beneficiaries and ensure that they are financially responsible. They also help make sure that the government can recoup taxpayer money from agencies that default on their obligations and fail to repay Medicare or Medicaid, which has been a problem.

We will collect on surety bonds only as a last resort after a home health agency defaults on its obligations to repay Medicare money owed. Without this ability to collect on otherwise uncollectible overpayments, money owed by these home health agencies will never be returned to the Medicare trust fund.

We strongly believe that surety bonds are a necessary protection for the Medicare home health benefit. However, we have put the bond requirement on hold while the General Accounting Office studies its impact. We will review the GAO findings and consult with Congress before proceeding. As a result, home health agencies no longer have a date by which they must obtain a surety bond.

Once we review the GAO report we will consult with the Congress. Only after these consultations will we issue a new regulation. Home health agencies will not have to obtain bonds until 60 days after that regulation is published and not before February 15, 1999.

To date, about 40 percent of all home health agencies have obtained bonds. We are concerned about fairness for those agencies which have obtained bonds. The Balanced Budget Act provides that any cost in connection with bonding may not be reimbursed by Medicare. We are evaluating our options to see if there is any way to accommodate these agencies.

We are also working toward implementing a Balanced Budget Act requirement for all durable medical equipment suppliers to obtain surety bonds. Like the home health bond, the DME bond uses private sector market forces to screen providers. We will take the GAO findings on the impact of the home health bond requirement into account as we proceed with the DME bond requirement.

The BBA makes much-needed reforms to the Medicare home health benefit to curtail unsustainable growth and fight fraud and abuse. But with change comes challenges. We will continue to work with Congress and home health providers to fine-tune these changes so that taxpayers and beneficiaries are protected from unscrupulous or unstable providers, so tax dollars are used wisely and so reputable agencies can provide the care that we all agree is so important.

Mr. SHAYS. Thank you.

[The prepared statement of Ms. Thompson follows:]

Testimony of Penny Thompson
Director of Program Integrity, Health Care Financing Administration
before the
House Government Reform and Oversight Subcommittee on Human Resources
"Medicare Home Health Agencies: Still No Surety Against Fraud and Abuse"
July 23, 1998

INTRODUCTION

Chairman Shays, Committee members thank you for giving us the opportunity to describe our efforts to protect the integrity of the Medicare home health benefit and implement the Balanced Budget Act provision requiring home health agencies to obtain surety bonds.

The bond requirement is one of several steps to raise the bar for home health agencies. Until this year, home health agencies had to meet few standards to participate in Medicare. That contributed to unsustainable spending growth, widespread waste, fraud and abuse, and in some cases questionable quality of care for the vulnerable beneficiaries who rely on this benefit.

Because of problems documented by the HHS Inspector General and the General Accounting Office, we declared a moratorium on new home health agencies entering the program last fall, based on authority to take necessary steps to protect program integrity. The statute at section 1891(b) emphasizes that the duty of the Secretary is to assure that the requirements for home health agencies promote the effective and efficient use of public money. Section 1861(o)(7) similarly requires agencies to meet whatever requirements the Secretary finds necessary for the effective and efficient operation of the program. The moratorium was necessary because there was not an adequate system of requirements for home health agencies to ensure the kind of financial viability and accountability needed for the Medicare program.

The moratorium went into effect on September 15, 1997, and was lifted on January 13, 1998. It has had a marked impact on home health problems.

The moratorium helped turn the tide of unsustainable growth in the number of home health

agencies entering the program and in home health care spending. Home health care spending dropped for the first time ever in 1997. And, since the moratorium was implemented, fewer than 40 agencies have entered the program, versus the nearly 800 that were let into the program in 1997 before the moratorium.

The moratorium provided time for us to develop the surety bond regulation and implement other new, higher standards that help ensure home health agencies are financially secure and providing quality care. It sent an unequivocal message to the industry that we are serious about stopping waste, fraud and abuse.

And, during the moratorium, we doubled the number of home health cost report audits and increased medical review of claims by 25 percent. Home health agencies are now held to higher financial and quality of care standards, both before and after they are allowed to enter the Medicare program.

We strongly believe surety bonds are a necessary protection for the Medicare home health benefit. However, we have put the bond requirement on hold while the General Accounting Office studies its impact. We will review the GAO findings and consult with Congress about the surety bond requirements before proceeding. Home health agencies will not have to obtain bonds until 60 days after a new regulation is published, and not before February 15, 1999.

BACKGROUND

Medicare's home health benefit is crucial to millions of beneficiaries, allowing them to recuperate in the comfort of their own homes. Congress stipulated that care provided under this benefit be related to the skilled treatment of a specific illness or injury. Beneficiaries must be under the care of a physician who certifies that medical care in the home is necessary and establishes a plan of care. They must be confined to the home and need intermittent skilled nursing care, physical therapy, speech language pathology services, or have a continuing need for occupational therapy. If these requirements are met, Medicare will pay for: skilled nursing care on a part-time or

intermittent basis; physical and occupational therapy; speech language pathology services; medical social services; personal care related to treatment of an illness or injury on a part-time or intermittent basis; and medical supplies and durable medical equipment (beneficiaries must pay 20 percent of the cost of durable medical equipment).

GROWTH AND WASTE, FRAUD AND ABUSE

Unfortunately, this important benefit has been subject to widespread waste, fraud and abuse and unsustainable growth. Home health care accounted for just 2.9 percent of all Medicare benefit payments in 1990 but now accounts for nearly 9 percent. Total home health spending rose from $4.7 billion (in 1994 dollars) in 1990 to $17.2 billion in 1997.

During the same time period, the number of beneficiaries receiving home health doubled from two million to four million, and the average number of visits per beneficiary jumped from 36 to 80. The number of home health agencies providing services to Medicare beneficiaries has grown about 20 percent each year, from 5,656 in 1990 to 10,500 in 1997.

While some of this growth is due to changing demographics and medical advances, studies by the HHS Inspector General and the General Accounting Office document that a significant amount is due to waste, fraud and abuse.

In a July 1997 report, *Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas*, the Inspector General evaluated a sample of 3,745 services in 250 home health claims in four states and estimated that 40 percent of the services did not meet Medicare reimbursement requirements. Medicare claims processors had made appropriate payments based on the documentation submitted by the home health agencies. However, investigation beyond the documentation revealed that the services billed for should not have been paid for by Medicare because they were not medically necessary or not covered under the Medicare home health benefit.

In another July 1997 report, *Home Health: Problem Providers and Their Impact on Medicare,* the Inspector General found that one quarter of home health agencies in five states, accounting for 45 percent of home health spending in these states, were so-called problem providers. The Inspector General recommended that all home health agencies be required to obtain surety bonds of 100 percent of the agency's expected annual Medicare billings, and that the cost of the bond not be reimbursed by Medicare.

Similarly, the General Accounting Office in a June 1997 report, *Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings,* noted significant levels of inappropriate billings. A review of 80 high-dollar claims in one state revealed that 43 percent of the claims should have been partially or totally denied.

ACTIONS

Congress and the Administration acted to address these problems in the Balanced Budget Act by requiring home health agencies to obtain surety bonds, closing loopholes, and establishing incentives to provide care efficiently. The Administration also acted on its own to implement new entrance criteria and quality standards.

Surety Bonds

Surety bonds use a private sector mechanism to screen agencies that provide care to Medicare's homebound beneficiaries and ensure that they are financially responsible. They also help make sure the government can recoup taxpayer money from agencies that default on their obligations to the programs and fail to repay Medicare or Medicaid, which has been a problem with home health agencies. From 1993 to 1996, home health agencies left the Medicare program owing more than $154 million back to the Medicare Trust Fund. The percentage of uncollected overpayments to home health agencies that have defaulted nearly tripled from 5 percent in 1993 to 14 percent in 1996.

Surety bonds represent the last resort in recovering defaulted obligations, not a way to routinely

collect overpayments that occur in the cost-based system from providers who operate in good faith and repay their debts with Medicare and Medicaid. HCFA will collect on surety bonds only as a last resort, after a home health agency defaults on its obligation to repay Medicare money owed. Without this ability to collect on otherwise uncollectible overpayments, money owed by these home health agencies will never be returned to the Medicare Trust Fund.

The statute mandates in section 4312(b) that home health agencies, regardless of size, provide on a continuing basis a bond of not less than $50,000 in order to participate in Medicare and Medicaid. Under the terms of the Balanced Budget Act, HCFA has no discretion to lower the $50,000 minimum amount set by Congress for all agencies, regardless of size. We have, however, used our discretion to allow small agencies with combined Medicare and Medicaid revenues of less than $334,000 to obtain just one bond for both Medicare and Medicaid.

Our regulation implementing the bond requirement calls for a bond in the amount of the $50,000 minimum set by Congress, or 15 percent of annual payments, whichever is greater. An analysis of 89 home health agencies in 14 states that were terminated from the Medicare program in FY 1996 show that 68 percent had overpayments that were greater than 15 percent of their Medicare reimbursements. The 15 percent requirement evens the burden so that small agencies will be buying smaller bonds than larger agencies, and it helps ensure that we have a last resort for recoupment of funds in proportion to the amount of Medicare dollars at risk for each home health agency. However, the 15 percent requirement is significantly less than 100 percent of annual payments recommended by the HHS Inspector General in her July 1997 report.

We believe we complied with Congressional intent with our bond regulations. The law specifically states bonds must be *at least* $50,000, indicating that requiring larger bonds is both authorized and appropriate for agencies with greater financial risk. The law includes the provision for home health surety bonds under a section entitled "Improvements in Protecting Program Integrity" (BBA Title IV, subtitle D, chapter 2), indicating that bonds could be used not just to prevent questionable agencies from entering the program, but also to protect the Medicare Trust Fund

from agencies that default from the program and fail to repay Medicare or Medicaid. The regulations were promulgated in full compliance with the Congressional Review Act and the Administrative Procedures Act.

On June 1, 1998, we made technical revisions to the regulation to address concerns the surety industry had about the length of liability of the bonds. These changes are in keeping with standard industry practice, and make bonds more affordable without weakening the purpose of the bond, which is to keep unscrupulous and unstable agencies out of Medicare and Medicaid. These changes:

- limit liability so bond companies are responsible only for determinations made during the year for which a bond is written, so that the actual risk to the bond company is easier to determine and they can offer them at more affordable prices;
- place a limit on bond company liability by establishing that the bond company has liability for two years after an agency leaves Medicare and Medicaid;
- give a bond company the right to appeal overpayment assessments if an agency has not appealed itself, and has failed to assign its right of appeal to the bond company.

To date, about 40 percent of all home health agencies and 34 percent of small agencies, defined as those with annual Medicare revenues under $200,000, have obtained bonds.

While we believe our course in implementing the statue was reasonable, we have pulled back the date by which agencies must have bonds and are awaiting the findings of a General Accounting Office report on the issues surrounding the surety bond requirement. As a result, home health agencies no longer have a date by which they must obtain a surety bond. Once we review the GAO report, we will consult with Congress about the surety bond requirements. Only after these consultations will we issue a new regulation. Home health agencies will not have to obtain bonds until 60 days after that regulation is published, and not before February 15, 1999.

We are concerned about fairness for agencies that in good faith have obtained bonds. Section 4312(b)(2) of the Balanced Budget Act of 1997 provides that any costs incurred by a home

health agency in connection with bonding may not be reimbursed by Medicare. We are evaluating our options to see if there is any way to accommodate these agencies.

Higher Standards

Medicare has taken other steps to raise standards for home health agencies and protect program integrity. We established new minimum capitalization requirements for new agencies to ensure that they have enough funds on hand to operate responsibly. We instituted a new requirement that agencies have treated at least 10 patients before they are allowed to enter the Medicare program. We now look at the care home health agencies provide before they are allowed into the program. We have increased survey frequency for problem agencies. We have authority now to exclude providers who have been convicted of health care-related fraud, and we can require new agencies to disclose related party ownership so we can determine whether any principals have a history of questionable practices. And we have proposed new regulations which require agencies to use a standardized system to assess patient needs and improve quality of care.

The minimum capitalization requirements ensure that new agencies are financially sound and able to finance their services for the first few critical months after entering the Medicare program. The requirement that agencies serve at least 10 patients before entering Medicare allows us to evaluate the quality of care they provide, not just their administrative set-up as did the old survey process.

During the moratorium, we instructed state survey agencies to focus on home health agencies that have egregious deficiencies or that are repeat offenders. Any home health agency identified in any State, regional, or national fraud and abuse initiative is now surveyed at least once a year, versus every three years for HHAs with good performance records.

We now have authority to refuse to let a home health agency owner participate in Medicare if they have been convicted of a felony. If they have been convicted twice for a health related crime for which a mandatory exclusion can be imposed we can exclude them for a minimum of 10 years, and upon a third conviction we can exclude them permanently. We can also exclude their family

members or members of the household if ownership or control is transferred in anticipation of, or following, a conviction, assessment or exclusion related to the Medicare program. And we can require that home health agencies disclose the identity of each person with an ownership or control interest in the home health agency or any subcontractor in which the home health agency directly or indirectly has a 5% or more ownership interest. This addresses situations documented by the HHS Inspector General in which home health agencies used complex business arrangements to misappropriate Medicare funds and thwart efforts to recoup overpayment efforts and impose sanctions.

We are developing proposed regulations that would require agencies to be recertified every three years, and to submit an independent audit of the records and practices as part of the re-enrollment process.

We expect to soon publish final regulations requiring home health agencies to use a standardized system called OASIS, the Outcomes and Assessment Information Set, to monitor patients' conditions and satisfaction. This will be required as a Condition of Participation, the health and safety standards that providers must meet in order to receive Medicare payments. Home health agencies would be required to conduct systematic and continuous patient assessment with OASIS. Within 48 hours of the home health referral agencies will have to use OASIS to determine the immediate care and support needs of the patient. They must continuously update this assessment until a patient is discharged to reflect changes in the patient's condition and to measure patient and family satisfaction. And they must apply OASIS data to their continuous quality improvement programs. The OASIS data will allow us to better assess and improve quality, and to detect instances where patients may be receiving too many or too few visits. A determination of the patient's "homebound" status also is required in the OASIS assessment in order to address what has been a significant problem with widespread violation of the requirement that a patient be generally unable to leave the home in order to receive Medicare home health services.

We proposed new home health agency Conditions of Participation on March 10, 1997 which would prohibit agencies from employing home health aides with a conviction or prior employment history of child or client abuse, neglect, or mistreatment, and require agencies to immediately investigate allegations of mistreatment, neglect, or abuse; prevent future abuse; and report the results to HCFA and appropriate State officials.

They would place responsibility on agencies to directly provide a majority of the skilled services. The proposed rule would require a majority of all skilled professional (nursing, therapy, social work) services to be provided directly by home health agency staff, rather than by contracted personnel, in order to ensure that agencies exercise an appropriate level of quality control.

They would clarify HCFA's unequivocal authority to decertify home health agencies found out of compliance with any Federal, State, or local law or regulation. This will enable us to cite agencies whenever violations affect the health and safety of patients, the ability of agencies to deliver quality services, the rights and well-being of patients, and the agency's ability to recruit qualified staff.

And they would require the home health agency's governing body to assume full legal responsibility for management of services and fiscal operations and to appoint a qualified administrator. The home health agency board and administrator would be held to an even higher standard to ensure sound fiscal operation. They also will allow us to hold an agency's branch offices accountable to the same requirements as the parent office. Where an agency's branch office is not located sufficiently close to the parent to effectively share administration, supervision and services, the branch would be required to have its own Medicare provider number, meet the Conditions of Participation, and be subject to routine surveys.

DME BOND

We are also working toward implementing a Balanced Budget Act requirement for all durable medical equipment (DME) suppliers to obtain surety bonds. We began internal discussions about

requiring bonds for DME suppliers in 1995, based on authority provided by Congress in 1994 requiring additional standards for suppliers of durable medical equipment [1834(j)]. After receiving specific authority in the Balanced Budget Act, we published a proposed regulation January 20, 1998. We expect to publish a final rule this fall. Like the home health bond, the DME bond uses private sector market forces to screen providers for financial stability. Suppliers must obtain bonds for 15 percent of the amount paid to them by Medicare in the previous year, and not less than $50,000 and not more than $3 million. We do not expect implementation to be delayed by Year 2000 activities. We will take the GAO findings on the impact of the home health bond requirement into account as we proceed with the DME bond requirement.

CONCLUSION

The Balanced Budget Act of 1997 makes much needed reforms to the Medicare home health benefit to curtail unsustainable growth and fight waste, fraud and abuse. But with change often comes challenges. Home health agencies must be better managers of taxpayer money by delivering care more efficiently, and billing only for services covered under law. Agencies also must demonstrate to surety companies that they do not pose an undue financial risk to the Medicare and Medicaid program. We will continue to work with Congress and home health providers to fine tune these changes so taxpayers and beneficiaries are protected from unscrupulous or unstable providers, so tax dollars are used wisely, and so reputable agencies can provide the care that is so important.

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Mr. SHAYS. Mr. Grob.

Mr. GROB. Good morning, Mr. Chairman and members of this subcommittee. I thank you for this opportunity to discuss surety bonds for Medicare and Medicaid home health agencies and medical equipment suppliers.

I wish to begin by emphasizing the importance of these bonds. We in the Office of the Inspector General see them as an integral element in any strategy to reduce the vulnerabilities in these programs. We recognize that there are divergent views on this topic, and we can see how strongly held and expressed they are. I believe the strength of these views on the subject emphasize how important it is to the home health and medical supply equipment programs, and we welcome the opportunity to discuss the various aspects of the program and of these bonds.

Through our audits, investigations and evaluations, we found serious program vulnerabilities in the home health program. Audits of specific home health agencies in Florida, Pennsylvania and California revealed error rates from 19 to 64 percent. Other audits and investigations showed substantial billings for unallowable expenses.

In order to determine if these were merely isolated cases, we conducted a Statewide audit in Florida in 1995. The error rate was 20 percent. Last year, we issued a report covering California, Illinois, New York and Texas. The error rate was 40 percent. The errors were due to unnecessary services, patients not home bound, inadequate physician authorization and lack of supporting documentation. We estimated losses to Medicare of $2.6 billion in these four States over a 15-month period.

While some errors may be due to innocent mistakes, others are the result of abuse and exploitation of the program or outright fraud. This is evident in the result of our investigations.

For example in 1992, two men who served time in prison together for narcotics sales opened a home health agency in Los Angeles upon their release from prison. They paid a physician to sign home health certificates for patients that did not need home health, did not exist or were deceased. They billed Medicare over $10 million and were paid $5.5 million. One had a $2.5 million home and four luxury cars.

In 1993, the home health agency went out of business. In 1994, we issued a search warrant, seized assets and recovered approximately $300,000 but do not expect to recover any more. Both men pled guilty to Medicare fraud in September 1995.

The situation with medical equipment suppliers is similar. In 1996, we made unannounced visits to a sample of medical equipment suppliers who had recently received or applied for Medicare billing numbers; 1 out of every 14 approved suppliers and one 1 of every 9 applicants did not have the required physical address.

For example, in Brooklyn a supplier's address was in a building which consisted of four apartments over a laundromat. The company name was not on the mailbox or any other part of the premises. Two of the residents said they did not know the supplier, and one said that the space was formerly used as "a post office box operation," unquote.

Twenty percent of the suppliers were absent from their business addresses at the time of our inspection. In those cases where we were able to interview a representative, we found obvious failures to meet Medicare supplier requirements. Forty-five percent provided no consumer information, 20 percent did not allow for return of unsuitable items, and 17 percent did not provide for warranty repairs.

For both home health and medical equipment, the ease of acquiring a Medicare or Medicaid billing number is a serious programmatic vulnerability. At the time of our study, there was little or no investment required and very little verification of application information. Applicants needed no health care credentials and were not required to demonstrate financial integrity or fitness for managing a business.

It is conceivable that the cause of these errors could have ranged through the following spectrum: They could be due to innocent errors, perhaps incompetent management, perhaps irresponsibility and recklessness, perhaps abuse and exploitation, perhaps outright fraud. But the result is the same. It is a loss of programmatic and tax dollars and the risk of even more loss.

We have made numerous recommendations to overhaul these programs and tighten up entry to and oversight of them. One of the recommendations was for surety bonds. This was included in the recently enacted Balanced Budget Act.

The Health Care Financing Administration issued a final rule for home health and a draft rule for medical equipment in March of this year. However, because of concerns raised by the home health industry and Members of Congress, HCFA announced it would suspend the home health surety bond requirements and await the findings of a GAO study of the issues.

Prior to the suspension of the rules, approximately 40 percent of the Medicare home health agencies had obtained bonds. This may be seen as an indication that it is possible for home health agencies to obtain bonds or that it is not possible. If the latter interpretation is correct, then Medicare and Medicaid are facing a serious dilemma. If private sector surety companies are unwilling to back these agencies, is it appropriate to expect Medicare and Medicaid programs and taxpayers to step in and do so? There must be a middle ground where legitimate agencies can survive and compete in the marketplace while the Medicare trust fund and State Medicaid programs are protected from risk.

We offer the following principles for consideration.

First, all home health agencies and medical equipment suppliers should be required to obtain surety bonds.

Second, the amount of the bond should be sufficient to discourage fly by-night providers from entering the program and to provide some continuing financial protection to Federal and State programs from the risks inherent in the program.

Three, the amount of the bond should be related to the experience of individual home health agencies and medical suppliers as well as these industries as a whole.

And, four, the surety bond requirement should be subjected to periodic evaluation to gauge its effect on Medicare and Medicaid programs and their service providers.

Beyond these general principles, we recognize that there are many details that need to be worked out; and we look forward to working with the Congress, the administration and the industry in designing a fair and effective surety bond requirement.

Mr. SHAYS. Thank you very much, Mr. Grob.

[The prepared statement of Mr. Grob follows:]

Testimony of
George F. Grob
Deputy Inspector General
for Evaluations and Inspections
Department of Health and Human Services

Good Morning Mr. Chairman. I am George F. Grob, Deputy Inspector General for Evaluation and Inspections of the Department of Health and Human Services. I am here today to discuss surety bonds for Medicare and Medicaid home health agencies and durable medical equipment suppliers. I wish to emphasize the importance of the recently enacted requirement for these bonds. We see them as an integral element in any strategy to reduce the vulnerabilities associated with the program.

HOME HEALTH

Through audits, investigations, and evaluations done by the Inspector General's office, we have found the home health benefit to be a program that grew too quickly with inherent vulnerabilities and inadequate controls. The result has been estimated annual losses to the Medicare program in billions of misspent dollars. Although I will focus on our experiences with the Medicare program, most of the concepts and concerns apply to Medicaid as well.

Over the last several years, we alerted the Congress and policy officials about our concerns. In fact, Inspector General June Gibbs Brown testified on this subject before this Subcommittee in March 1997. In our most recent reports, we recommended a threefold approach to correct these problems: 1) reform the payment method, 2) prevent entry of abusive providers, and 3) tighten oversight. These and similar recommendations proposed by the Health Care Financing Administration (HCFA), the Congress, and the home health industry itself, were adopted in the Balanced Budget Act of 1997 and in the regulatory and administrative initiatives of the Department of Health and Human Services, following a moratorium on enrollment of new home health providers--an approach which we had also recommended. They are now being implemented through the development of a prospective payment system, increases in the number of audits, more thorough enrollment and re-enrollment procedures, and various new penalties for abusive actions.

One of our recommendations was to require home health agencies to obtain surety bonds. This was intended to prevent potentially problematic providers from entering the program and to prevent the Medicare trust fund from incurring losses due to their activities. The Balanced Budget Act contains a surety bond requirement. It requires home health agencies to post a surety bond of a minimum of $50,000 as a condition of participation. To implement this provision, HCFA issued a final rule on January 5, 1998 requiring home health agencies to post a bond obtained from an acceptable authorized surety company in an amount that is the greater of $50,000 or 15 percent of the annual amount Medicare pays the home health agency as reflected in their most recently accepted Medicare cost report. On June 26, 1998, HCFA announced that it would suspend the surety bond requirement and await the findings of a General Accounting Office investigation on surety bonds for home health agencies.

Identifying Program Vulnerabilities

Our concern about home health was initially prompted by the tremendous growth in benefit expenditures. As you know, the home health benefit had been one of the fastest growing components of the Medicare program. In fiscal year 1997, Medicare expenditures for home health were close to $18 billion. This is five times the $3.5 billion spent in 1990. Home health expenditures now account for approximately 9 percent of total Medicare spending compared to 3.2 percent in 1990. Visits per home health beneficiary also increased from an average of 36 visits a year in 1990 to 78 visits in 1997. Additionally, in 1997, there were close to 10,500 home health agencies participating in the Medicare program, growing at an average rate of 100 new agencies each month.

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

When Medicare was established, it was not designed with potentially abusive billers and defrauders in mind. The structure of Medicare's claims system is based on the assumption that providers normally submit proper claims for services actually rendered, that are medically necessary, and that meet Medicare requirements. However, the home health benefit has been particularly susceptible to exploitation compared to other types of health services. This is because the care is provided in patients' homes with no oversight; there is limited physician involvement; there is no limit on the number of visits a home health agency can provide; there is no copayment; and, until a prospective payment system is implemented, it is a cost based service. Further, the home health agency usually develops the plan of care and is responsible for ensuring that the care is necessary and of adequate quality. While these functions are subject to review by Medicare's regional home health intermediaries, only a small portion of claims are reviewed and most of those are paper reviews of the records submitted by the home health agency. Similarly, few cost reports are examined beyond a cursory desk review. Thus, the home health agency has primary responsibility for monitoring the care it provides -- and the bills it submits for that care.

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

Improper Payments

In our work, we have identified an exceptional level of inappropriate payments made under this program. Our first evidence came from audit reports and investigations of certain providers suspected of defrauding the program. We also conducted a Statewide audit in Florida in 1995. We found an error rate--the percent of the home health visits paid for by Medicare but which did not meet Medicare guidelines--of about 20 percent.

New impetus was given to our work by Project Operation Restore Trust, the Secretary's two year anti-fraud demonstration initiative. This was a crackdown on fraud and abuse in the areas of home health, nursing home services, and durable medical equipment in five States--California, New York, Florida, Texas, and Illinois-- that account for close to 35 percent of the nation's Medicare beneficiaries and program expenditures. Audits of specific home health agencies in Florida, Pennsylvania, and California revealed error rates in paid services from 19 to 64 percent. These were due to visits that were not reasonable or necessary, patients who were not homebound, visits which were not documented or even provided to Medicare beneficiaries, improper or missing physician authorizations, and even forged physician signatures.

In our recent report, "Review of Medicare Home Health Services in California, Illinois, New York, and Texas," issued in June of last year, we reviewed 250 claims accounting for 3,745 services from a randomly selected sample of home health agencies. For these cases, our auditors interviewed beneficiaries, family members, knowledgeable acquaintances, and certifying physicians and obtained medical review by Medicare's home health intermediary personnel. They found that in those four States, 40 percent of the total services provided during the 15-month period ending March 31, 1996 did not meet Medicare reimbursement requirements. The explanations were similar to those of the earlier audits: unnecessary services, patients not homebound, inadequate physician authorization and lack of supporting documentation. This represents $2.6 billion in charges, or 39 percent of the $6.7 billion of the universe of claims represented by the sample.

Enrollment and Oversight

Medicare's initial survey and certification process was not designed to screen out potential violators of Medicare's reimbursement requirements, but primarily to assess whether a home health agency is capable of delivering quality home health services. Practically anyone who has met State and local requirements for starting a home health agency has been almost certain of obtaining Medicare certification. According to a recent GAO report "Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies" (GAO/HEHS-98-29), it has been rare for a home health agency not to meet Medicare's three fundamental certification requirements: 1) being financially solvent; 2) complying with Title VI of the Civil Rights Act of 1964, which prohibits discrimination; and 3) meeting Medicare's conditions of participation. The GAO report concluded that "home health agencies self-certify their solvency, agree to comply with the law, and undergo an initial certification survey that few fail." HCFA is currently revising its conditions of participation for home health agencies.

In other recent work, we have explored further program vulnerabilities associated with allowing problem providers into the Medicare home health program. On the same day we issued the four-state audit just mentioned above, we issued another report, "Home Health: Problem Providers and Their Impact on Medicare." This report was based on a statistical analysis of home health agencies in New York, Florida, Illinois, Texas, and California which met our definition of a problem provider--one that was identified by HCFA, an intermediary, a state certification or licensing agency, or our own Office of Inspector General as having a history of significant uncollected overpayments, unreliable and un-auditable cost reports, medically unnecessary services, services not rendered, significant certification deficiencies, and referrals to program integrity or fraud units.

Here we began to see a picture of a group of providers who were able to generate large profits with very little risk to themselves or their businesses. We are greatly concerned that irresponsible home health agencies pose a threat to the home health program and the Medicare trust fund. One illustration of this is that 60 problem agencies, selected at random in our study and analyzed in detail, had a combined outstanding debt to Medicare of $321 million; their individual agency overpayments ranged from $100,000 to several million dollars. Of that amount, at least $63 million will never be recovered, because eleven of these home health agencies are no longer in business, have no assets, or have filed for bankruptcy.

Recent evidence suggests that the vulnerabilities uncovered in our sample are likely to be reflected in the program at large.

The inability of Medicare to effectively identify improper claims before payment combined with the ease of entry of home health agencies into the program makes the Medicare trust fund especially vulnerable to losses from the home health program. In its January final rule on surety bonds, HCFA cited recent statistics indicating that the home health industry-wide ratio of overpayments to payments has risen dramatically over the past five years. In 1996, HCFA reported that 7 percent of payments to home health agencies represented overpayments. This amounted to approximately $1 billion. Of this, close to $154 million (14 percent) has still not been collected. Further, in 1996, 89 home health agencies left the Medicare program and currently still owe $66 million in overpayments.

We believe, however, that these numbers represent only the tip of the iceberg. As noted earlier, because of limited funding, regional home health intermediaries have only been able to do a very small number of in-depth claims and cost report audits. Our four-state audit of home health agencies which involved close scrutiny of a random sample of home health claims, revealed that 40 percent of these claims, representing $2.6 billion, should not have been paid. This error rate was discovered only by conducting intensive in-person interviews with patients and their physicians and by carefully examining the underlying medical records. Improved claims and cost report reviews would undoubtedly reveal far greater amounts of overpayments, and thus of potential non-recoveries, than HCFA is currently reporting.

Examples of Damage and Vulnerability

The examples below shed light on how easy it has been to defraud the Medicare home health program and how much irreparable damage can be caused. Here is a synopsis of some of our recent audit and investigative cases involving serious losses to the Trust Fund:

- Our review of home health claims submitted by St. Johns Home Health Agency during the fiscal year ending June 30, 1993 showed that 75.5 percent of the claims did not meet Medicare guidelines. Of the $45.4 million claimed by St. Johns during this period, we estimate that a minimum of $25.9 million did not meet the reimbursement guidelines. By suspending program payments, HCFA recovered approximately $1.6 million of the $25.9 million overpayment. However, St. Johns declared bankruptcy leaving most of the remaining overpayment unrecoverable.

- In 1992, two men who served time in prison together following a conviction for sales of narcotics in excessive amounts opened a home health agency in Los Angeles upon their release. They paid a physician to sign home health certifications for patients that did not need home health, did not exist, or were deceased. They billed Medicare over $10 million and were paid $5.6 million. One of the men had purchased a $2.5 million Bel Air home and owned a Rolls Royce, a Lexus, a Range Rover, and a Mercedes. Upon an intensive medical review of their claims in 1993, the home health agency went out of business. In 1994, we issued a search warrant and seized assets through asset forfeiture and recovered approximately $300,000 but do not expect to recover any more. Both men plead guilty to Medicare fraud in September of 1995.

- The former owner of a Missouri home health agency was sentenced to 21 months in prison and 3 years supervised release. From 1991 to 1994, the owner had falsified documents and files used to determine his agency's eligibility for Medicare participation and had failed to furnish accurate cost information to support interim payments he received. The individual also had his employees create false expense receipts and false records of committee and board meetings and ran numerous personal expenses through the cost report, including a Jaguar automobile. Through his actions, this individual collected more than $2 million to which he was not entitled. When questioned about missing documents, he testified that a "miniburst twister" had struck the barn where he stored records and destroyed them. The owner had served time previously for buying stolen semi-trucks, insuring them, and burning them. None of the $2 million overpayment has been collected.

- The owner of a Texas home health agency pled guilty to charges of mail fraud and obstruction of justice and was later sentenced to 18 months in prison. In 1996, he filed a cost report with more than $500,000 in unsubstantiated costs, most of which were payroll and bonuses never paid. He filed an amended cost report claiming another $62,000 in consulting fees which he allegedly paid in cash, but could not be substantiated. He later used false IRS forms to convince an auditor that the unsubstantiated costs were legitimate. Soon after his indictment, the individual closed his agency and transferred all of his patients to a home health agency owned by his sister. The current outstanding overpayment in this investigation is $312,800; none of it has been collected.

- The co-owner of a Washington, D.C. home health agency was sentenced to 27 months in prison and ordered to pay full restitution of $100,000 defrauded from the Medicare and Medicaid programs. The home health agency billed for 1,450 skilled nursing visits for which there was no corroboration. It also billed for nursing visits when patients were actually hospitalized. Another co-owner, a former DC taxi cab driver, was also convicted but did not appear at his sentencing and remains at large. Inspector General agents served a seizure warrant on the agency's bank accounts and thereby recovered approximately $38,000; the rest of the $100,000 has not been recovered.

Our investigators are currently working on numerous other cases. In one case, the loss for one year is estimated at over $10 million and it appears unlikely that Medicare will ever recover the loss.

Inappropriate Bankruptcy Protections

Even if a home health agency still has assets after filing for bankruptcy, under current law health care providers can use the protections afforded by the Bankruptcy Code to avoid the imposition of administrative sanctions or collection of Medicare overpayments. Specifically, providers can make strategic use of two devices -- the *automatic stay* and the *discharge* provisions of the Bankruptcy Code. Under the automatic stay provision, providers can respond to the threat or imposition of an administrative sanction by filing a petition in bankruptcy and then asserting that the automatic stay bars any further sanction activity. Indeed, in 1995, the U.S. Bankruptcy Court in the Eastern District of Pennsylvania found the Department of Health and Human Services in contempt for violating the court's automatic stay after DHHS sought to exclude a podiatrist who refused to repay his Health Education Assistance Loan. Under the discharge provision, the home health agency can assert that any overpayment or civil monetary penalty due to the Medicare program is discharged and does not survive the bankruptcy proceeding.

It is thus still possible for wrong doers to use bankruptcy protection as a way to avoid responsibility for repayment of overpayments, fines, or penalties and in some cases even circumvent a program exclusion. The cases we deal with are not those where a legitimate business declares bankruptcy because of unfavorable economic or business conditions. Rather, the bankruptcy is used subsequent to a fine or penalty to allow the agency to avoid completely any financial responsibility for wrong doing. We are also concerned about using the bankruptcy law to prevent the Secretary from suspending Medicare payments to a provider under investigation for fraud.

Recent Initiatives to Reduce Fraud and Abuse

Over the past year, we have emphasized that structural reforms alone will not be enough to prevent the fraud and abuse that is at least partially to blame for losses which this program is experiencing. It is also necessary to keep unsuitable home health care providers from participating in the program as well as to improve program controls that will prevent inappropriate expenditures while ensuring the availability of services and the quality of care. In addition to improved payment controls, we recommended that HCFA develop and implement program safeguards that would 1) strengthen its ability to identify potentially problem providers, 2) prevent unsuitable home health agencies from entering the program, and 3) prevent the Medicare trust fund from incurring further losses due to the activities of exploitive home health agencies.

The Balanced Budget Act, signed into law August 5, 1997, contains a number of important provisions to help prevent Medicare fraud and abuse and to promote responsible program enforcement. These measures, which include moving to a prospective payment system, will help to control the rapidly growing cost of home health benefits. Additionally, the Secretary has recently made significant changes to program operations to crack down on abuse in home health. All of these actions are consistent with and responsive to our past recommendations. The combined impact of enactment of the new legislation and strong administrative actions should go a long way to address problems in the home health industry.

Prospective Payment System

The most fundamental reform brought about by the Balanced Budget Act is the establishment of a prospective payment system for home health. We have been, and continue to be, strong advocates of such a system. The Act gives the Secretary of HHS authority to establish a prospective payment system for home health services. Instead of open-ended billing, HCFA will determine, in advance, what it will pay for a unit of service, how many visits will be included in that unit and what mix of services will be provided. Payment for a unit of home health service will be modified by a case mix adjustor to account for variations in cost due to differences in patient case-mix. Under this system, it will no longer be profitable for home health providers to provide unneeded services. Upon implementation of the prospective payment system, periodic interim payments will be eliminated.

Enrollment of New Providers

Legislative Changes. The Balanced Budget Act addresses a number of serious vulnerabilities in the process of enrolling home health agencies into the Medicare program. For example, it authorizes the Secretary to collect Social Security numbers and Employer Identification numbers from providers. The OIG, HCFA, and the GAO have been in general agreement in recent years that this authority is critical to monitor provider billing activities effectively and to keep excluded or other problematic providers from coming back into the program under the cloak of new business arrangements.

Additionally, the new law authorizes HCFA to refuse to enter into contracts with felons. The Secretary could stipulate, for example, that individuals convicted of embezzlement not be allowed to enroll as a Medicare provider even if the conviction did not occur in connection with a health care business. The OIG will also be able to exclude from the Medicare program entities owned or controlled by the family or household members of excluded individuals. For example, some excluded providers have been able to escape the impact of their sanctions by expediting transfers on paper of their ownership and control interests in health care entities to family or household members while retaining true, silent control of the businesses. We were also pleased to see the new "Three Strikes, You're Out" provision that mandates a lifelong exclusion from participation in any Federal health care program for any provider who is found guilty of health care fraud for the third time.

Administrative Remedies. From September 15, 1997 until January 13, 1998, the Administration placed a moratorium on admitting new agencies into the Medicare program. The moratorium was called in response to reports of "the steadily increasing volume of investigations, indictments, and convictions against home health agencies." The moratorium was intended to stop the admission of untrustworthy providers while HCFA strengthened its requirements for entering the program. HCFA used this time to develop the new surety bond regulations (as mandated by the Balanced Budget Act), capital requirements to ensure adequate operating funds, and procedures to better scrutinize the integrity of home health agency applicants. Prior to the moratorium, Medicare was certifying an average of 100 new home health agencies each month.

The Department has also proposed a requirement for home health agencies to re-enroll in Medicare every three years. As part of the re-enrollment process, agencies will be required to

submit an independent audit of their records and practices. If the agency does not meet the strict new enrollment requirements, they will not be renewed as providers in Medicare. This will help to detect fraudulent practices. Additionally, HCFA now requires agencies to serve a minimum of 10 private-pay patients prior to seeking Medicare certification. Serving private-pay patients will demonstrate experience and expertise in the field before an agency is allowed to serve Medicare and Medicaid's vulnerable populations. Further, HCFA will increase the number of claim reviews from 200,000 per year to 250,000 and the number of home health agency audits will double.

One key change that has been implemented by HCFA is a requirement that home health agencies supply information about related businesses they own. Often, unscrupulous home health agencies funnel fraudulent activities through subsidiaries or front companies that don't really exist. Home health agencies are also required to provide information pertaining to individuals and entities deriving financial benefit from the Medicare program. For example, information is required as to the identity of each person with an ownership or control interest in the enrolling entity or in any subcontractor that the enrolling entity has a direct or indirect ownership interest of 5 percent or more. Similar information is required for managing and directing employees. Home health agencies will have to file the form for the every-three-years recertification HCFA is planning.

Regional home health intermediaries will now be required to develop information systems which will enable them to scrutinize related business interests far more closely than in the past. For example, intermediaries will check on the accuracy against information such as state and local business registrations, bankruptcy, lien and judgement records. A history of related business problems, including bankruptcies, serious legal actions, felonies, a lack of business activity and slow payment to creditors would trigger medical reviews or audits of the home health agency in question and effectively serve to screen out prohibited providers. Knowing that a related business has a history of bankruptcy, for example, could help HCFA make certain the home health agency doesn't walk away from an overpayment debt owed Medicare.

Surety Bond Requirement

To establish the financial stability of home health providers serving Medicare and Medicaid patients, and to implement the Balanced Budget Act mandate, HCFA issued its final rule requiring surety bonds for home health agencies on January 5, 1998. This rule requires home health agencies to post a bond obtained from an acceptable authorized surety company in an amount that is the greater of $50,000 or 15 percent of the annual amount Medicare pays the home health agency as reflected in the home health agencies most recently accepted Medicare cost report. The 15 percent standard was adopted to allow HCFA more protection by permitting it to apply the standard to more recent payment history. Additionally, HCFA has the option to substitute the amount of prior overpayments as the bond amount when the overpayment amount exceeds 15 percent of payments. In addition to the surety bond requirements, a home health agency entering Medicare or Medicaid on or after January 1, 1998 must demonstrate that it actually has available sufficient capital to start and operate the home health agency for the first three months. In the final rule, HCFA said that it also intends to explore the possibility of allowing home health agencies to furnish a government security in lieu of a surety bond, as authorized by the Department of Treasury regulations.

The Florida Medicaid program has experienced success with its required $50,000 compliance type surety bond. Such a bond guarantees compliance with the rules and regulations mandated by the Medicaid Provider Agreement. All home health agencies operating less than one year, brand new enrollees and home health agencies with a history of "questionable claims" were required to obtain a surety bond as part of this re-enrollment process. The State claimed that this approach has worked as an effective screening mechanism to weed out unscrupulous providers. State budget officials estimate that the surety bond requirement, combined with additional anti-fraud measures, resulted in savings of almost $200 million over a two year period for Florida. According to the Florida Agency for Health Care Administration, the number of Medicaid home health agencies declined by 32 percent as a result of the State's initiatives. However, the State of Florida has received no complaints from physicians regarding access to care problems.

As designed, the Medicare home health surety bonds are considered financial guarantee bonds which obligates the surety to pay a certain amount of money if the home health agency does not perform its obligation. The bond must guarantee that within 30 days of receiving written notice from HCFA of an unpaid claim or unpaid civil money penalty or assessment, the surety company will pay HCFA, up to the stated amount of the bond, the full amount of the unpaid claim plus accrued interest and the full amount of any unpaid civil money penalty or assessment imposed by HCFA on the home health agency plus accrued interest. These types of bonds are considered hazardous and must be carefully underwritten. If an underwriter is unable to approve a bond request based on the qualifications given by the home health agency, the company may suggest depositing some form of collateral as an inducement to write the bond.

On June 1, 1998, HCFA revised the regulation to address concerns by the surety industry that they could assume high financial risk because of the uncertainty of the scope of their liability under the regulation. On June 26, 1998, HCFA announced that it would suspend the surety bond regulations and await the findings of a General Accounting Office investigation on surety bonds for home health agencies.

DURABLE MEDICAL EQUIPMENT

The situation with durable medical equipment suppliers is also risky for the Medicare and Medicaid programs. In December of last year we issued a report entitled "Medical Equipment Suppliers –Assuring Legitimacy." This report summarized the results of unannounced visits which we made to a sample of medical equipment suppliers who had recently received Medicare billing numbers or had open applications for them. This review was carried out in the 12 large cities in California, Florida, Illinois, New York, and Texas (except Miami where previous studies had already revealed serious problems). We discovered that 31 out of the 420 approved suppliers and 4 of the 35 new applicants did not have the required physical address. Some addresses were for businesses that had closed, some without leaving behind any forwarding address or other business information. For example, one landlord told us that a pair of physicians had suddenly closed their office and vanished, breaking their lease. Others had highly questionable addresses. Residents near the listed address were unable to say whether or not a supplier had ever been located there. For example, in Brooklyn, New York, a supplier's address shown on the application form was in a building that consisted of four apartments over a Laundromat. The DME company name was not shown on mailboxes or other parts of the

premises. Two residents of the premises said they had not heard of the supplier. One of the tenants said the Laundromat space was formerly used as a "post office box operation."

Twenty percent of the suppliers were absent from their business addresses at the time of our inspection. In many of the businesses where we were able to interview a representative we found obvious failures to meet at least one Medicare supplier standard. For example, 45 percent provided no consumer information, 20 percent did not allow for return of unsuitable items, and 17 percent did not provide for warranty repairs.

The ease and low expense of acquiring a Medicare supplier number presents vulnerabilities for both the Medicare program and its beneficiaries. There is no investment required for many supplier operations, and at the time of our study there was little verification of application information. Applicants needed no credentials and were not required to have any experience with medical equipment to obtain a supplier number. There was no requirement to formulate a business plan or demonstrate intent to service Medicare beneficiaries. For example, a Florida souvenir dealer whose shop is in his garage applied for and received a Medicare supplier number. His main business included stuffed alligator heads, alligator skin wallets, and stuffed turtles. He decided to add wheelchairs, lift chairs, and hospital beds to his line of business. He had no experience or credentials in the medical supply field. At the time of our visit he stated that he had submitted only one bill to Medicare. Situations like this are not good for Medicare or its beneficiaries.

Based on this and other studies of durable medical equipment, we have made a number of recommendations to prevent illegitimate businesses from participating in the Medicare program. These include proposals regarding surety bonds, application fees, site visits, training for new suppliers, purging of unused Medicare supplier numbers, requiring applicants to provide Social Security and tax identification numbers, improved enrollment forms and processes, and a 6-month delay in re-application for those who are denied billing numbers for cause. The Balanced Budget Act requires surety bonds for Medicare and Medicaid medical equipment suppliers. The requirements are nearly identical to those for home health. HCFA issued for comment a proposed regulation for surety bonds for Medicare medical equipment suppliers in March of this year.

NEED FOR SURETY BONDS

The new initiatives of both the Congress and the Administration will go a long way to solving the serious problems that have plagued Medicare's home health and medical equipment benefits. Both are to be commended for the boldness of their actions. Unfortunately, in the absence of the surety bond requirement, these actions do not go far enough to adequately protect the Trust Fund.

In underwriting traditional insurance products, the goal is "spread of risk." In suretyship, surety professionals view their underwriting as a form of credit so the emphasis is on prequalification and selection. The following basic factors are taken into consideration in some format. 1) Capacity: Does the applicant have the necessary skill and ability to perform the obligation; 2) Capital: Does the financial condition of the applicant justify approval of the particular risk; and, 3) Character: Does the applicant's record show him to be of good character and likely to perform the obligation he assumes? Since surety companies want to be certain that providers fulfill their

promises, less reputable home health agencies are not likely to qualify for a surety bond. This pre-qualification process is a valuable service provided by surety companies. For example, a surety company would have been reluctant to bond the two former convicts whose home health agency, formed after their release from prison, collected $5.6 million from Medicare and then went out of business.

Further, as I noted earlier, HCFA has been limited in its ability to detect inappropriate payments; therefore, overpayments to fraudulent providers as well as to those simply with little financial backing may have already exposed the Trust Fund to substantial losses. In this testimony, I have identified examples of both the most egregious as well as the more common types of cases we have worked on. Losses stemming from the behavior of individual home health agencies and medical supply companies can be in the hundreds of thousands and even millions of dollars. In such cases, a $50,000 bond would have provided little deterrent to abuse and would offer little with which to offset losses. Indeed, in some cases $50,000 would be a small drop in the bucket.

For example, consider a home health agency with Medicare payments of $3.5 million and overpayments of $485,000, all uncollected. A $50,000 surety bond would have reduced this loss to Medicare only slightly. If the bond were written for 15 percent of the $3.5 million, Medicare's loss would have been eliminated entirely.

Prior to the suspension of the home health surety bond requirement, approximately 40 percent of Medicare home health agencies were able to obtain bonds. If private creditors are unwilling to provide credit to home health agencies without adequate financial backing, is it appropriate to ask our taxpayers to step in and do so? There must be a middle ground, where legitimate home health agencies can survive and compete in the marketplace, and where the Trust Fund is protected from fraud and abuse. We must find a way to provide quality home health care to those in need while not simultaneously funding the lavish lifestyles of those who would abuse the program. Surety bonds are an excellent way to do this. However, because of industry concerns over particular elements in the surety bond rules, HCFA suspended the surety bond regulation while these problems can be worked out.

We recommend the following general principles in redesigning the surety bond rules:

- All home health agencies and durable medical equipment suppliers should be required to obtain a surety bond.

- The amount of the bond should be sufficient to discourage fly-by-night providers from entering the program and provide for some continuing financial protection to the Trust Fund from risks inherent in this program.

- The amount of the bond should be related to the experience of individual home health agencies or medical equipment suppliers as well as to these industries as a whole. For example, if a home health agency has a history of overpayments, the amount of the bond should be no less than the home health agency's recent overpayments.

- The surety bond rule should be subject to periodic evaluation to gauge its effect on the Medicare program and its beneficiaries and service providers.

Beyond these general principles, we recognize that many important details need to be worked out. I look forward to working with the Congress, the Administration, and the industry in designing a fair and effective surety bond requirement.

In closing, I must reemphasize our belief that surety bonds are an essential tool in reducing the inherent vulnerabilities in the Medicare and Medicaid home health and medical equipment benefits. This concludes my prepared statement. I welcome any questions that you may have.

Mr. SHAYS. I want to recognize two other outstanding members of our subcommittee, Mr. Snowbarger, who is the vice chairman, and Mr. Kucinich. We are prepared to ask questions.

Do you want to make an opening statement?

Mr. SNOWBARGER. No.

Mr. SHAYS. I am actually going to begin, Mr. Grob, and ask you—first, I am going to come right down to this point. I first need to know what surety bonds would actually do and how they would, in fact, be a protection. And in that case, once I clear that hurdle, I agree there has to be some kind of a middle ground, and my sense would be the purposes of the committee would be to find that middle ground.

Also, I am going to jump in and say that we need to find a way to deal with the very real problem that Mr. Towns talks about, that we need to make sure that there is entry into this field by minorities and other entrepreneurs who really could make a good go of it but are prevented by all of the rules and regulations.

If I turn to page 5 of your statement, you give examples, and let's take the two men who are felons. First off, I am willing to say to you that, once you serve time in jail and you have paid your debt to society, you have a record and you have to live with that record, but I do believe people should be able to rebuild their lives. But, obviously, there are indications of past conduct which should have some impact.

How would a surety bond have saved us money? Give me an example of how we would have gotten more back. Tell me the impact of the surety bond in each of the cases.

Mr. GROB. One example can be used to illustrate it. First of all, if I could establish kind of a principle that I would have in the back of my head which is that it has been extraordinarily difficult for the government to administer programs that detect the business worthiness, the business readiness of people who participate in our various programs and that an approach that might work in this case is to rely on the private sector to do that. That is one concept, and it is not something that everyone would agree with, that the Federal Government might not want to allow in its programs people whose competency is not good enough to allow them to compete in the private sector.

Mr. SHAYS. One of your points, and I am only going to allow myself 5 minutes, but in some cases they would not get a bond and they don't deserve to get a bond, and that becomes one way of filtering out?

Mr. GROB. That's right.

Mr. SHAYS. Let's say that these two gentlemen were able to get a bond?

Mr. GROB. The surety company might have noticed that they were felons and might not have wanted to give them a surety bond.

Mr. SHAYS. Non-felons can also do crooked things.

Mr. GROB. Second, there are lots of ways to design a bonding requirement, but the way that we understood the bonding requirement to be designed was that we would have been able to recover from the bonding company up to 15 percent of that company's expenditures from the previous year if we had not been able to recover it from them through the recovery of overpayments.

Mr. SHAYS. You got $300,000, and how much did they owe you?

Mr. GROB. Four or five million. They received about $5 million. So if someone can help me with the math, 15 percent of that is—who is good at this? So we could have received up to $750,000 from the bonding company had those rates been in effect.

Mr. SHAYS. Ms. Thompson, you have been in for only 2 months now, as you pointed out. What is the position of HCFA as it relates to this, as specifically as you can tell me, on surety bonds? Do you advocate it? Do you have questions about it?

Ms. THOMPSON. We think that it is an appropriate protection for the program to engage in to make sure that we are doing business with people who are not engaging in fraudulent practices, who are not unscrupulous, who are not irresponsible and can pay back money to the government if they receive it improperly through improper claims or inaccurate information submitted in order to get a periodic interim payment.

Mr. SHAYS. I'm going to go to Mr. Towns. Thank you.

Mr. TOWNS. Thank you, Mr. Chairman.

You know, when the bond idea was first proposed, I expressed concern that this would adversely effect small and minority businesses. I know that you are familiar with the letter from the Small Business Administration Office of Advocacy that expressed the opinion that small businesses will be adversely effected by a bond requirement. Would both members of the panel care to comment on the possibility that small businesses will be adversely effected?

Ms. THOMPSON. I would be happy to comment on that. I think that is an issue that we are very concerned about as well.

One of the things that we did when we started to track who got bonds was to track that by type of business, and we looked very closely at agencies that had less than $200,000 worth of revenue from the Medicare program. Those are very small businesses, and we wanted to see whether they were able to obtain bonds.

They were able to obtain bonds—about 35 percent of them were able to obtain bonds as opposed to about 40 percent of the larger agencies in general. So they were a little less likely to be able to obtain a bond, but there was still a significant portion which did obtain a bond.

We have also heard that the Small Business Administration has a subsidy program for small and minority-owned businesses that must obtain surety bonds, but I think that we believe that legislation will be necessary for Medicare bonds, and this is an area where we need to get more information, and it would be helpful for GAO to look at this issue during the course of their review.

In particular, I would suggest that they look at the very small agencies that were able to obtain bonds and compare them to the very small agencies that did not obtain bonds and try to determine what the characteristics were of those agencies.

Mr. TOWNS. Thank you.

Mr. Grob.

Mr. GROB. We share the same concerns. We all have an interest in seeing that there is a home health care program and everyone qualified to provide the services be allowed to do it. It is a dilemma because the program, as designed, makes it easy for people who are disreputable to make an application and receive funding through it

and then to run away from their responsibilities, and almost always these programs would be small when they start.

So if we are successful in preventing the disreputable companies from joining or staying in the program, they will be small businesses that will be affected.

So I think there is no question that small businesses will be affected by the bonding requirement, and I think the statistics to date show that they were having a harder time getting the bonds. The larger ones might be associated with hospitals and have capital that the surety companies can fall back on, and they might have other businesses. They might have been in business a longer time and the surety companies felt more comfortable offering bonds to them.

There is no question this is a special concern for small businesses, and the dilemma we have is to find a way to do it so that those that are reputable and responsible and capable can participate and those trying to get a free ride and free money don't get in. We have to figure it out.

Mr. TOWNS. Thank you, Mr. Chairman.

I would like to enter a copy of a letter from the Office of Advocacy in the record.

Mr. SHAYS. Without objection.

[The information referred to follows:]

April 15, 1998

Health Care Financing Administration
Department of Health and Human Services
Attn: HCFA-1152-FC
P.O. Box 26688
Baltimore, MD 21207-0488

Re: Regulatory Flexibility Act Requirements; Petition for Amendment of the Final Rule on Surety Bond and Capitalization Requirements for Home Health Care Agencies; 63 Fed. Reg. 292 (January 5, 1998); 63 Fed. Reg. 10,730 and 63 Fed. Reg. 10,732 (March 4, 1998); File Code HCFA-1152-FC.

Dear Dockets Management Clerk:

On January 5, 1998, the Heath Care Financing Administration (HCFA) published a final rule with comment period concerning surety bond and capitalization requirements for home health care agencies (HHAs). This regulation implements the surety bond requirement for such agencies established in the Balanced Budget Act of 1997 (BBA). The regulation also imposes additional minimum capitalization requirements on the agencies and includes an additional 15 percent surety bond requirements not contained in the BBA. The goal of the BBA and this final rule is to reduce Medicare/Medicaid fraud by regulating HHAs that do not or cannot reimburse Medicare/Medicaid for overpayments.

To address complaints by the surety bond industry and the HHA industry regarding the compliance deadline for obtaining surety bonds, HCFA published a final rule on March 4, 1998 deleting the February 27, 1998 effective date for all HHAs to furnish a surety bond. The new compliance date is on or about April 28, 1998, or 60 days after publication of the final rule.

In addition, to address complaints by the surety bond industry and members of the Senate Finance Committee regarding the potentially unlimited liability of sureties under the final rule, HCFA published a Notice of Intent to Amend Regulations on March 4, 1998 (concurrently with the final rule to extend the compliance date). The notice announces HCFA's intent to amend the final rule so as to limit the surety's liability under certain circumstances. It also establishes that a surety will only remain liable on a bond for an additional two years after the date an HHA leaves the Medicare/Medicaid program; and gives a surety the right to appeal an overpayment, civil money penalty or an assessment if the HHA fails to pursue its rights of appeal. HCFA claims that the changes will help smaller, reputable HHAs, like non-profit visiting nurse associations, to obtain surety bonds.

The Office of the Chief Counsel for Advocacy of the U.S. Small Business Administration was created in 1976 to represent the views and interests of small business in federal policy making activities.(1) The Chief Counsel participates in rulemakings when he deems it necessary to ensure proper representation of small business interests. In addition to these responsibilities, the Chief Counsel monitors compliance with the Regulatory Flexibility Act (RFA), and works with federal agencies to ensure that their rulemakings demonstrate an analysis of the impact that their decisions will have on small businesses.

The Chief Counsel has reviewed the final rules in the instant case and has determined that HCFA has not adequately analyzed the impact on small entities. This determination does not mean that regulating the problem of fraud and abuse is not an important public policy objective. Nor does it mean that small business interests supersede legitimate public policy objectives. Rather, the determination is based on the principle that public policy objectives must be achieved by utilizing recognized administrative procedures. The purpose of the procedures is not to place an unnecessary burden on federal regulatory agencies, but to ensure the promulgation of common

sense regulations that do not unduly discourage or destroy competition in the marketplace.

The final rule is troubling for a number of reasons: 1) The proposal, although probably within HCFA's regulatory and statutory authority, goes far beyond the requirements contemplated by Congress when they enacted the BBA; 2) HCFA's good cause exception and waiver of the proposed rulemaking may be arbitrary and capricious under the Administrative Procedure Act (APA); and 3) Nearly all of the significant procedural and analytical requirements of the RFA were overlooked.

Action requested: Inasmuch as the rule is now final and in effect, the Chief Counsel of the Office of Advocacy herewith petitions the agency, pursuant to 5 U.S.C. § 553(e), to amend the final rule to exclude the provisions concerning the 15 percent bond requirement and the capitalization requirement until such time as a proper and adequate analysis can be prepared to determine the impact on small entities.

I. Legislative History and Intent

Prior to August 5, 1997, there were no provisions in the law pertaining to a surety bond requirement for home health agencies. Under the House bill (The Balanced Budget Act of 1997, H.R. 2015), there remained no provisions for the surety bond requirement. Under the Senate bill (as amended) (S. 947), a requirement was introduced to provide state Medicaid agencies with surety bonds in amounts not less than $50,000. Finally, in the conference agreement, the final bill was modified to require a surety bond of not less than $50,000, or such comparable surety bond as the Secretary may permit (applicable to home health care services furnished on or after January 1, 1998).(2) Congress, therefore, intended there to be a $50,000 or "comparable" bond, but did not intend the bond to be higher. The surety bond issue had not been the subject of public hearings, and some members of Congress expressed concern about the potential impact of the fraud and abuse provisions.

According to a floor statement by Senator Hatch, the fraud and abuse provisions found in the amended Senate version were actually based on provisions contained in the Administration's fraud and abuse legislation introduced earlier in 1997, and on which no hearings were held in the Senate. Senator Hatch was concerned that the fraud and abuse provisions might have "unintended consequences or implications that would penalize innocent parties who are following the letter of the law."(3) He further stated that, "As a general rule, we in the Congress should not act without the full and open benefit of hearings so that all parties have an opportunity to comment, and so that legislation can be modified as appropriate."(4) With regard to the surety bond requirement, it seems that the affected business community had no real opportunity to provide meaningful input or comment.

After the legislation was enacted, HCFA had little choice but to implement the surety bond requirement. However, the agency created additional bonding and capitalization requirements and incorporated them into the instant final rule.(5) Not only were law abiding home health agencies denied an opportunity to comment during the legislative process, they are now faced with additional burdensome requirements effective almost immediately-with no true recourse (since the agency waived the notice of proposed rulemaking and the 30-day interim effective date).

Congress clearly intended to eliminate or reduce waste and fraud in the Medicare/Medicaid system and to preserve quality patient care. The presumably unintended effects of the legislation and HCFA's final rule are that legitimate, law abiding home health agencies will be forced to file bankruptcy, go out of business or curtail their business operations significantly. Patient care will likely suffer when there are not enough home health agencies to meet increasing public demand in an aging population. Moreover, the resulting lack of market competition and bloating of the large, hospital-based and government-based home health agencies may lead to increased prices.

II. Waiver of Administrative Procedure

An agency is subject to the notice and comment requirements contained in 5 U.S.C. § 553 unless the agency rule is exempt from coverage of the APA, or the agency establishes "good cause" for not complying with the APA and waives notice and comment. When an agency waives the notice and comment procedures required by the APA, however, there should be compelling reasons therefor. In fact, courts have held that exceptions to APA procedures are to be "narrowly construed and only reluctantly countenanced." *New Jersey v. EPA*, 26 F.2d 1038, 1045 (D.C.Cir. 1980).

In the instant case, the agency waived both the notice and comment requirement and the requirement to allow a 30-day interim period prior to a rule's effective date. The agency based its "good cause" waiver on three factors: 1) Issuing a proposed rule would be impracticable because Congress mandated that the effective date for the surety bond requirement be January 1, 1998-five months after Congress passed the BBA of 1997; 2) Issuing a proposed rule is unnecessary with respect to Medicare regulations because there is a statutory exception when the implementation deadline is less than 150 days after enactment of the statute in which the deadline is contained; and 3) A delay in issuing the regulations would be contrary to the public interest.

First, with regard to the impracticability of issuing a proposed rule, as a general matter, "strict congressionally imposed deadlines, without more, by no means warrant invocation of the good cause exception." *Petry v. Block*, 737 F.2d 1193, 1203 (D.C.Cir. 1984). In addition, there is no good cause exception where "an agency unwilling to provide notice or an opportunity to comment could simply wait until the eve of a statutory . . . deadline, then raise up the 'good cause' banner and promulgate rules without following APA procedures. *Council of Southern Mountains, Inc. v. Donovan*, 653 F.2d 573, 581 (D.C.Cir. 1981).

By way of example, in *Petry v. Block*, the court concluded that the passage of a complex and extraordinary statute concerning changes in administrative reimbursements under the Child Care Food Program that imposed a 60-day deadline for the promulgation of interim rules justified the agency's invocation of the good cause exception. Also, in *Methodist Hospital of Sacramento v. Shalala*, 38 F.3d 1225 1236, (D.C. Cir. 1994), the court stated that the agency had good cause to waive notice and comment because Congress imposed a statutory deadline of about 4 1/2 months "to implement a complete and radical overhaul of the Medicare reimbursement system." (Emphasis added). Moreover, "[o]nce published, the interim rules took up 133 pages in the Federal Register: 55 pages of explanatory text; 37 pages of revised regulations, and 41 pages of new data tables." *Id.*

In the instant case, HCFA had five months to implement a relatively simple provision to require a $50,000 or comparable surety bond from home health agencies. After HCFA added additional bond requirements and capitalization requirements (never requested or contemplated by Congress), the regulation took up 63 pages in the Federal Register: 18 pages of explanatory text, 6 pages of revised regulations, and 39 pages of application documents. The final rule appeared in the Federal Register on January 5, 1998-four days after the mandatory effective date.

The Office of Advocacy opines that if HCFA had not included the additional requirements, which were not intended by Congress, and therefore not intended to be implemented within the five month window, there would have been ample time to follow proper notice and comment procedures. Based on the circumstances of this rulemaking and pointed case law, HCFA cannot rely on the impracticability argument to demonstrate that it had good cause to waive notice and comment.

Second, HCFA also based its good cause exception to notice and comment on the fact that they have the statutory authority to do so with regard to this particular type of rule. The agency states:

"Issuing a proposed rule prior to issuing a final rule is also unnecessary with respect to the Medicare surety bond regulation because the Congress has provided that a Medicare rule need not be issued as a proposed rule before issuing a final rule if, as here, a statute establishes a

specific deadline for the implementation of a provision and the deadline is less than 150 days after the enactment of the statute in which the deadline is contained."(6)

HCFA cannot rely on this statutory provision because the agency has gone way beyond their statutory mandate in issuing this final rule. Again, Congress only intended there to be a $50,000 or comparable surety bond. Therefore, only those provisions contemplated by Congress should be subject to the statute that permits HCFA to waive notice and comment when the deadline is less than 150 days.

Third, HCFA claims that a delay in implementing the final rule would be contrary to public policy. Quite the contrary-implementing the final rule as written would be contrary to public policy. The final rule imposes serious economic burdens on an industry already under increased scrutiny and financial hardship including a recent moratorium on entrants to the Medicare program and repeated audits.(7) HCFA has also announced its intention to include home health agencies in the enormously complicated prospective payment system now used by hospitals and physicians. As such, availability of home healthcare for those communities not served by giant hospital-based providers will surely decrease. This result seems contrary to the stated public policy objective of Congress and HCFA.

Finally, it should be noted that HCFA did insert a post-effective date comment period in the final rule. However, the fact that HCFA attached a comment period to the final rule is not a valid substitute for the normal provisions of the APA. The third circuit stated that:

"[i]f a period for comments, after issuance of a rule, could cure a violation of the APA's requirements, an agency could negate at will the Congressional decision that notice and an opportunity for comment must precede promulgation. Provisions of prior notice and comment allows effective participation in the rulemaking process while the decision maker is still receptive to information and argument. After the final rule is issued, the petitioner must come hat-in-hand and run the risk that the decision maker is likely to resist change." *Sharon Steel Corp. v. EPA*, 597 F.2d 377, 381 (3rd Cir. 1979).

HCFA's waiver of administrative procedure would be less troubling if the rule were not so burdensome. By waiving notice and comment procedures, the agency conveniently removes itself from the obligation to carefully analyze and solicit input on the impact of the rule. Such an analysis could have yielded other, less burdensome alternatives that would have accomplished the agency's public policy objectives.

Since HCFA improperly waived notice and comment, the agency must comply with the Regulatory Flexibility Act.

III. Regulatory Flexibility Act Requirements

Even when a regulation is statutorily mandated, agencies are obligated by law to adhere to certain requirements prior to issuing the implementing regulations. Specifically, the RFA requires agencies to analyze the impact of proposed regulations on small entities and consider flexible regulatory alternatives that reduce the burden on small entities-without abandoning the agency's regulatory objectives. Agencies may forgo the analysis if they certify (either in the proposed or final rule) that the rule will not have a significant economic impact on a substantial number of small entities. Agency compliance with certain provisions of the RFA is judicially reviewable under section 611 of the RFA.

It is not clear from the instant rule whether HCFA has actually certified the rule pursuant to section 605(b) of the RFA or attempted a final regulatory flexibility analysis (FRFA) pursuant to section 604 of the RFA. In either case, the agency failed to comply with the requirements of the RFA.

HCFA expresses confusing "certification-like" statements throughout the text of the final rule.(8) However, the actual certification and statement of factual basis are not to be found in the final rule. If the agency was attempting to certify, then it did so erroneously for reasons discussed more fully below. On the other hand, perhaps HCFA did not intend to certify, but instead intended to prepare a FRFA. The agency did do some type of analysis: "we have prepared the following analysis, which in conjunction with other material provided in this preamble, constitutes an analysis under the [RFA]." 63 Fed. Reg. at 303. The problem with that declaration is that there is more than one type of analysis under the RFA. There is the preliminary assessment analysis which helps agencies determine whether to certify, and in the case of a final rule, there is a FRFA when an agency determines that certification is not appropriate. If HCFA was attempting a FRFA, then the FRFA was not adequate because it contained no analysis of alternatives to reduce the burden on small home health care providers. This, too, is more fully discussed below.

A. Certification

When an agency determines and certifies that a rule will not have a significant economic impact on a substantial number of small entities, then it is logical to assume that the agency has already performed some basic level of analysis to make that determination. *Will a substantial number of small entities be impacted?* In the instant case, the agency admits that all home health agencies will be affected. According to SBA's regulations, a small home health care agency is one whose annual receipts do not exceed $5 million, or one which is a not-for-profit organization.(9) Although the Office of Advocacy does not have data based on annual receipts, data is available based on number of employees. 1993 data obtained from the U.S. Bureau of the Census by the Office of Advocacy indicates that about 7% of home health care services (489 out of 6,928) have 500 or more employees and earn 51.2% of all annual receipts for the industry, 93% of home health care services (6,439 out of 6,928) have fewer than 500 employees and earn about 49% of all annual receipts for the industry, and 52.5% of home health care services (3,637 out of 6,928) have fewer than 20 employees and earn 6.3% of all annual receipts for the industry. Although it may be difficult to reconcile employment-based and receipt-based size standards, it is still fairly clear from the available data that a substantial number of small entities will be impacted by this final rule.

Will there be a significant economic impact? To determine whether the final rule is likely to have a significant economic impact, further analysis is required. It is not enough to claim that elimination of fraud and abuse in the Medicare/Medicaid system outweighs the need for further analysis. It is not enough to assume that only those agencies with "past aberrant billing activities" will be impacted. It is not enough to say that reducing a surety's liability means that there will not be a significant economic impact on home health agencies. The Office of Advocacy opines that the agency's "analysis" was doomed from the outset because of the agency's flawed assumptions about the number and type of small entities likely to be impacted, and about the cost of compliance.

Which small entities will be impacted? The agency did not take the basic and necessary step of adequately explaining why other small entities (presumably those whose billing practices are not "aberrant") will not be affected or whether small home health providers are even the primary offenders. At the least, the agency must consider the impact the bonding requirement will have on all small home health providers and not just the ones with "aberrant" billing practices. After all, the majority of home health agencies apparently do not have aberrant billing practices. HCFA presents evidence that, in 1996, Medicare overpayments were 7 percent of all claims paid to HHAs, and of that 7 percent, 14 percent remained uncollected by Medicare. Fourteen percent of 7 percent is .0098.(10) In other words, Medicare fails to collect overpayments less than one percent of the time. Despite this extremely low occurrence of failure to collect overpayments, HCFA deemed it necessary to place extremely costly and burdensome requirements on the entire industry. However, HCFA did not identify what percentage of the industry is contributing to the fraud problem, whether certain offenders were recidivist, or whether those offenders are primarily large or small.

With regard to the capitalization requirement, HCFA states that, "An organization that is earnest in its attempt to be a financially sound provider of home health services under the Medicare program will already be properly capitalized without the need for Medicare to require such capitalization." This statement is basically true. However, the issue of adequate capitalization is relative and fungible because it is based on a number of factors like varying overhead costs, location, profit margins, competition in the area, etc. Surely some home health agencies cannot meet the capitalization requirements set by HCFA, but desire to be "earnest" in their efforts to be "sound providers". The capitalization requirement is a barrier to market entry for all new home health agencies and not just the ones who enter the market for purposes of defrauding Medicare. A careful look at the questions like the ones raised in this and the preceding paragraph would have yielded a conclusion that the rule would have a significant economic impact on a substantial number of small businesses.

Congress weighed in on the issue of impact after the final rule is published. Even members of Congress recognized that HCFA went beyond its mandate and imposed a significant economic burden on home health agencies. Specifically, a bi-partisan group of three senators from the Senate Finance Committee, on January 26, 1998, asked HCFA to delay and modify the requirement that all home health agencies secure a surety bond. The Senators believed that home health agencies would not be able to obtain bonds by the original February 27 deadline. According to a recent news article, the senators reportedly wrote that:

"HCFA has imposed conditions that go beyond the standard in the surety bond industry. Some of the biggest problems include cumulative liability, a short period of time in which to pay claims, and bond values of 15 percent of the previous year's Medicare revenues with no maximum, the letter said.

'The cumulative effect is that many surety companies are opting not to offer bonds to Medicare[home health agencies] at all,' the letter said. 'Those companies which are offering the bonds are doing so at a cost which is prohibitive, or with demands for collateral or personal guarantees that HHAs cannot provide.'

The letter said Congress enacted the surety bond requirement to keep risky agencies out of the Medicare program. However, HCFA's rule seems to use the bonds as security for overpayments to providers, the letter said.

'We simply doubt that it is realistic to expect bonding companies to embrace a role as guarantors for overpayments from HCFA,' the senators wrote."(11)

It should be fairly obvious to HCFA, as it was to these members of Congress, that obtaining a $50,000/15 percent bond in addition to the 3-month reserve capitalization requirement (where there were no such requirements before) is likely to be prohibitively costly for small home health care providers-particularly new providers or providers operation only a few years that typically have few hard assets and relatively little credit.(12) Moreover, most home health patients are Medicare patients. If a home health agency is not Medicare certified, then it is very difficult to attract patients; and without patients, there is no opportunity to increase capital. There is already a requirement in many states (pursuant to "Operation Restore Trust") that home health agencies have a minimum number of patients prior to obtaining a Medicare license. How can these small home health agencies absorb losses on these ten patients (--possibly long term patients requiring multiple services several times per week--), never be reimbursed for services to these patients, and continue to raise capital? It's a vicious circle and there is a tremendous cumulative effect of all the various state and federal regulations. In any event, it seems that with only a cursory analysis and a little industry outreach, HCFA should have been able to determine that the final rule would have a significant economic impact on a substantial number of small entities. Therefore, under the RFA, HCFA should have prepared a final regulatory flexibility analysis with all the required elements for that analysis.

B. Final Regulatory Flexibility Analysis

The preparation of a FRFA may be delayed but not waived. Section 608(b) of the RFA reads:

"Except as provided in section 605(b) [where an agency certifies that there will be no significant economic impact on a substantial number of small entities], an agency head may delay the completion of the requirements of section 604 of this title [regarding the preparation of FRFAs] for a period of not more than one hundred and eighty days after the date of publication in the Federal Register of a final rule by publishing in the Federal Register, not later than such date of publication, a written finding, with reasons therefor, that the final rule is being promulgated in response to an emergency that makes timely compliance with the provisions of section 604 of this title impracticable. If the agency has not prepared a final regulatory analysis pursuant to section 604 of this title within one hundred and eighty days from the date of publication of the final rule, such rule shall lapse and have no effect. Such rule shall not be repromulgated until a final regulatory flexibility analysis has been completed by the agency."

FRFAs may not be waived because they serve a vital function in the regulatory process. The preparation of a FRFA allows an agency to carefully tailor its regulations and avoid unnecessary and costly requirements while maintaining important public policy objectives. Without a careful analysis-which should include things like data, public comments and a full description of costs-agencies would be operating in a vacuum without sufficient information to develop suitable alternatives.

Since the agency did not issue a proposed rule, the agency had an obligation to consider carefully all of the significant comments regarding the impact of the final rule. After all, the agency was apparently unsure of the impact.(13) The congressional letter should have been some indication that there would be a significant economic impact and that further analysis was required. HCFA did extend the deadline for obtaining a surety bond for 60 days, and in some ways limited the liability of sureties. However, the agency did not change the bond or capitalization requirements, or explain why such changes were not feasible. Inasmuch as the agency failed to heed any of the comments regarding impact-even those from Congress-the comment period served no real function here.

The dearth of information regarding less costly alternatives is possibly the most serious defect in the analysis presented. To begin with, HCFA never demonstrated why the $50,000 bond was insufficient or would not accomplish the objective of discouraging bad actors from entering the Medicare program. The agency did not demonstrate why the 15 percent rule would not cause a significant economic impact-particularly when the $50,000 bond amount changed from a maximum level to a minimum level. There is no evidence that HCFA attempted to find less costly alternatives. Before heaping on additional regulations, would it not be prudent to first determine whether the programs and policies recently put in place by the Administration, and the prospective payment rules yet to come will work?

IV. Conclusion

Not everyone in the home health industry is a bad actor. More importantly, home health providers that cannot afford to comply with HCFA's regulations are not necessarily bad actors either. HCFA has twisted Congress' intent and changed the rule into a vehicle for punishing legitimate home health agencies and for securing overpayments by Medicare rather than a vehicle to discourage bad actors from entering the Medicare program. There must be a middle ground-a place where legitimate home health providers can survive and compete in the marketplace, and where fraud and abuse can be controlled. This final rule is not that place.

Therefore, the Office of Advocacy petitions HCFA to amend its final rule to remove the 15% bonding requirement and the capitalization requirement until such time as proper notice and comment procedures can be completed. Thank you for your prompt attention to this urgent

Mr. TOWNS. I am concerned about the capitalization requirements. I don't believe that being well-financed means that you can deliver excellent service. Can the panel explain the relationship between capitalization and delivery of service?

Ms. THOMPSON. One of the reasons why we wanted to have a capitalization requirement for new agencies entering the program was because we were concerned that if revenues did not come into that agency as expected that that would disrupt patient care.

As an agency begins to do business in the home care industry, it is going to anticipate that a certain volume of patients will be served, and many of its revenues may come from the Medicare program. Our concern was, if there wasn't a basic initial capitalization of those companies, a very small amount, 3 to 6 months worth of capitalization, that if the volume of patients did not materialize as expected that the patients being cared for by that agency would be severely harmed. Either there would be significant reductions in the staffing, reductions in the amount of services that were being provided to them, or the agency would discharge them.

Mr. TOWNS. I am concerned that HCFA may have declared war on the home health industry. Can you tell the committee about the moratorium and would it really avoid waste, fraud and abuse?

Ms. THOMPSON. There are a number of concerns about all of the activities that we are taking with regard to home health, and I think that certainly has created a very challenging environment for home health providers and for the agency to administer.

We are making payment reforms. We are changing our enrollment standards, the way that we do survey and certification. And then we are trying to proceed to implement a surety bond requirement requiring capitalization, requiring a patient load to be administered before a home health company can come into the program.

Clearly, these are a long list of changes that are affecting the home care industry. I think that it is worth noting that when we proceeded with the moratorium and the Secretary announced it, she made clear that she considered this to be an unprecedented step by the Department. I don't know that we have ever done anything like that before.

And the concern was that, because of the amount of information that we had about improper payments, whether they be based on fraud or whether they be based on all of these other factors that Mr. Grob has noted and the unsustainable growth of the amount of payments made under the program, we felt the entire benefit was at risk. The Secretary said that. The administrator said that. We felt that we needed to take strong and unprecedented action to make sure that we had this home health benefit in the program and that we had it for future Medicare beneficiaries.

Our goal is not to initiate war with home health agencies. They are our partner in providing necessary home health care to beneficiaries, but our goal is to preserve the program.

Mr. TOWNS. Thank you. Keep in mind there are big crooks and little crooks.

I yield back, Mr. Chairman.

Mr. SHAYS. There is an unprecedented amount of overpayment and waste, and we see gigantic growth in this industry. We are

going to pursue this as a subcommittee and try to nail this down as to why we are having a problem.

Mr. Pappas.

Mr. PAPPAS. Thank you, Mr. Chairman.

I think both or at least one of you threw out some figures, 20 percent in one State, 40 percent, and there were several other figures thrown out there. Can you tell us how many claims were reviewed, what regions of the country?

Mr. GROB. There were several different studies and each of them follows a standard pattern for doing these audits. Let me take the big one, which was the four-State audit in Texas, California, New York and Illinois.

That was—there were about 3,500 services that were examined, coming from 250 claims that were randomly drawn. The sampling precision for that particular study, because the number of services which was the unit of analysis was so large, well over 3,000, was plus or minus 3 percent. It is one of the more precise surveys that we have done. Ordinarily, in audits we may look at 100 claims with the services, and this was 250. It gave us a lot more precision. So from a sampling point of view it was rather precise.

The other question that might be raised about it is how accurate was the information that we gathered. Because if you look at the Medicare statistics and the payments that are made by the contractors to the industry, you see that they generally pay most of the claims. They don't deny most of the claims just because they are doing it based on the evidence given to them when the claim is presented.

What we did in our work, we went out into the field. We talked to the patients. We talked to the physicians. We had medical experts look at their medical records. So we had a much closer look at this than would ordinarily be had, and so we found a much higher error rate than if you were just looking at the paper.

In the Chief Financial Officer's audit we found that HCFA correctly paid 98 percent of the claims, but when we looked behind them, we found error rates of 11 and 14 percent across the board in the Medicare program for pretty much the same reason.

Mr. PAPPAS. Any of these that were among those 3,500 services or 250 claims, were any of those appealed and were there any reversals or any denials?

Mr. GROB. I don't know the state. They were randomly drawn, so each one could be allowed to be appealed. It is true that we picked this up at the point where the payment had been denied. If any of them are under appeal, it is possible that the final decisions could be lower.

Mr. PAPPAS. So if the final decision was different, than the error rates may differ from what you are originally stating?

Mr. GROB. It is conceivable that they could be lower.

In some of the other studies where this has happened given the evidence in the studies, the appeals do not overturn the decisions. If you look at the experience in the Medicare program, you see when the providers appeal the decisions, a certain number of them are overturned. But, again, the difference that we have with what we are doing here, we have a lot of evidence on the ones because

we are so intense in our review, so they are not as likely that they will be overturned because of the evidence that we have.

Mr. PAPPAS. Are there any differences between the for-profit and nonprofit in the reviews?

Mr. GROB. We did not make those distinctions. We randomly drew the claims, and the sample was not large enough for us to make those distinctions with precision.

What we found in some studies earlier that we had done—and I am not going to claim that the studies were an indication of fraud and abuse—but where we saw a very rapid increase in the number of claims, where we saw an above-average number visiting the homes and being reimbursed, we tended to find these in the free-standing for-profit a bit more than those attached to a hospital or large institution. So the entrepreneurial spirit we believe may be accounting for some of that.

Mr. PAPPAS. Were there any realizations through your study that some of these errors may have been unintentional violations of applying regulations which obviously are complex and error rates—if you can elaborate on that. Are some of them misdirected resources or are some of them actual, conscious decisions to defraud Medicare?

Mr. GROB. In our investigations, those are clearly demonstrated to be deliberate and systematic. In these audits that we do, we don't make a judgment about that. It is conceivable that these could be due to errors.

The spectrum I use is innocent errors, incompetent management, irresponsibility or recklessness, abuse and exploitation or outright fraud. And we can't tell from the audits where they lie in that spectrum, but we know that people lie across that spectrum.

Our concern is that it hardly matters in the end, if 40 percent should not have been paid. We are paying something that we should not have paid for. Let's suppose that they were all innocent errors. I am not comfortable that we would misspend 20 to 40 percent of my money because someone made mistakes.

Mr. SHAYS. Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman.

I would like to followup on this discussion. To give you my experience from Maine, from the agencies that I talked to, what strikes me is that this surety bond, however much sense it may make in trying to stop new agencies who may be at risk when applied to nonprofits who have been in existence for years who can't put—who can't recover the cost of the bond in their—as part of their reimbursement, it is simply a financial burden that seems to make no sense, and that is really what I am hearing. And I wanted to followup, Mr. Grob, with your comment.

There is a difference, it seems to me, between nonprofit agencies or agencies that have been in the health care business for a substantial period of time and people who are coming into this arena to make money. And whereas in one case the for-profits—I don't know if this is your experience or not—the for-profits coming in as they do with some capital and intending to make money, it seems to me may be better able to bear the cost of a surety bond than some of the nonprofits. I'm not sure about that. But, at the same time, they may be the ones where HCFA should be most concerned

about. I am wondering if—I would be interested in your assessment of the different types of players in this field.

And then the followup question, of course, is can the surety bond requirement be structured in such a way to reflect some of those differences so that we are not—we are putting the burden where it should be placed and not on every agency across the board?

Mr. GROB. I don't want to use up all of your time, so I will try to make my philosophical meandering as short as possible.

We were concerned about that distinction, and we ran it in the earlier study. There was less of a growth among the more traditional nonprofit agencies. It was the entrepreneurial ones where we saw the growth spurt and more home health aides as opposed to skilled nursing care. As far as, is there a way to distinguish, I don't think the distinction is really so much the nonprofit versus for-profit as it is could you really tell who is reputable or not. That is where we have the problem.

If we had a way of knowing that an agency was not ripping us off and was responsible, then I think the amount of the bond could reflect that, or even the existence of the bond. The trouble is, how do you know, because the standard mechanisms that we have don't seem to get deep enough. It is a problem. If we could solve that problem, then I think we could make those distinctions.

Mr. ALLEN. How about history? Suppose you had no problem with an agency for 2 to 5 years, can you reduce the requirement of the bond or eliminate it based on past history?

Mr. GROB. That, I think, makes a lot of sense to consider that. There remains a problem which is, even over a long period of time, we can't always tell. An investigation usually takes 3 to 5 years to conduct. So if you need to prove that somebody is doing something deliberately, you can't run the program that way. It is not a good structure to do it.

But if there were a way—see, another problem, people may have overpayments that are not intentional. They are not really to be penalized either. But the measures we have right now are not reliable enough because they are based on the papers and there is not enough background. Whenever we have looked behind it, we have found a lot more going on.

I think the points you are raising are very important and are really things that need to be considered in this moratorium that we are having now, where we have the opportunity to look over this policy.

I would like to put on the record, in the past when I have made statements about the entrepreneurs or the for-profits, we don't have a policy that favors one or the other. I think that some companies that are not-for-profit can make a lot of money through their salaries and lose a lot of money through sloppiness because they don't care about the bottom line. Some for-profits see themselves as competing and can be very efficient; and of course, the opposite of what I just said can be true, too.

Mr. ALLEN. Is there a way to go at this by trying to figure out the competence of the entity in the health care field? That is, we are looking today mostly at financial requirements, capitization requirements for surety bonds. Is there another route which has

something to do with measuring the efficiency and the professionalism of the agency?

Ms. THOMPSON. Indeed, and I think that is also a good question for you to pose. And I know that we have a surety bond representative in the next panel, but my understanding is that indeed those are the kinds of issues that they would examine in deciding whether or not to write a bond. It is not a question of the financial resources or assets of a company, but also the character of the people running the business, their reputation in the community, the experience that they have in providing those services and their management philosophy and management practices. So indeed I think that a surety bond can reflect considerations of exactly those kinds of qualities.

If I can comment, as well, on the comments that Mr. Grob made about the nonprofit versus for-profit, we simply don't have the data to say, these are the good guys and these are the bad guys. That is part of the problem. I don't think that we can characterize a certain kind of agency as always good or another kind as always bad. Some of the data is striking as to the differences among agencies and between like kinds of agencies and among different parts of the country, and even within a part of the country, within a certain kind of provider, as to how much money they receive from Medicare and what their average reimbursement for each beneficiary is.

So I don't know that in any of the data that we have before us about errors, et cetera, that we can say, these are the kinds of providers that make most of the errors and these are the sources of the errors. I don't think that we have that available to us right now.

Mr. ALLEN. Thank you.

Mr. SHAYS. Thank you.

Mr. Snowbarger.

Mr. SNOWBARGER. Thank you, Mr. Chairman.

First of all, I am concerned—coming from a rural State, I am concerned about the availability of these kinds of bonds, the affordability of those bonds and, very frankly, the expertise of the surety companies to investigate and provide the kind of information that you are asking for. I am not sure that exists in all of my communities, and if you are looking for someone who is going out into the community to find community reputation, you are bringing them in from Chicago or New York, they are not going to have any better feel than you would for it.

I heard—Mr. Grob, you were the one who made two comments that I find fascinating. One of them, I think you indicated, it is too easy for these companies to apply?

Mr. GROB. Yes.

Mr. SNOWBARGER. And who controls that?

Mr. GROB. This was true at the time we conducted our studies. And because of what we found, that it was in fact just that easy, there was almost no review, no certifications, no review of business practices, it was extraordinarily easy to join. But the Congress and the administration and the industry, I think, banded together to develop some reforms and came up with a lot in the Balanced Budget Act, and through the administrative action that Ms. Thompson has referred to, gave a long list of reforms.

I think now it is more difficult. We are really beginning to tighten that up and get that under control. I am heartened to see those reforms and those mechanisms put into place where we can do background checks on people, have more stringent requirements for their medical care ability, as well as their business ability; so I am heartened by what has happened in the years right before the law was passed.

Mr. SNOWBARGER. Is the agency doing more to investigate these applications before they are put into the payment system?

Ms. THOMPSON. Yes, we are. We have a new provider of enrollment process. We have established new capitalization requirements.

Mr. SNOWBARGER. I understand that we have raised the bar, and somehow we think that screens folks out, which I am not sure is the case. Apparently, it didn't screen out the $5 million loss; maybe that was before this was put in place.

Ms. THOMPSON. Yes, it was.

Mr. SNOWBARGER. I have concerns that any time the Federal Government sets up a new payment program—by now we should have figured out somebody somewhere is going to figure out a way to take advantage of that, and you would think at some point in time the Federal Government would get ahead of them and prevent that entry.

Mr. Grob, you indicated in answer to Mr. Pappas' question, even if most of this 20 percent that you found in the four States was the result of innocent error, you would be concerned about a system that has that kind of error rate?

Mr. GROB. Yes.

Mr. SNOWBARGER. I am, too. I think we ought to be looking at the system and seeing whether or not that is operating appropriately as long as we are looking at all of these things and intending to call it "fraud and abuse," which I doubt.

Let me go to a different kind of question. Surety bonds come in different ways. One, you might say, is sort of faithful performance in the sense that they assure that there is not fraud and abuse. A second level gets you to financial guarantees, which may more directly impact the overpayment situation.

It seems that HCFA has gone more toward the latter—of financial guarantee, as opposed to surety bonds that go more toward the fraud and abuse. Could you explain why we have gone that direction as opposed to just trying to protect the fraud and abuse—against the fraud and abuse?

Ms. THOMPSON. Our interpretation of what Congress intended was that we were to use the surety bond as a protection from both the unscrupulous and the fraudulent and the irresponsible. I think there are figures in my testimony on the amount of overpayments uncollected from home health agencies and the amount is growing as a percentage of overpayments.

We decided that the goal was to provide both a screening mechanism to prevent unacceptable home health agencies from entering the program and also to provide security for the program in the way that—the financial protection against defaults owed to the government, and so we thought that a performance bond gave us what we needed.

There has been discussion about a so-called "fraud and abuse bond" and a "compliance bond." Again, I think those would be useful for the GAO to weigh in on in its study as to whether those are better models to use. Our assessment was that a compliance bond would not help us, and how would it add to what we are doing through our enrollment and survey and certification process; and the fraud bond would essentially protect only those who are fraudulent and wouldn't address some of the other issues of people making improper claims against the government for money because of the characteristics that Mr. Grob mentioned.

Mr. SNOWBARGER. It seems to me that going that route is, in essence, an admission that the larger problem is the overpayment which may be a result of the complexity of the system, errors in reporting, errors in making claims as opposed to the fraud and abuse. I think Congress is more concerned about the fraud and abuse. We certainly don't want overpayments and we—at least I would think that we want to get at that system of overpayment. But some of that is built into your process, and we ought to be looking at that process to see whether or not it needs to be revised, and then going after those for fraud and abuse where you think that potential is high.

Thank you, Mr. Chairman, I yield back the balance of my time.

Mr. SHAYS. What is interesting about this debate is that views that I might hold as a Republican in terms of a market system and not wanting to see so much fraud and abuse come in conflict with other so-called views I might hold as a Republican. I just wonder, if we said that fraud was 12 percent, we would be outraged; 20 to 40 percent, we almost can't comprehend it.

Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

I am sort of listening and I am hearing something that seems to me that you are structuring up to deal with somebody in terms of fraud and abuse, but I don't get the feeling that you want to do something before all of this happens. I mean, the certification, I don't hear anything about certification. I don't hear anything about even qualifications in terms of a person having a health background.

You talked about the two guys coming from prison; did they have a health background? I mean, I am not hearing anything there on that end. I am just hearing stuff on the back end.

Ms. THOMPSON. Then I have been remiss.

We do work very hard to make sure even before people come into the program they are capable of providing quality services to beneficiaries. We have conditions of participation which we are in the process of revising. Those conditions of participation have existed for home health companies since 1973. There are been changes and they have not really reflected the changes which have occurred in the marketplace itself, and so we are working to create ones that focus on the patients and make sure that agencies are qualified to provide those services and lay out qualifications for the kinds of people who can be in various positions within home health agencies.

Again, we have always said that now, before we certify a provider to come into the program, they have to have some experience

treating patients; and we want to see patient medical records before we allow them to come into the program. So that is another kind of reform.

I think that we are taking steps. This is a recertification process. There is a survey and certification every 3 years. We want to look at problem agencies which are reflecting a problem in quality of care or a problem in terms of evidence about their claims process; we want to go to them more often so we can concentrate more of our resources on those problem agencies.

Mr. TOWNS. Thank you. I am happy to hear you say that.

Some agencies have already secured a bond. What would happen to the funds that they have paid if there was a postponement?

Ms. THOMPSON. We are talking about that now. I understand one of the things would be to release the surety bond companies from being liable, and the surety bond company would provide a refund on a prorated amount. Another possibility is providing more relief for companies with surety bonds in terms of repayment plans. So those are under active consideration now. It is very much a concern to us that we want to be equitable. People were getting bonds in anticipation of a requirement to have a bond. We have now changed course, and we want to do something for those agencies, and we are looking at what we can do.

Mr. TOWNS. Let me throw it out and you might want to think about this.

I believe that the reason this rule ran into trouble, I really believe it, is because it was enacted without public hearing or any opportunity for the affected people to comment on the issue. They didn't have an opportunity. And during the rulemaking process what efforts were made to bring home health care or the surety bond agencies involved—did you talk to them?

Ms. THOMPSON. We did have quite a number of consultations with representatives of the home health industry, as well as with surety bond company representatives, as I understand it.

I think that it is clear that we wanted to publish an interim final rule with comments because we wanted to place the surety bond requirement in place. We wanted to lift the moratorium with that in place. We wanted to meet the deadlines in the BBA. I think, in retrospect, we probably should have just done a notice and comment period, but the reason that we didn't do that is because we wanted to move forward. And, in fact, we haven't moved forward. In retrospect, it was a mistake not to do that.

Mr. TOWN. My last question, I received a list from HCFA that lists the number of home health care agencies with bonds as of June 1998. According to this list, there was a wide variation of compliance. Places like Texas, Mississippi and Arkansas have compliance rates of under 30 percent, while places like Maine, Vermont and Minnesota had compliance rates above 70 percent.

What do you believe accounts for the difference in compliance rates?

Ms. THOMPSON. In terms of differences around the country and people having bonds, I think that is difficult to tell. I think people were operating under different assumptions and people were making different business decisions in terms of what our rule would look like and what our compliance date would be.

When we provided people with notice that we were going to make technical improvements, that caused more confusion. Then we introduced those technical improvements. Some people were "wait and see," some people decided to wait and see how long they could go without a bond, and some people got a bond to make sure that they were in compliance.

I think it is hard to understand or predict what people were doing during that time, because we were not clear and consistent to people in our message of what our expectations were going to be. Some of those issues about who got bonds and who didn't get bonds, I think would be a very useful issue for the GAO to examine so we understand whether that would be reflective of the experience when we implement it in February.

Mr. TOWNS. It appears to be regional. From what we have here, just from general observation, it looks like it is a regional problem.

Mr. Chairman, I yield back.

Mr. SHAYS. Mr. Pappas.

Mr. PAPPAS. Thank you, Mr. Chairman.

I want to shift gears a little bit because, besides my familiarity with home health care agencies back in central New Jersey, I have worked with especially nonprofits as a county-elected official being in charge of social services. But, last fall, I became acquainted with the IPS and how I think that between that concern that I have and what we are speaking about today, many agencies are getting clobbered from two ends, and I am wondering whether HCFA—sometimes we wonder if the right hand knows what the left hand is doing. And the concern that I have for nonprofit agencies is that those that are efficient, those who could be I think devastated and, therefore, the clients that are being served and the employees who could be without work could be devastated by the change of reimbursement. Has your agency taken that into consideration? What both of these, if they are done at the same time, do to these kinds of agencies and the people that are served and the employees?

Ms. THOMPSON. What I can tell you is that the administrator has said that she wants to monitor the whole range of activities that we are doing for home health, both in terms of how we are proceeding and making decisions and in terms of what the impacts of that are based on the data that we have on the home health providers who are participating in the program and terminating from the programs, beneficiaries and their access to services in various parts of the country.

So she has convened a group on a number of different occasions to examine that data so we are assessing the impact of all of our actions in totality on our beneficiaries and the home health community.

Mr. PAPPAS. We have a bill to deal with the IPS. I have a bill that has 97 cosponsors which deals with the IPS, and I don't think that we—there are over 200 of us who have weighed in on this, whether it is writing letters or cosponsoring or sponsoring legislation, and I think we need to work with you in coming up with a solution. We don't think—I don't think that the approach up to this point has been one that is going to accomplish what we all want, which is to have people who need service to be served.

Next question, in the committee brief there was a reference made that HCFA had notified Congress on June 25, 1998, attachment 7, and it is this document here, and I just tried to skim it to see if I could find where within this this might be contained. But the committee memo states, "Because of the need to focus far more resources on the year 2000 computer problems, several of the BBA-mandated changes, including a prospective payment system for home health, were being postponed until after January 1, 2000," and I am wondering if you can elaborate on that.

Ms. THOMPSON. That is correct. What the administrator has done at the advice of a number of different people is to take a hard look at our year 2000 problem priorities and establish a list of things that we can and can't do. The private and public sector are struggling to make sure that all of their systems are compliant by January 1, 2000. That is the top priority for HCFA.

We have gone through a very difficult process and I might say painful process of looking at all of the things that we need and want to do that affect our systems and our ability to accommodate those changes and meet our Y2K needs.

The administrator has decided and on the list of things that we cannot do is home health prospective payment, in part because of the timing. We have been given the advice that the last thing that we want to do in the last quarter of 1999 is introduce significant new system changes, and that will disrupt us from potentially meeting our goal on January 1.

Mr. PAPPAS. I don't mean to be out of order, Mr. Chairman, and insert another subject into this hearing, but the agencies are having to deal with both of these issues. And Mr. Schneider represents one agency, and I am sure that there are others who do or work with other agencies, and that is something that we are responding to because we are representing these folks.

Mr. SHAYS. If the gentleman will suspend, the longer you are here, you realize you seize the opportunity when you have it, so feel free.

Mr. PAPPAS. I just want to work with you and your agency. The IPS I view as very problematic. Agencies are going to find it very difficult, and Mr. Schneider will probably talk about the over $50,000 expenditure that they are having to make which is affecting the ability to provide service. And with the IPS possibility of having to lay off people, all of this is affecting the citizens that we are trying to serve.

And if they are being forced into an institution which could require greater reimbursement by Medicare, what we are saving? What are we accomplishing? So the left hand is not necessarily knowing what the right hand is doing and what is that accomplishing in the bigger, overall scheme of things?

Thank you, Mr. Chairman.

Mr. SHAYS. I am going to read just a paragraph from Mr. Grob's testimony on page 2. He wrote, "When Medicare was established, it was not designed with potentially abusive billers and defrauders in mind. The structure of Medicare's claims system is based on the assumption that providers normally submit proper claims for services actually rendered, that are medically necessary, and that meet Medicare requirements. However, the home health benefit has been

particularly susceptible to exploitation compared to other types of health services. This is because the care is provided in patients' homes with no oversight; there is limited physician involvement; there is no limit on the number of visits that a home health agency can provide; there is no copayment; and, until a prospective payment system is implemented, it is a cost-based service."

Congress designed this system and it seems to me it is almost irrelevant whether they are profit or nonprofit. I know a lot of nonprofits whose agencies pay their employees more than the profit, and the profit in a sense goes to the employees. I almost view it as an employee-owned operation as opposed to a non-employee owned operation.

Where I come down on it, I come down on the fact that we have gone from less than $4 billion to $18 billion in a short period of time and it is very clear that the fraud or waste in the system is extraordinarily excessive. I look at opportunity costs, and I see if we eat our health care dollars this way, we don't get to spend it somewhere else. The uniqueness about home health care is that they are, in many cases, smaller operations; and we have lots of contact from our constituents; and so we hear from those who are trying to provide this service.

So what I want to know to start with is, what are we doing right now—I have one question, whether certification is a better way to do it than through bonding, but then I think of my Republican principles of who the heck can go into this business because you say that I have a certification.

What powers, Ms. Thompson, do you have to get the bad players out right now? We have the issue of recouping our dollars, but can we send them to jail? Can we fine them and hold them accountable years later? What do we have?

Ms. THOMPSON. We do have authorities and some new authorities because of the BBA in terms of things that we can do.

I would say, though, that with the volume of claims that Medicare processes, and this is a general proposition, this is not just true of home health, with the volume of claims that Medicare processes for the amount of money at stake, for the number of providers billing us, for the number of beneficiaries in all sorts of different settings across the country, it is extraordinarily difficult to administer that program in a way that assumes what is being billed is incorrect.

The administrator made the comment before in the past that we have gone around and said how wonderful it is we have low overhead as compared to private sector insurance companies. Maybe we don't have enough money in our administrative overhead to make sure that all of those claims are paid properly.

Mr. SHAYS. You review how many of the bills?

Ms. THOMPSON. Ten percent of the bills get reviewed for something or other. That 10 percent includes claims that are coming in that are hitting a medical edit, not necessarily claims that are suspended for a human review. The amount of resources——

Mr. SHAYS. That review—in other words, you are not really able to track——

Ms. THOMPSON. Those reviews include things like are we billing for a certain kind of service when the diagnosis doesn't support that.

Mr. SHAYS. They could have put in a fraudulent bill?

Ms. THOMPSON. That is correct. When you start to look at the claims themselves, on the face of the claims everything looks fine, lots of times. That does not mean that the service was actually provided. That does not mean that the information provided on the claim is accurate.

Mr. SHAYS. Ten percent reviewed, you are saying if the paperwork looks good?

Ms. THOMPSON. A large part of it is if the paperwork looks good. The OIG and the CFO audit has determined that our contractors do a pretty good job of making the right determination based on the claims that get submitted to the program. On the face of it, everything looks fine.

I think there was a comment earlier about, can't we get ahead of these people who are abusing the system? And it is true, when we make a change, the people figure out what they need to say and do in order to get their claims paid.

One of the things that we have done is increased the amount of medical review and auditing, but, again, it is impossible for us to get to a point where we are reviewing the majority of claims. We are always going to be reviewing a small majority of claims.

Mr. SHAYS. How do you get the bad players out?

Ms. THOMPSON. We are trying to do more data analysis to examine those providers that look aberrant and launch exploration of their billing patterns and to ask for more documentation. That is part of what we call focused medical review. We are not an enforcement agency.

Mr. SHAYS. Once you do that, how do you get them out of the system?

Ms. THOMPSON. One of the things that we have to do is refer them over to the Office of Inspector General for an enforcement action.

Mr. GROB. We are aggressively pursuing that. You have held hearings in the past on our ability to pull people out of the program when they are found to have been guilty of crimes against the program, and we have made a lot of progress in that regard. I can comment on that if you wish.

Mr. SHAYS. Yes.

Mr. GROB. Overall, in the Medicare program in 1996, we had excluded 1,400 individuals. In 1997, the number was doubled. It was 2,719. And so far in——

Mr. SHAYS. Did you say individuals?

Mr. GROB. It could be an individual or it could be a company. In fact, I will say something about that in-home health. It is a combination of both. To date, the number of exclusions is already 2,218, and that is only 7 months into the year.

Mr. SHAYS. Out of a universe of 100,000?

Mr. GROB. There are more providers than I can count.

Mr. SHAYS. Is this just home health?

Mr. GROB. No, overall. In home health, in 1996, there were a total of 23 exclusions, 4 of which were home health agencies. So

far, in 1998, there have been 57 exclusions by our action, 14 of which are home health agencies, and some of the remaining 43 are executives or owners or accountants of the agency. So it has the same effect, basically, of excluding them from the business. So there has been a dramatic increase in that activity.

Mr. SHAYS. I think we are scratching the surface.

Mr. Snowbarger.

Mr. SNOWBARGER. Just a quick comment, and it goes to your comment, Mr. Chairman. You have agonized about Republican principles this morning and how they are getting confused here; and I would like to say, I don't think that it is any shock to you or me that I am a little bit to the right of where you are in terms of government and its role. I think the mixed feelings that we are all getting here come out of the fact that this is not the free market at work. The Federal Government created this market and has interfered with it significantly as a third party payer.

I am concerned that when you get third party payers involved, the market forces in the situation kind of go out the window. In a sense it doesn't bother me to be more involved in regulating a program that we set up than what might be out there in the market as a whole.

If there was a home health market prior to Medicare being involved and it had developed at a pace where private suppliers could handle the demand, that is one thing. But when you go out there and you say, guys, we think home health care is great, here is a pile of money, come get it, I think we have an obligation to say, wait a minute, only one of you can come and get it, and we need to make sure that they are providing the service that we are paying for and, ultimately, that the client, the patient, gets the benefit. So I don't see any complication here at all or any conflict at all.

Mr. SHAYS. Do you want to talk about Republican principles, Mr. Towns?

Mr. TOWNS. I was just thinking, based on that, I can be associated with that.

Mr. SNOWBARGER. My guess is that he thinks that Republican principles is an oxymoron.

Mr. SHAYS. I just want to ask, are there any other comments?

We are truly scratching the surface, but we have a lot of good staff that are going to get into this deeper, and we are going to be attempting to make some recommendations here. We value your testimony, both vocal and written, and we will be able to use that in helping us with our report. Thank you.

Ms. Thompson, we welcome you to HCFA, and one of the comments that I am going to make to you is that it is refreshing, and please don't lose it the longer you are at HCFA, in terms of saying, maybe we should have done this, especially when it is your decisions that you are evaluating. Because, ultimately, we will do a better job when that happens. I found that very refreshing and want to encourage it. Thank you very much.

Mr. SHAYS. And now if the second panel will come forward: Lynn Schubert, president, Surety Association of America; Bill Koniers, senior vice president for business development, AMH Health Group, Inc., Connecticut; William A. Dombi, vice president for law, National Association for Home Care; Jayne F. Quinn, home care co-

ordinator, York Hospital Home Care, York, ME; Steve Richard, CFO, Sun Home Health Service, Northumberland, PA; and Steve Schneider, CEO, VNA of Central New Jersey. Welcome all of you.

I am going to do it in the order that I called, so it is going to be Schubert, Koniers, Dombi, Quinn, Richard and Schneider; and I ask you at this time if you would stand and raise your right hands, please.

[Witnesses sworn.]

Mr. SHAYS. For the record, all six of the witnesses have responded in the affirmative.

We will let you go over the 5 minutes a little bit. Frankly, I welcome witnesses using some of their time to talk about the questions that we asked the previous panel because those are obviously things that we are focused in on, and you are probably in some cases eager to respond to them since this is your field and your area.

We will start with you, Ms. Schubert.

STATEMENTS OF LYNN M. SCHUBERT, PRESIDENT, SURETY ASSOCIATION OF AMERICA; BILL KONIERS, SENIOR VICE PRESIDENT FOR BUSINESS DEVELOPMENT, AMH HEALTH GROUP, INC., CONNECTICUT; WILLIAM A. DOMBI, VICE PRESIDENT FOR LAW, NATIONAL ASSOCIATION FOR HOME CARE; JAYNE F. QUINN, HOME CARE COORDINATOR, YORK HOSPITAL HOME CARE, YORK, ME; STEVEN RICHARD, CFO, SUN HOME HEALTH SERVICE, NORTHUMBERLAND, PA; AND STEVE SCHNEIDER, CEO, VNA OF CENTRAL NEW JERSEY

Ms. SCHUBERT. Thank you. The Surety Association is a nonprofit trade association of companies that write surety bonds. Our 650 member companies write the overwhelming majority of surety bonds written here in the United States and around the world, including bonds that protect the Federal Government such as Customs bonds or contract bonds that are written for Federal construction projects. In that instance, the Federal Government is the person that is protected or the party that is protected, what we call the obligee on the bond. On a bond that has the Federal Government as the obligee, we think one of the major benefits is that it protects taxpayer dollars.

From the beginning, the Surety Association has supported the efforts of Congress and the Health Care Financing Administration to combat fraud in the Medicare and Medicaid systems. We were pleased to see Congress again recognize the value of surety bonds in the BBA of 1997. We believe that surety bonds are a valuable tool.

And in answer to the chairman's question to Mr. Grob, there are two major things that surety bonds do: First, they provide prequalification. They prequalify parties being paid with taxpayer dollars to ensure that they will be parties that will properly apply those taxpayer dollars; that they will be paid for services that they are actually providing.

The second thing they do is pay claims. If the surety is wrong in its prequalification process, which unfortunately does happen in the surety industry, the surety guarantees that those moneys will not be paid from taxpayers dollars but instead will come out of the

surety's pocket. Those are the two benefits, prequalification and then the claims-paying process.

From the government's perspective, what the surety guarantees is that the principal; in this case, today's discussion, the HHA, will provide the services that they say they will provide, and they will only take dollars from the taxpayers for services that are actually provided.

The availability of a bond and the underwriting terms of a bond will depend totally on the obligation that is being guaranteed. The potential amount of the loss must be balanced with the likelihood that there will actually be a loss and that the surety will be called upon to perform.

The Surety Association has worked with HCFA staff beginning in the late summer or early fall of 1997 to provide technical assistance from our experience in the surety industry as they worked to implement the BBA surety bond mandate. We explained how surety bonds worked, what types of surety bonds there are, what kind of provisions normally would be in a surety bond, what type of provisions normally would adversely effect the marketplace if they were included in a surety bond requirement, and we even went so far as to provide a sample bond form to HCFA back in October of last year, an antifraud bond which I believe we have attached to the written testimony.

In January 1998, a final rule was published, and the type of bond that was required under that final rule was what we would call a financial guarantee surety bond, a bond that would guarantee repayment of overpayments, not just repayment of losses to the Medicare system caused by fraud or abuse. This financial guarantee type bond is more difficult to underwrite from a surety's perspective than a simple antifraud bond.

Again, you go back to what is the obligation and what has to be considered. The potential of loss, as we understand the overpayment system and the repayment system, is particularly high. Now that the IPS has been put in place, it appears from our limited understanding of the Medicare system that overpayments are virtually insured at some point. Certainly they are very commonplace in the system.

So, first, you have to evaluate, are there going to be overpayments? Second, you have to evaluate, is the HHA going to be able to repay those overpayments in the regular routine process of the HCFA system or is there going to be a loss caused by that? If there is a loss caused by that, meaning the surety comes in and repays those overpayments, the surety then has to evaluate, will the HHA be able to repay the surety its losses?

It is important to understand the primary principle of suretyship, and that is: the surety is secondarily liable. In other words, the surety guarantees that someone else will perform what he or she promises to perform. That person remains liable. What we do as a surety is guarantee that that person's failure does not cause losses to the taxpayer. That does not mean that we then don't go against the person who is primarily liable to recover our losses.

We understand that some HHAs are very uncomfortable with the underwriting criteria for the financial guarantee bond. Again, it is a continuum. If you have a bond with a lesser obligation, you are

going to find it easier to obtain and you are going to find the underwriting criteria a little less strict. If you have a bond with a stronger obligation such as financial guarantee, you are going to find it less available and with stronger underwriting criteria.

What we found most interesting is that bonds have been available under the financial guarantee regulation. We don't know if they would be more available under an antifraud regulation, although our members tell us that would be true. And the HHAs who we have spoken with tell us they would be more comfortable making a guarantee back to the surety that they will stand behind their promise if they are promising their own integrity and honesty versus compliance with the payment system which is currently in place with HCFA.

Mr. SHAYS. Thank you.

[The prepared statement of Ms. Schubert follows:]

Medicare Home Health Agencies:
Still No Surety Against Fraud and Abuse

Statement of
The Surety Association of America
to the
United States House of Representatives
Committee on Government Reform and Oversight

Subcommittee on Human Resources

July 22, 1998

The Surety Association of America ("SAA") is a voluntary, non-profit unincorporated association of companies engaged in the business of suretyship. It presently has approximately six hundred-fifty member companies, which collectively underwrite the overwhelming majority of surety bonds written in the United States.

We would like to thank the House Committee on Government Reform and Oversight Subcommittee on Human Resources for addressing the important issue of the new surety bond requirement mandated for certain providers of Medicare and Medicaid services by the Balanced Budget Act of 1997 ("BBA"). As clearly indicated by the title of this hearing, although the BBA required surety bonds to be effective January 1, 1998, there currently is no date by which these bonds must be filed, and no way for sureties or home health agencies ("HHAs") to know what regulations ultimately will govern the bonds. This has resulted in the situation described in the title, "still no surety against fraud and abuse."

From the beginning, the SAA has supported the efforts of Congress and The Health Care Financing Administration ("HCFA") to combat fraud, waste and abuse in the Medicare and Medicaid systems. In fact, staff from the SAA met with the sponsors of the surety bond requirement in the BBA to assist them in this endeavor. We were delighted to see Congress once again recognize surety bonds as a prequalification mechanism for entities being paid with tax dollars. We felt at the time and continue to believe that a surety bond is an excellent tool to assist in the fight against fraud in the Medicare and Medicaid systems.

Once the BBA surety bond mandate was enacted, staff members from the SAA began extensive discussions with staff from HCFA to attempt to provide technical assistance to them as they wrote regulations to implement the directive of Congress. These discussions involved the concept of regulations both for HHAs and for suppliers of durable medical equipment ("DMEs"). Our assistance was offered due to our expertise in the field of surety bonds. While none of our

staff had had much previous experience with the Medicare or Medicaid programs, bonds for this type of an obligation were not unique. We believed at that time that we could assist HCFA as they drafted bond regulations that both furthered the intent of Congress and provided a viable market for the bonds.

These discussions first took place by phone and mail while the SAA still was located in New Jersey. At that time we were attempting to provide HCFA with technical assistance to draft a bond form which would provide the coverage and terms on which they were insistent. As we moved to Washington in the fall of 1997, we met personally with HCFA staff to further present our positions as to what actually should be covered by the bond and how it normally would be written in the marketplace.

Attached are copies of two letters, the first from the SAA and the American Insurance Association ("AIA") discussing our visit with HCFA staff in late September. The second is a follow-up letter sending a proposed bond form drafted by SAA to HCFA. This bond form contained an obligation that the surety would guaranty HCFA against loss caused by the fraud of an HHA or its officers, directors, stockholders or employees. This type of anti-fraud bond is common, and the underwriting is fairly simple.

At some time after this October 31, 1998, letter to HCFA, HCFA determined that the surety bond mandated by Congress should be crafted not just to protect against fraud, but to protect the Medicare and Medicaid Trust Fund against loss caused by overpayments to providers. This essentially is a type of surety bond called a financial guarantee bond. Through discussions with HCFA staff, it soon became clear that HCFA would not accept our proposal of an antifraud bond, but would insist on a financial guarantee bond. We again worked with HCFA staff, advising them as to the way the surety bond industry worked in an attempt to assist them in drafting regulations to make such a bond requirement as reasonable as possible. At some point shortly after the October 31st letter HCFA staff told us that they no longer could talk with us about the regulation drafting process.

On January 5, 1998, HCFA published regulations requiring the submission of a surety bond by February 27, 1998. The bond required was the overpayment, financial guarantee bond, and the regulations contained a number of provisions that made underwriting the bond extremely difficult.

This was unfortunate for sureties, HHAs, HCFA and Congress. When the BBA mandating this new surety bond requirement first was enacted, many surety companies geared up to enter this new market. When the January regulations were published, however, the regulations contained many problems which forced companies to reverse their decisions.

Through significant discussions between the surety industry and HCFA, HCFA determined that certain technical corrections to the regulations would assist in making this bond more available, while still preserving the protections HCFA desired, i.e., a bond to secure overpayments. A notice of intent to make those changes was published in March, and the actual changes were made in June. It appears that the drafters of the HHA regulations did not anticipate the effect of a financial guarantee-type surety bond on the interest of sureties to write the bonds and the requirements which would be imposed on HHAs to obtain the bonds by those sureties that remained in the market.

It is our understanding that very few bonds were written for HHAs prior to the publication of the March notice of intent, despite the original deadline for submitting bonds of February 27, 1998. Between March and the publication of the June 1st technical corrections, many surety companies individually determined that, based on the regulatory changes enumerated in the March notice of intent, they would be able to be a viable market for these bonds after all. Companies established entire departments devoted to this new product and marketed it aggressively. As the date by which bonds were required to be filed approached, more and more HHAs obtained bonds. It is our understanding that by June 11, 1998, forty-one percent of all HHAs required to get bonds had filed them with a fiscal intermediary. Prior to publication of the June technical corrections, thirty-three percent already had obtained bonds. According to a listing produced by the fiscal intermediaries, approximately sixty-five separate surety companies have written bonds for HHAs under the existing regulations.

It is impossible to estimate how many applications for bonds have been submitted, and how many rejected. We have been told that some HHAs have not submitted applications since the date for filing the bonds continued to be postponed. Further, we have been told that some have not submitted applications because of a belief that Congress will change its mind and eliminate the surety bond requirement. We do know that some HHAs have chosen not to purchase a bond because they are not willing to comply with the requirements of the surety offering the bond. Certainly there are HHAs who cannot obtain a bond because they do not have the necessary financial capacity, either in the business or personally.

Two things particularly have affected the availability of these bonds for small HHAs: the type of obligation, i.e., financial guarantee; and the requirement that the bond be in an amount of not less than $50,000 each for both Medicare obligations and Medicaid obligations. These two factors may have combined to make the implementation of the bond requirement problematic for some small businesses. However, that is very difficult to determine at this point.

It is our belief that if the date to provide bonds had not been postponed indefinitely, a significant percentage of the HHAs required to have bonds would have filed them by the July 31st deadline. Surety companies were writing these

bonds as defined by the June regulations, and many companies are willing to continue writing these bonds, both for large and small HHAs. However, these bonds would be underwritten as a financial guarantee ensuring the repayment of overpayments, pursuant to the HCFA regulations.

It is our understanding that many HHAs are uncomfortable with signing the personal indemnity agreement often required to obtain an overpayment bond. This is not because they have doubt in their own honesty or intent to comply with the requirements of HCFA, but rather because they are concerned that under the interim payment system overpayments are virtually ensured, and they may not know in time to be able to pay them back. Since these HHA owners currently are not personally liable to HCFA for these overpayments, they do not want to take on that obligation to a surety company. However, due to the nature of suretyship, personal indemnity is a very common underwriting tool.

Under a surety bond, the principal, in this case the HHA, remains primarily liable for the obligation; while the surety is secondarily liable. Thus, while the surety pays the obligee (HCFA or the state Medicaid agency) its losses, it is entitled to recover those losses from the HHA. This is not unique to this bond requirement. In all cases of suretyship, both statutory and common law, the principal (the party promising to perform an obligation) is primarily liable for its promise. A surety merely guarantees that the obligee (a third party contracting for that promise) will receive what is promised, or an agreed upon sum of money. Once the principal fails in its promise and the surety performs, the surety is entitled to indemnity from the principal for losses caused by the principal's failure to perform.

The best known surety bond is a contract surety bond, or a bond to guarantee construction of a building or other construction project. Under these bonds, a surety guarantees that the principal (the contractor) will build the building and pay the people who work on the project. If the principal defaults in this obligation, the surety either completes the work and pays the laborers, or pays an agreed upon sum of money to the obligee (the owner of the construction project). Under common law and under a contract signed by the principal (the general indemnity agreement), the principal then is liable to pay that money back to the surety. Due to this guarantee of the contractor's promise, an owner can be comfortable awarding work to a contractor based on a low bid, regardless of the contractor's financial situation. The owner knows that the surety stands behind the principal. The surety bears the risk of loss if its underwriting analysis is erroneous.

Therefore, sureties prequalify principals on many bases, including ability to perform the promise, likelihood of performance, and ability to repay the surety any losses incurred due to the principal's failure to perform. The first two are based on the obligation; what the surety is guaranteeing, and the third is based

on the financial strength of the principal or someone willing to stand in for the principal in the event of a default.

Turning back to the HHA bond situation, the obligation being guaranteed is the likelihood of overpayments by HCFA or a state Medicaid agency and the ability of the HHA to pay them back. The ability to repay the surety if the surety makes payment on behalf of the HHA remains the third basis of analysis.

When this new bond requirement was enacted, sureties began to investigate how Medicare and Medicaid systems operated. As sureties learned more and more about the HHA reimbursement system, it became clear that overpayments are commonplace. As they learned more about the new interim payment system, overpayments appeared to be almost ensured. Thus, the surety first must consider whether or not an HHA will be able to repay those overpayments to HCFA, and if not, after the surety makes payment, whether or not it will be able to repay the surety.

Since many of these HHAs provide only services reimbursed by Medicare or Medicaid, and the HHA is not entitled to make a profit on those services, the HHA itself often does not have the capital to repay the surety. In cases like this in all areas of suretyship, for all types of surety bonds, a surety often will ask for the personal indemnity of the owner of the business or perhaps the posting of collateral.

It is imperative to understand that these two underwriting tools are part and parcel of the surety industry and often are the only tools that will allow certain bond applicants to obtain the bonds which it needs to stay in business. Sureties often require and rely on personal indemnity in order to issue a bond. For some other bond applicants, collateralization is the only tool that permits a surety to issue the necessary bond. Elimination of these two underwriting tools would interfere with the traditional underwriting process and dramatically reduce the availability of bonds.

We have been told by representatives of HHAs that many HHA owners would not have the same reluctance to sign a personal indemnity agreement or post collateral if they were guaranteeing their own honesty and compliance with licensing requirements rather than the return of overpayments under the HCFA system.

This situation clearly needs to be addressed as expeditiously as possible. A different type of bond obligation, in other words, a bond that guaranteed against the dishonesty or fraud of the HHA, and an allowance that the HHA provide one bond only to cover both Medicare and Medicaid payments, should allow many HHAs a much better opportunity to provide the bond on terms with which they would be more comfortable.

It is our understanding that the date by which bonds must be furnished to HCFA by HHAs has been postponed yet again, and that the Senate Committee on Finance plans to request the General Accounting Office ("GAO") to conduct a study on surety bonds and HHAs. While we are heartened by the intent to include GAO in this issue, we do have some concern about bonds which already have been written for and purchased by providers. Although the existing rules allow surety bonds to be canceled, it is unclear what liability the surety will have on any canceled bonds for the time during which they were in effect. Only if the obligee on the bond, HCFA or the state Medicaid agency, provides a full release of the bond can the surety be sure that no claim might be made on that bond. If the bond were released, then any question of a prorated return of premium or release of collateral would be governed by applicable state law. This issue must be addressed as soon as possible.

It is our understanding that the discussions in Congress surrounding the proposal of the surety bond requirement in the BBA centered on an existing similar requirement by the State of Florida Agency for Health Care Administration ("Florida Agency"). As implemented, that requirement assisted Florida in weeding out many fraudulent providers. It is important to note that the implementation of that requirement in the field was not identical to the written requirement. As successfully implemented, the requirement was as follows:

1. The bond required was essentially a faithful performance bond. As implemented, the Florida Agency never used this bond to guaranty repayment of overpayments. Rather, it was used to guaranty against fraud or dishonesty of the provider.

2. The bond was required for all providers.

3. The bond was required to be continuous and was required until the Medicaid provider agreement expired.

4. The bond amount was $50,000, and it clarified that the aggregate liability of the surety was $50,000.

A similar requirement could be created for the federal bond mandate. We would be delighted to work with Congress and HCFA in crafting a similar bond requirement to address the intent of Congress to use surety bonds in the fight against fraud in the Medicare and Medicaid systems.

Again, we applaud you for your efforts in examining why the surety bond mandate of the BBA still has not been implemented, and we stand ready to assist Congress and HCFA in moving this forward. We would be very pleased to discuss further these issues with you.

The Surety Association of America

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LYNN M. SCHUBERT
President

October 9, 1997

[redacted]
Health Care Financing Administration
7500 Security Blvd.
[redacted]
Baltimore MD 21244-1840

Dear [redacted]

First, we are writing to thank you for the opportunity to meet with you on September 30, 1997, at the Health Care Financing Administration (HCFA). You were thoughtful to provide such an array of participants in our dialogue on the Medicare surety bond regulations.

Second, you requested bond provisions that normally would be found in license and permit bonds, which the Medicare surety bond will resemble. You also requested provisions that typically would not be found in such a bond. In response, we are providing the information below. It is our understanding that the HCFA regulators do not intend to promulgate a bond form, but rather that they will include bond specifications in the regulations, allowing each company to develop its own bond form in conformance with the regulations.

Incorporation of traditional bond provisions will help assure the high degree of prequalification that HCFA seeks. Accordingly, we have listed below the traditional bond provisions that you should consider incorporating into the regulatory specifications:

1. **Aggregate liability clause.**

A typical aggregate liability clause uses this language: "The aggregate liability of the surety for any and all breaches of the conditions of the bond shall in no event be more than the penal sum of the bond."

2. **Continuous bond.**

A continuous bond would reduce paperwork and administrative oversight for the surety and for HCFA. Thus, once the term of the bond has expired, the bond would continue to run until cancelled either by the surety or by the provider. However, this could be misinterpreted to provide for cumulative liability. See below.

3. **Cancellation clause.**

The surety should have the option to cancel a bond, giving sixty days' written notice to HCFA and the provider.

4. **Statute of limitations.**

The right to bring a claim or suit against the surety should expire one year after cancellation or termination. Such language might provide as follows: "No action, suit or proceeding shall be commenced hereunder by any claimant unless the same is instituted and service of process is made upon the principal and surety within one year following the effective date of termination of this bond, or within one year following the termination of the Medicare provider agreement, whichever occurs first."

5. **HCFA as sole obligee.**

The bond must run only to HCFA and not to third parties.

6. **Sliding scale for bond amount.**

HCFA should establish a tiered approach to bonds, based on providers' annual billings, with a minimum of $50,000.

The following provisions typically are not found in surety bonds such as the Medicare surety bond:

- **No forfeiture clause.**

Surety bonds typically are conditional instruments in which the surety's liability is conditioned on the occurrence of one or more specified events. Therefore, forfeiture clauses are inappropriate.

- **No cumulative liability.**

The penal sum of the bond must remain the same for each year and not cumulate from year to year. Any provision to cumulate liability would be prohibitive to sureties' entering this new market.

- **No attorneys' fees provision.**

Each party to a suit should bear the cost of its own attorneys' fees.

We hope that this information is helpful as you continue your promulgation process. Please do not hesitate to call us if we can be of assistance. We would be very pleased to meet with you again.

Sincerely,

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The Surety Association of America

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LYNN M. SCHUBERT
President

October 31, 1997

[redacted]
Health Care Financing Administration
7500 Security Blvd.
[redacted]
Baltimore, MD 21244-1840

Dear [redacted]

I am writing to follow up on our phone conversation about specific and appropriate language to amplify certain elements of the Medicare surety bond suggested by The Surety Association of America (SAA).

Continuous bond incorporating a cancellation clause. A continuous bond would reduce paperwork and administrative oversight for HCFA and for the surety. Under such a continuous bond, although a premium is charged for each year, the bond continues to run until cancelled either by the surety or by the provider. For example:

> "The term of this Bond shall commence upon the delivery of a fully executed original of the Bond to HCFA and shall terminate on the earliest of the following:
>
> (a) sixty days following the receipt by HCFA of written notice from the Surety that it is canceling the Bond, except that cancellation for non-payment of any premium due for this Bond or for any renewal or extension thereof shall be effective immediately upon HCFA's receipt of the written notice;
> (b) immediately upon the furnishing by Principal and acceptance by HCFA of a replacement Bond;
> (c) immediately upon Principal ceasing to be an approved Medicare provider; or
> (d) immediately upon HCFA learning that Principal or any of its officers, directors, stockholders or employees has committed a dishonest or fraudulent act in connection with any federal or state government contract including, but not limited to, any contract for Medicare or other health care services or equipment."

HCFA as sole obligee. The bond must run to HCFA and not to third parties. For example:

> "HCFA is the sole Obligee of this Bond, and no action may be brought on it by or for the use or benefit of any other person or entity."

I am enclosing a sample bond form in reply to your question regarding how a formal Medicare bond form might look. Our General Counsel, Edward Gallagher, and I would be happy to meet you in Baltimore to address directly any additional technical questions you might have.

I look forward to hearing from you. I have a direct phone number that will get you to me without intermediaries: (202) 778-3637.

Sincerely,

Martha Hamby
Vice President
Public Affairs and Government Relations

MEDICARE ANTI-FRAUD BOND

KNOW ALL MEN BY THESE PRESENTS: that subject to the terms, conditions and limitations of this Bond, _____ as Principal, and _____, as Surety, are held and firmly bound unto the United States of America, Health Care Financing Administration (hereinafter "HCFA"), as Obligee, in the Penal Sum of _____ Dollars ($_____) for the payment of which Principal and Surety bind themselves, their heirs, executors, administrators and assigns, jointly and severally, by these presents.

WHEREAS, Principal desires to act as a provider of Medicare services or equipment; and

WHEREAS, the Secretary of the Department of Health and Human Services (hereinafter, the "Secretary"), pursuant to the Medicare Anti-fraud Amendments of 1997 or other applicable laws or Regulations, requires that Principal provide a Surety Bond.

NOW THEREFORE, the condition of this Bond is that the Principal shall repay to HCFA any and all amounts which Principal obtained through fraudulent or dishonest acts as a medicare provider, including fraudulent or dishonest acts committed by Principal's officers, directors, stockholders and employees, subject, however, to the following:

1. That said fraudulent or dishonest acts must have been committed during the term of this Bond and discovered during the term of this Bond or within one year thereafter.

2. That the term of this Bond shall commence upon the delivery of a fully executed original of the Bond to HCFA and shall terminate on the earliest of the following:

(a) sixty days following the receipt by HCFA of written notice from the Surety that it is canceling the Bond except that cancellation for non-payment of any premium due for this Bond or for any renewal or

extension thereof shall be effective immediately upon HCFA's receipt of the written notice;

(b) immediately upon the furnishing by Principal and acceptance by HCFA of a replacement Bond;

(c) immediately upon Principal ceasing to be an approved Medicare provider; or

(d) immediately upon HCFA learning that Principal or any of its officers, directors, stockholders or employees has committed a dishonest or fraudulent act in connection with any federal or state government contract including, but not limited to, any contract for Medicare or other health care services or equipment.

3. The total aggregate maximum liability of the Surety is the Penal Sum stated above without regard to the number of claims, the number of dishonest or fraudulent acts, the number of officers, directors, stockholders or employees involved, or the number of years this Bond may have been in effect.

4. HCFA is the sole Obligee of this Bond, and no action may be brought on it by or for the use or benefit of any other person or entity.

5. No action may be brought on this Bond more than two (2) years after termination of the Bond pursuant to paragraph 2 above.

In witness whereof we have set our hands and seals on this ___ day of _____, 1997.

Principal: _____

By: _____

Surety: _____

By: _____

Mr. SHAYS. Mr. Koniers.

Let me just say, because Mr. Pappas has to leave, we are going to make Mr. Schneider fourth and work in. So, Ms. Quinn, you are going to be sixth. I always favor the last person, Ms. Quinn.

Mr. KONIERS. Mr. Chairman, before I officially begin presenting my summarized testimony, I request that the written testimony submitted yesterday for NAMES appears in the record as submitted and read. Thank you.

Mr. SHAYS. You are welcome.

Mr. KONIERS. Mr. Chairman and members of the Human Resources Subcommittee, on behalf of the National Association for Medical Equipment Services and our thousand-plus members, I appreciate this opportunity to testify today.

Mr. SHAYS. That sounds very congressional the way that you did that. Do you have any ambition for congressional office?

Mr. KONIERS. I would like to talk to you about that later.

Mr. SHAYS. In Connecticut, you are not allowed. Let us go to the next speaker, Mr. Dombi.

Mr. KONIERS. I do want to make a distinction for the committee that the home medical equipment industry is a little different from nursing. We represent the other half of home care in that our services are equipment related.

Again, I am the senior vice president of business development for AMH Health Group in Stratford, CT, and very proud to be a NAMES member.

The AMH Health Group is the parent of three established businesses with real, physical addresses with a history of serving Connecticut's residents for an aggregate of 83 years. The businesses are Genox Homecare, Collins I.V. Care and Collins Pharmacy. Our three sites have 110 employees including respiratory therapists, pharmacists, registered nurses certified in human infusion and HME technicians. We serve over 3,000 patients Statewide 24 hours a day, 7 days a week. Our home care businesses are JCAHO accredited, and Collins I.V. Care has received the highest JCAHO accreditation with commendation.

Mr. Chairman, I invite you to visit our company to see how we serve the great constituents of Connecticut every day.

NAMES was supportive of the surety bond provision found in Section 4312 of the Balanced Budget Act. By way of background, NAMES endorsed a $50,000 surety bond requirement for new providers and onsite inspections to weed out the bad apples in the industry. Providers with an established track record in Medicare programs and providers that were licensed by a State or accredited by a nationally recognized accrediting body would have been exempt from the bonding requirement under our NAMES proposal.

As you know, the idea for a surety bond for HME was originally tried in Florida in an attempt to curtail home health care fraud in the Medicare program. NAMES was very much involved in 1995 in working with officials of the Florida Medicaid program to identify fraud and abuse in the HME services industry, especially on what to look for in identifying a legitimate HME provider. Both the State of Florida and the HME services industry found the surety bond requirement to be reasonable and an effective tool in combatting fraud and abuse.

Mr. Chairman, the principal benefit of surety bonds is to discourage unethical and unscrupulous individuals from entering a particular line of business, whether HME or home construction. Unfortunately, it appears from the outside that the HCFA officials who were charged with implementing the surety bond requirement failed to recognize that, while surety bonds may be effective at preventing fraud, they are not appropriate for addressing overpayment concerns.

Because HCFA tried to accomplish too much with its surety bond proposal for home health and HME, the agency ran into a buzz saw of opposition from the affected industries and bipartisan Members of Congress. As we recently saw, HCFA has withdrawn its surety bond proposal for home health agencies and in conversations with the HCFA staff we have been led to believe that the HME final rule may be delayed while HCFA and the GAO study this issue further.

As we said in our comments on the proposed rules, NAMES continues to believe that a $50,000 surety bond requirement is reasonable to enter the Medicare program. However, increasing that requirement to 15 percent of a company's Medicare business up to $3 million went far beyond the congressional intent. More importantly, HCFA took a surety bond requirement that would have imposed a reasonable cost on the HME services provider and multiplied that cost to a level that was prohibitive.

In addition, by failing to exercise the authority Congress gave HCFA to waive the surety bond requirement for providers that met comparable surety bond requirements imposed by a State, the provision became even more onerous and costly. As a result, HME providers that also participate in State Medicaid programs would also be required to purchase two surety bonds.

We believe that there are several steps HCFA can take in both the short and long term to address our mutual concerns about fraud and abuse in the Medicare program.

One, require all HME providers to obtain a surety bond of $50,000 in order to enroll or reenroll in the Medicare program. Providers that are certified or licensed would be exempt.

Two, permit a waiver of the Federal surety bond requirement in States where a comparable State surety bond requirement for HME exists. In other words, require providers to obtain only one bond.

Three, require participation in an HME certification program in order to enroll in the Medicare program. Providers that are originally certified would be exempt from the surety bond requirement.

While we believe that the bulk of fraud and abuse in our services industry is being committed by a small number of suppliers, NAMES has been and remains committed to working with Congress and the administration to eliminate all fraud and abuse in our industry. The Medicare HME benefit has been ripe for fraud because, unlike most other areas of Medicare, the ability to deliver HME services has been open to virtually anyone. While the surety bond requirement will cause a significant percentage of illegitimate HME suppliers to leave the business, and we applaud that fact, it alone will not restore confidence in HME suppliers like the AMH Health Group.

Mr. Chairman, as an industry we have recognized for some time that aggressive steps were necessary to clean up this business. NAMES leadership, therefore, has endorsed a process of certification for HME suppliers. This is a key point. We have recently met with HCFA officials responsible for overseeing this area to present our ideas. We are clearly in the early stages of development of these standards, and we hope to work in partnership with this agency.

In addition to the program we are now developing, a large voluntary HME accreditation has been in place for several years through national organizations such as JCAHO, and while we can encourage adherence to industry-wide standards for our members, those efforts will have little overall impact until adherence to these standards affects a supplier's ability to participate in Medicare.

Mr. SHAYS. Let me stop you. I have read your last two paragraphs. I appreciate it very much. Thank you.

[The prepared statement of Mr. Koniers follows:]

NAMES

National Association for
Medical Equipment Services

Mr. Chairman, members of the Human Resources Subcommittee. On behalf of the National Association for Medical Equipment Services and our 1,000 plus members, I appreciate this opportunity to testify today. My name is Bill Koniers. I am the Senior Vice President of Business Development at AMHealth Group, Inc. in Stratford, Connecticut, and a NAMES member.

AMHealth Group is the parent of three established businesses servicing Connecticut residents for an aggregate of 83 years. These businesses are Genox Homecare, Collins I.V. Care, Inc. and Collins Pharmacy. Our three sites have 110 employees including respiratory therapists, pharmacists, registered nurses certified in home infusion and HME technicians. We serve over 3,000 patients statewide 24 hours a day, seven days a week. Our home care businesses are JCAHO accredited. Our Collins I.V. Care, Inc. has received the highest JCAHO accreditation, "With Commendation". Mr. Chairman, I invite you to visit our company to see how we serve your constituents every day.

We have been asked to comment, on behalf of NAMEs on:

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- our experience with the Health Care Financing Administration's efforts to implement the durable medical equipment surety bond requirements of the Balanced Budget Act of 1997;
- the HME services industry's position on surety bonds as a means for controlling waste, fraud and abuse; and
- our recommendations for addressing waste, fraud and abuse.

NAMES was supportive of the surety bond provision found in Section 4312 of the Balanced Budget Act. By way of background, NAMES endorsed a $50,000 surety bond requirement for new providers and on-site inspections to weed out "bad-apples" in the industry. Providers with an established track record in the Medicare program and providers that were licensed by a state or accredited by a nationally recognized accrediting body would have been exempt from the bonding requirement under the NAMES proposal.

As you know, the idea for a surety bond for HME was originally tried in Florida in an attempt to curtail home health fraud in the Medicaid program. NAMES was very much involved in 1995 in working with officials of the Florida Medicaid program to identify fraud and abuse in the HME services industry, especially on what to look for in identifying a legitimate HME provider. Both the state of Florida and the HME services industry found the surety bond requirement to be a reasonable and effective tool in combating fraud and abuse.

Mr. Chairman, the principal benefit of surety bonds is to discourage unethical or unscrupulous

individuals from entering a particular line of business -- whether HME or home construction. As House Ways and Means Health Subcommittee Ranking Minority Member Pete Stark noted in his comments on HCFA's proposed rule, "The purpose behind my legislation was to stop the fly-by-night companies and make sure that precious Medicare dollars go where they belong - - to provide health care for our seniors." NAMES members couldn't agree more.

Unfortunately, it appears from the outside, that the HCFA officials who were charged with implementing the surety bond requirement failed to recognize that while surety bonds may be effective at preventing fraud, they are not appropriate for addressing overpayment concerns.

Because HCFA tried to accomplish too much with its surety bond proposal for home health and HME, the agency ran into a buzz saw of opposition from the affected industries and bipartisan Members of Congress. As we recently saw, HCFA has withdrawn its surety bond proposal for Home Health Agencies and in conversations with HCFA staff, we have been led to believe that the HME final rule may be delayed while HCFA and the GAO study the issue further.

As we said in our comments on the proposed rule, "NAMES continues to believe that a $50,000 surety bond is a reasonable requirement to enter the Medicare program." However, increasing that requirement to 15% of a company's Medicare business up to $3,000,000 went far beyond Congressional intent. More importantly, HCFA took a surety bond requirement that would have imposed a reasonable cost on the HME services provider and multiplied that cost to a level that was prohibitive. In addition, by failing to exercise the authority Congress gave HCFA to waive

the surety bond requirement for providers that met comparable surety bond requirements, imposed by a state, the provision became even more onerous and costly. As a result, HME providers that also participate in state Medicaid programs would be required to obtain two surety bonds.

We believe there are several steps HCFA can take in both the short term and long term to address our mutual concerns about fraud and abuse in the Medicare program:

1. Require all HME providers to obtain a surety bond of $50,000 in order to enroll or re-enroll in the Medicare program. (Providers that are certified or licensed would be exempted from this requirement.)
2. Permit a waiver of the federal surety bond requirement in states where a comparable state surety bond requirement for HME exists. In other words, require providers to obtain only one bond for both the Medicare and Medicaid programs.
3. Require participation in an HME certification program in order to enroll in the Medicare program. (Providers that are certified would be exempt from the surety bond requirement.)

While we believe the bulk of the fraud and abuse in the HME services industry is being committed by a small number of suppliers, NAMES has been and remains committed to working with Congress and the Administration to eliminate all fraud and abuse in the HME services industry. The Medicare HME benefit has been ripe for fraud because unlike most other

areas of Medicare, the ability to deliver HME services has been open to virtually anyone. While the surety bond requirement will cause a significant percentage of the illegitimate HME suppliers to leave the business -- a result that we applaud -- it alone will not restore confidence in HME suppliers.

Mr. Chairman, NAMES membership and leadership are committed to working with the Health Care Financing Administration and the four Durable Medical Equipment Regional Carriers to prevent waste, fraud and abuse in the Medicare program. As an industry, we have recognized for some time that aggressive steps were necessary to clean up this business.

NAMES leadership, therefore, has endorsed a process of certification for HME suppliers. We have recently met with HCFA officials responsible for overseeing this area to present our ideas. We are clearly in the early stages of development of these standards, but we hope to work in partnership with the agency.

In addition to the program we are developing, a large voluntary HME accreditation process has been in place for several years through national organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). And while we can encourage adherence to industry-wide standards for our members, these efforts will have little overall impact until adherence to these standards affects a supplier's ability to participate in Medicare.

We are already seeing the private sector adopt HME accreditation standards as a condition of

doing business and this is having the desired effect. But in Medicare, HME suppliers that subject themselves to rigorous oversight and inspection are treated no differently than those companies that fail to adhere to these standards. Unless HME suppliers see that the government values adherence to these standards, our concern is that over time, fewer and fewer companies will agree to comply.

We have met with your Subcommittee's staff to outline some of our ideas and would like to continue working with them as this process continues. At some point, we may ask for some prodding from Congress. However, we are comfortable working with HCFA to adopt reasonable standards for the HME services industry. We look forward to working with your office and I would be happy to answer any questions you may have.

Mr. SHAYS. Mr. Dombi.

Mr. DOMBI. Thank you for the opportunity and support that this committee has given to the very difficult efforts to address fraud and abuse in health care, and in particular I thank Mr. Pappas for his support on the IPS issue of trying to deal with the difficult balance of efficient program management while retaining access to care.

Mr. SHAYS. You are not from New Jersey and you want to thank the gentleman?

Mr. DOMBI. No. In that respect, I am a Connecticut native, a graduate of the University of Connecticut, undergraduate and law school, a diehard UConn Husky fan.

Mr. SHAYS. Say no more. You have 10 minutes.

Mr. DOMBI. And I drove through New Jersey on my way to Washington.

Mr. PAPPAS. Right through my district.

Mr. SHAYS. Start his clock over. I interrupted him.

Mr. DOMBI. Thank you for that.

We heard Mr. Grob speak in terms of the various percentages of waste, fraud and abuse in home health care. We don't care whether it is 40 percent or 5 percent. Zero tolerance is the standard.

The major problem that came to home care was its massive overnight growth, both in terms of the numbers of providers, the utilization of services, the selection of patients, the marketing techniques and everything else. The only right value that works with home care when dealing with Medicare and Medicaid is the value of caring. If someone comes into the Medicare program with a value different than that, they are sadly mistaken as to where they will end up. If they intend to commit fraud, it is a victimization of all of those good providers as well as the Medicare program, its patients and the American people at large.

Is a surety bond the solution to that? Unfortunately, we believe it is an inadequate solution. It does not address the character of the people who come into the program, and even more importantly perhaps, it doesn't address their competency. We have long advocated for very strong admission standards into the Medicare program, and as Ms. Thompson indicated, there have been changes along that direction but the changes to date are still inadequate.

It is important that a home health agency demonstrate its capacity to deliver quality of care. We believe that it is also important that they demonstrate their ability to financially manage the organization, to make a determination between covered and non-covered services, and to ensure compliance with the myriad of rules and regulations that govern the Medicare program.

Caring has to drive the home health agency because, with the Byzantine nature of the Medicare structure, it is the only way that you can retain your sanity. It is because you see what is important at the end of that effort.

The surety bond itself was intended as a device to keep out the fraudulent and abusive providers of servicers. It can be strengthened to accomplish that end, but as a device to deal with overpayments, with the nature of the bond generally requiring personal guarantees of that obligee, we are looking at something which cannot work.

If I am a home health agency, I cannot guarantee not only that my employees do not fail to comply with the rules but, more importantly, that HCFA doesn't change those rules retroactively, that HCFA doesn't reinterpret those rules retroactively, and even third parties beyond that.

An illustration of that is out of the State of Florida. A home care agency was subjected to a demand of half a million recoupment for claims that were not properly certified by a physician. A requirement of Medicare coverage is proper certification. This agency brought the claims to the physician's office. The certification statement was signed by somebody identifying himself as the physician, dated appropriately as well. Only months later the agency finds out that it wasn't the physician who signed it but the office manager trying to shortcut for that doctor all of the time necessary to complete that paperwork. No repercussions to the physician, all victimization being the home health agency. They were forced into the position of paying back nearly a half million dollars for services they delivered.

So overpayments are not necessarily just the fault of the home health agency, but they are the fault of others who they cannot control, and you can't insure against that. I am not going to stake my child's education fund, my home that I keep my family in, my livelihood on the actions of people that I can't role control. My own I can.

Years ago, I was an altar boy. I found out what values can bring where we had to find our way into this clique of altar boys only by shoplifting on Friday afternoon. If that is the sense of value within altar boys, I am scared for the rest of the country. At that point, I chose not to shoplift. I chose to go to law school instead.

We would recommend that the bond requirement be revisited and, as stated by previous witnesses, be limited to true fraud and abuse, that it be set at a $50,000 maximum and that agencies be evaluated as to whether or not they are in good standing so as to then waive the bond requirement for those agencies.

It was somewhat disconcerting to hear Ms. Thompson indicate in retrospect that they wished they had gone through the rulemaking procedures under the Administrative Procedures Act and the Regulatory Flexibility Act. We see nothing in their promise to revise these regulations which indicate an intended compliance with those rules in the next revision. We do not want to have to revisit this problem again. That would be another one of our recommendations.

Mr. SHAYS. We will followup on that.

Mr. DOMBI. Finally, we would encourage the committee to work with us and others to continue to strengthen program admission and participation requirements, to establish certification programs on competency on all elements of program operation, claims and coverage and reimbursement and the like.

We also encourage the establishment of appropriate standards for operation for the government agency and its agents as well. The appeal reversal rate is outstanding. Eighty percent of all claims reviewed by an ALJ are reversed. That is an error rate well beyond allowability.

Finally, we think that it is important that a mandatory compliance plan be required of home health agencies. The Office of the

Inspector General will shortly release its model compliance plan for home health agencies similar to that issued for hospitals and laboratories already. It is voluntary. Our organization supports it becoming mandatory.

Mr. SHAYS. Thank you.

[The prepared statement of Mr. Dombi follows:]

Mr. Chairman,

Thank you for the opportunity for the National Association for Home Care (NAHC) to provide testimony on issues related to the Health Care Financing Administration's (HCFA) efforts to implement the home health and durable medical equipment (DME) surety bond statutes.

The National Association for Home Care is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's nearly 6000-member organizations are every type of home care agency, including nonprofit agencies such as the visiting nurse associations, for-profit chains, hospital-based agencies and freestanding agencies.

NAHC is deeply appreciative of the attention the Chairman and Members of the subcommittee have shown in efforts to combat fraud and abuse in federal health care programs. All parties involved, including the providers of health care services, must continually work to preserve the integrity of these programs and to eliminate any and all waste. Through a cooperative interchange between government and the private sector, crucial programs like Medicare and Medicaid will have a bright future as a means of meeting the health care needs of our citizens. The home health care industry has been and intends to continue to be in the forefront of these efforts.

I would also like to take this opportunity to acknowledge several members of the Subcommittee who have called for reform of the interim payment system (IPS) that is having a devastating impact on home health providers and beneficiaries. Specifically, NAHC would like to commend Rep. Mike Pappas (R-NJ) for sponsoring H.R. 3567, the "Medicare Home Health Equity Act" which would restore the home health cost limits to 112% of the mean and establish a more equitable per-beneficiary cap. In addition, NAHC would like to thank Reps. Snowbarger, Gilman, Towns, Allen, Lantos, and Sanders for cosponsoring IPS reform legislation and taking a stand in support of home care providers and the beneficiaries they serve.

As part of its effort to stem fraud and abuse in health care, Congress set out a mandate in the Balanced Budget Act of 1997 (BBA) for Medicare and Medicaid participating home health agencies to maintain a surety bond. However, as a result of HCFA's failure to promulgate rational and appropriate regulations to implement the legislation, the protection to Medicare and Medicaid that could be secured through the surety bond has been delayed. It is our hope that through hearings such as the one being held by the Subcommittee, the development and implementations of sensible regulations can be advanced.

Background

HCFA has long had the authority to institute a bonding requirement for participation of home health agencies as Medicare providers of services. As part of the Omnibus Reconciliation Act of 1980, authorization was provided to establish bonding or escrow

account requirements "as the Secretary finds necessary for the financial security of the program." Over the years, the Secretary did not exercise that authority. With the Balanced Budget Act of 1997, the authority was altered from discretionary to mandatory, as home health agencies are now required to have a surety bond, at a minimum of $50,000, to participate in Medicare and/or Medicaid.

The surety bond mandate was triggered from a recommendation made by the Health and Human Services Inspector General, based on the Florida Medicaid program's experience with the surety bond requirement for home health agencies and durable medical equipment suppliers. That recommendation was presented out of the growing concern of an increase in fraud, waste, and abuse within the Medicare home health benefit. The Office of Inspector General (OIG) had engaged in several studies and issued reports outlining concerns with the growth in home care expenditures, the utilization level of home health services, and incidence of noncompliance with Medicare rules and regulations. In addition, the OIG and the Department of Justice had successfully prosecuted several home health agencies and their principals for Medicare fraud and violations of federal antikickback laws. As home care has grown, the risks of abuses by providers of care has also increased. This risk is especially heightened with new entrants into home care where the original values of home care may not be shared.

The purpose of this testimony is to address the issue of whether a surety bond is a valuable tool in addressing the problems of waste, fraud, and abuse that have been identified in the home health industry. Further, NAHC will address its concerns surrounding the published surety bond regulations over the past six months and their impact on access to bonds for home care agencies nationwide. This testimony will also address the relationship of the surety bond requirement to the earlier moratorium on new home health agencies. Finally, this testimony will offer additional antifraud remedies that could successfully contribute to efforts to eliminate fraud and abuse.

A Surety Bond: Does it Work as an Antifraud Mechanism?

If properly developed, a surety bond requirement for participation in Medicare and Medicaid programs for home health agencies could have some value as a device to curtail fraud, waste, and abuse. However, due to the nature of the bond concept, its true value would be limited.

As originally contemplated, the surety bond requirement was intended to prevent individuals and organizations that present high risk of abuse from participating in Medicare or Medicaid. The expectation was that the bond requirement would act as a screening device to insure that only reputable home care organizations secured the privilege of participating in Medicare and Medicaid. However, due to the qualifying criteria utilized by the bond companies in the evaluation of a surety bond applicant, the actual value to the programs in achieving that notable goal is not significant.

It is possible that a surety bond company may conduct a full background and character screening of the applicant. Through that evaluation, an individual with a criminal record

or a history of financial and business abuses might be uncovered. More often, the surety bond company will screen applicants based primarily on financial criteria, reviewing the organization's profit/loss ratio, cash flow, and net worth. In addition, the surety bond company would look to secure its risk through collateral and personal indemnification.

This financial review and security arrangement may be appropriate for the bond company to determine its risk of a financial loss, but it does not necessarily relate to whether the applicant creates a risk of fraud and abuse within the Medicare and Medicaid programs. It may very well appear that the financial circumstances of an applicant organization are risk worthy due to the accumulation of assets and net worth through fraudulent activity. This is particularly the case with home health services. Since the Medicare benefit operates on cost reimbursement, any profit for a home health agency is either attained through alternative revenue sources or dishonesty. A reputable home health organization which has not accumulated assets, shows no profit, yet has been fully compliant with Medicare program requirements may either not qualify for a bond or, if qualified, be required to post unavailable collateral or assume extensive personal indemnification at two or three times the face value of the bond.

While a few surety bond companies might engage in the background screening of the principals of a home care organization, it is less likely that the bond companies will analyze and evaluate the background of agency management and employees. The findings and conclusions of the OIG and the General Accounting Office indicate that fraud and abuse in home care is not limited to owners and operators of home health agencies. Both the federal programs and the home care organizations have been victimized by fraud and abuse perpetrated by staff. Accordingly, the value of the surety bond as a tool to prevent this type of abuse is insignificant.

HCFA Implementation Oversteps Congressional Mandate

Surety bonds were meant to serve as a deterrent to "fly by night" providers in Medicare and Medicaid - to screen out entities that pose a significant risk to the integrity of the programs. In its January 5, 1998 initial regulatory promulgation, HCFA significantly altered the purpose and concept of surety bonds for home health agencies in stating its intent to also use surety bonds to insure against the loss of any program overpayments. As such, HCFA implemented the surety bond requirement in a manner which not only protected the programs against the financial losses occasioned by fraud and abuse, but also to serve as an insurance against any overpayments that could occur through the honest human error of a home health agency or the errors of the program administration by HCFA and its agents. This approach was taken despite the fact that HCFA, in its January 5, 1998 regulation promulgation, stated that less than 2/10 of 1% of program revenues for home health services result in unrecouped overpayments. Therefore, the burden of imposing a bond obligation and its corresponding qualifications or limitations on access was both unnecessary and excessive.

The results of HCFA action were immediate. Upon review of the standards set out in the January 5 regulation, surety bond companies withdrew from the Medicare market, home

health agencies were rejected by bond companies nationwide, and still other home health agencies were put in a position where acquisition of a bond was not reasonable or rational. Ultimately, HCFA indicated its intention to amend the rule and it withdrew the February 27 compliance date.

On June 1, 1998, a revised regulation was issued by HCFA that modestly modified the January 5 requirements. Those modifications specifically addressed only concerns raised by the surety bond industry: bond company appeal rights, the risk of cumulative liability, and the length of time which a bond company held a risk of liability. No real substantive changes were made in the bond requirements which would have the effect of increasing reasonable access to bonds by reputable home care agencies.

In the first iteration of the regulatory implementation, NAHC's analysis concluded that about two-thirds of the home health agencies which were required to obtain a bond could not effectively or reasonably do so. The amended regulation issued on June 1 improved matters only slightly, and in NAHC's estimation, approximately 60% of home health agencies could not effectively or reasonably secure the bond with these revisions.

With both regulatory standards, the home health agencies that were able to secure a bond fell into common categories. These categories were:

- Hospital based home health agencies
- Some large chain home health agencies
- Home health agencies with significant non-Medicare/Medicaid revenue sources
- Certain not-for-profit long-standing community based visiting nurse associations

Similarly, home health agencies which had difficulty or impossibility in securing a bond included:

- Small, rural providers of services
- Freestanding, privately held home health agencies
- Certain not-for-profit community based home health agencies

The differences between the two categories of home health agencies were purely financial. For example, the hospital based home health agencies were able to obtain a bond by securing that bond with the collateral of the hospital facility or the ability to demonstrate positive net worth for the entire health service organization. The chain organization home health agencies were publicly held corporations that had positive net worth. With certain not-for-profit visiting nurse associations and other community based agencies, bonds were available because of accumulated assets, reserves, endowments, or the willingness of the bond company to recognize the long standing existence of a financially solvent organization even in the absence of accumulated net worth.

The second category represents providers where bonds were either inaccessible or effectively unavailable due to the conditions of the bonding companies. The prevalent reason for this result was the requirement of bond companies to demand a personal

indemnification by the owner or members of the board of the home health agency. Generally, the personal indemnification represented an amount equivalent to two to three times the face value of the bond in order to cover recoupment costs. This requirement is a standard element of a surety bond. With home health agencies, it was imposed whether the agency was for-profit or not-for-profit. Some not-for-profit agencies reported to NAHC that the personal indemnification requirement was made on its community-based board of directors. In another instance, the employed administrator and her spouse secured a bond by guaranteeing it through a pledge of their home.

The personal indemnification was required by the surety bond companies regardless of historical experiences of the home health agency with the Medicare and Medicaid programs. It became a significant roadblock to accessing a bond because the individuals either did not have personal assets sufficient to support a guarantee or they were unwilling to take such a personal risk when there was not offsetting opportunity for gain in a cost reimbursement program. Many others were unwilling to take the risk due to the ongoing arbitrary and inconsistent administration of the home health benefit where revised interpretations of long standing rules are applied retroactively.

The reasons for rejection of other home health agencies cover a wide range including insufficient net worth, unavailability of collateral, existing overpayments with Medicare (even where in the process of repayment), and low rates under the interim payment system.

It is NAHC's opinion that the continuation of a surety bond requirement in the manner promulgated by HCFA would lead to a significant loss of access to services throughout the country. In many of the rural areas, there would be no adequate alternative provider available to substitute for an agency that could not secure a bond. With inner city home health services, a similar lack of substitution exists. In other circumstances, the nature of the population served by a specialty home health agency, e.g. infusion therapy for infectious disease patients, ventilator dependant children, and services for the mentally retarded and handicapped may be lost due to the inadequacy of alternative care providers. A particular problem arises with Medicaid providers of services resulting from limited caseloads and low levels of reimbursement. In such circumstances, the loss of a participating Medicaid provider could close out access to services for the Medicaid population in that region.

As previously stated, NAHC's concerns with the January 5 and June 1 surety bond regulations remain essentially unchanged. The modifications improved the financial risks for the surety bond companies, thereby opening up the availability of bonds to a limited degree. However, HCFA failed to address any of the home care industry concerns. These concerns are as follows:

- The surety bonds were not limited to the financial risks posed Medicare/Medicaid programs through fraud and abuse.

- Using the surety bond concept to insure against the loss from any program overpayments, effectively creating an insurance against the program's own erroneous administration and failure to properly oversee expenditures.
- HCFA set the bond value at the greater of $50,000 or 15% of previous year's revenues from Medicare and/or Medicaid programs.
- The minimum $50,000 amount can raise serious problems from small, often rural, home health agencies. Further, the 15% calculation could lead to a prohibitively high cost for a home health agency. This cost is represented in both the nonreimbursable bond cost as well as the level of obligation to present collateral or personal indemnification. HCFA's implementation of the 15% calculation is sensible only if every agency incurred the maximum potential overpayment and every agency failed to repay any part of the overpayment. The historical recoupment of overpayments demonstrates that the level of protection sought in unnecessary.
- HCFA required separate bond requirements for Medicare and Medicaid services. In a post regulatory policy issuance, HCFA allowed for a single bond where the combined revenue for the home health agency was $344,000 or less. However, even with this exception, low Medicaid reimbursement rates nationwide may discourage home health agencies from continuing participation as the result of the cost and conditions of a separate Medicaid bond.
- HCFA failed to consider whether the home health agency is in good standing with the Medicare and Medicaid programs. HCFA exercised its authority to establish a waiver of the requirement for government operated home health agencies on the basis that the interests of Medicare and Medicaid programs are already adequately protected in these agencies. A similar standard should apply to other home health agencies that have demonstrated ongoing compliance and fiscal responsibility to the programs.
- As previously stated, HCFA intended to use the surety bonds to address unrecouped overpayments. NAHC recommends that this standard be changed. However, if HCFA retains this use, NAHC is very concerned that the surety companies can become the payors of first resort, rather than allowing home care agencies to establish a repayment plan for any overpayments. Currently, there is no consistent, objective criteria established for determining whether a home health agency qualifies for a repayment plan and what that plan might be. If home care agencies are not first given an opportunity to repay the amount, calling the bond could lead to the termination of the provider agreement even in cases where the home health agency is willing and able to repay the amount.
- Clarification is needed from HCFA regarding the requirement that new providers secure bonds before being permitted to participate in Medicare and/or Medicaid. It is unknown whether the requirement applies to existing providers with branch offices that are transitioning to subunits under HCFA's August 1997 policy directive. These home health agencies should be allowed to achieve provider status without securing a bond.
- HCFA's bonding requirement was continuous. Unlike the Florida bond standard where only a first year bond is generally required, HCFA's standards require a continuous bond for the home health agency.

- NAHC also has raised serious questions regarding the authority and appropriateness of HCFA's waiver of rulemaking protections available under the Administrative Procedures Act (APA), as well as HCFA's compliance with the Small Business Regulatory Enforcement Fairness Act (SBREFA). An opinion of the Small Business Administrations Office of Advocacy (attached as Exhibit 1) detailed HCFA's complete failures in this area. Had HCFA properly undertaken proposed rulemaking and performed the necessary impact analysis prior to the implementation of the surety bond regulations neither the initial revisions nor the revisions still in planning would have been necessary. The purpose and design of the APA and the SBREFA are to achieve appropriate regulations as efficiently as possible.

Surety Bond Recommendations

1. HCFA should develop the surety bond regulations based on the intended principle and purpose of screening out inappropriate home health agencies rather than as an insurance policy against overpayments.

2. Legislation should be enacted to allow recognition of the costs of a surety bond.

3. The bond amount should be reduced below $50,000 for small home health agencies.

4. HCFA should reduce the bond amount to no greater than $50,000.

5. HCFA should establish standards for waiver of the bond requirement for any home health agency in good standing.

6. HCFA should establish objective criteria for the eligibility of a home health agency for a Medicare repayment plan.

7. HCFA should postpone the bond compliance date for new subunits so that it is consistent with the time standards for existing home health agencies.

8. HCFA should not implement or enforce the surety bond regulations until completion of the notice and comment procedures required under the APA.

9. HCFA should comply with all procedural requirement of SBREFA, including Congressional notice and the exploration and evaluation of alternatives.

The Home Health Agency Moratorium

On September 15, 1998, President Clinton announced the imposition of a moratorium on new Medicare home health agencies. The purpose of the moratorium was to put a hold on new agencies until HCFA could implement strengthened program admission

standards, including the surety bond rule. Subsequently, HCFA issued program guidelines establishing certain admission standards, such as the minimum number of patients that needed to be served (generally ten), before Medicare participation could be considered. The issuance of these guidelines and the publication of the surety bond and initial capitalization rule led to the lifting of the moratorium.

While NAHC had generally supported a moratorium, the manner in which it was imposed was unacceptable. The lack of advance warning left many organizations that had committed significant financial investment to advance an effort toward Medicare certification at great risk. In some instances, the moratorium blocked certification for agencies that had proven compliance with the qualifications only a few hours too late.

The implementation of the surety bond requirement made only a minor difference for applicant agencies when the moratorium was lifted. In fact, a new home health agency often had an easier time securing a surety bond than a long time agency. A new agency brought no accumulated risk of liability for the bond company as its Medicare slate was empty and clean.

As an antifraud tool, the moratorium accomplished very little. The strengthened program admission standards – the surety bond, capitalization and minimum patient requirements – still failed to address core issues of competency and compliance. It should be seriously questioned as to whether the moratorium benefits outweighed its harm.

Additional and Alternative Antifraud Remedies

As discussed above, the value of a surety bond as a tool in addressing fraud, waste, and abuse is extremely limited. Generally, it offers only a screening process regarding the financial viability and solvency of an organization. It does not act as an adequate screen for the prevention of fraud by the home care organization, its principals, or employees.

As implemented, the surety bond requirement creates a protection for the Medicare and Medicaid programs from their own negligent administration or administration by their agents. An overpayment to a provider of services cannot presumptively be attributed to the fault of the provider of services. For example, in the administration of the Medicare program, the regional home health intermediaries have erred in reimbursement and coverage determinations leading to overpayments that are not readily uncovered by the provider of services. In addition, these intermediaries reject claims for payment, wrongfully leading to additional costs such as appeals.

A noteworthy illustration of intermediary error which lead to overpayments occurred during the administration of the cost limit freeze in 1994 and 1995. A former regional home health intermediary, Blue Cross and Blue Shield of New Mexico, notified numerous providers of their annual cost limits. The intermediary set the limits at levels greater than that set out in the federal regulation. These cost limit levels are calculated by the intermediary on an annual basis. Individual notice is sent to the provider of services prior to that provider's fiscal year. Interim payment rates are set based upon these cost

limits with final settlement at the close of the provider's fiscal year. In this instance, with higher than appropriate cost limits, home health agencies were provided interim payment rates greater than allowable. The resultant overpayments created significant financial problems for the involved home health agencies. It had been reported to NAHC that some agencies were forced to close over the error of this intermediary.

Similar administrative concerns exist in the area of claims processing and payment. Consistently over the past several years, intermediary performance in distinguishing covered from noncovered claims has proven to be less than exemplary. With tens of thousands of appeals each year, the intermediary claim determinations are frequently reversed. As the attached HCFA letters indicate reversal rates by the intermediaries themselves at reconsideration approximate 40% of claims reviewed. Appeals presented to Administrative Law Judges result in over an 80% reversal rate. (Exhibit 2) These intermediary errors generally require home health agencies to secure lines of credit with an interest cost that is ultimately passed on back to the Medicare program. Intermediaries in the meantime are reimbursed for the costs of their efforts to correct their own errors through their contracts with HCFA.

In September 1997 NAHC convened a strategic planning session involving representatives from home health agencies across the country. The purpose was to develop a plan to combat fraud and abuse in home health care. Multiple recommendations came from that plan. Many of these recommendations mirror those presented to Speaker of the House Newt Gingrich in our August 22, 1995 letter. (Attached as Exhibit 3). These recommendations present viable alternative tools to combat fraud and abuse in a manner which prevents the offense rather than addresses it with post offense sanctions such as recoupment and other financial penalties. These recommendations include:

1. Mandatory implementation of a corporate compliance plan. The Office of Inspector General, in cooperation and consultation with the home health industry, will soon release a model compliance plan for home health services.
2. The institution of a requirement that all principals of a home health agency undergo a screening and background check. The home health agency would also be responsible for conducting screening and background checks for all employees.
3. The institution of strengthened enrollment standards, including requirements for demonstration of competency in matters related to reimbursement, claims, and coverage. Current enrollment standards look only to the quality of services provided by a home health agency without regard to the agency's competency to manage within the Medicare program overall. NAHC has already implemented a certification program for home care administrators and is in the process of developing a certification program for chief financial officers.
4. Expedited implementation of prospective payment. PPS implementation would go a long way to eliminate the perverse incentives created in cost

reimbursement as well as the opportunities to commit cost report related fraud.

5. Improved consumer information regarding Medicare home health services. The consumer should become an active partner in securing the integrity of the home health benefit. This can only be done through adequate information regarding Medicare standards.
6. Improved government performance standards. Currently, HCFA has limited and inadequate standards for determining internal performance quality and the quality of performance of its agents, the intermediaries.
7. Competency testing of program administrators to complement that of provider participants.
8. Establishment of collaborative education where both providers and the intermediaries can be trained and educated in a consistent manner.
9. Establishment of outcome based compliance standards. HCFA has long operated through a series of prescriptive requirements which ultimately have little bearing on outcome performance. For example, a claim may be denied for a technical reason such as lack of a physician's order, forcing the provider of services into an appeals process to prove the existence of that physician's order. A much less expensive and time consuming reopening could easily accomplish the same result. On a positive note, HCFA is moving toward outcome based compliance standards for quality of care controls. These regulations are expected in 1999.
10. Issuance of rules in plain English and compliance with the APA. In the last two years, HCFA has shown an increasing tendency to avoid public rulemaking. This can lead to disastrous results as shown with the surety bond rule.

A Changed Environment at HCFA

NAHC, since its inception in 1983, has worked with HCFA. HCFA has adopted various philosophies in dealing with providers of services over that time. At one point, HCFA viewed providers as both partners and customers. That relationship no longer exists. Instead, it appears that HCFA views providers as adversaries and presumptively fraudulent. Handling of the surety bond rule promulgation evidences this attitude.

From the enactment of the surety bond requirement under the Balanced Budget Act of 1997, NAHC attempted to open a dialogue with the policy makers at HCFA. At every turn it was apparent that they heard but did not listen to what home care had to say about the developing surety bond requirements. While HCFA officials were willing to meet with NAHC and receive NAHC telephone calls, these meetings and calls did not lead to open discussion. Crucial pleas to expedite the timely issuance of implementing regulations were ignored, leading to the initial promulgation on January 5, 1998 with an effective date of January 1. Prior to that time, home care agencies from across the country experienced high anxiety over attempting to comply with yet to be issued rules where failure to comply meant risk of program termination.

Once issued, the dialogue with HCFA over the regulations maintained a consistency with the preissuance dialogue. It was not until it reached crisis proportions and Congressional intervention occurred that HCFA finally understood that home health agencies were unable to access appropriate bonds.

Where HCFA is unwilling or unable to dialogue with affected parties prior to the issuance of its rules, compliance with the prior notice and comment obligations of the Administrative Procedures Act is paramount to successful rulemaking. With the surety bond rules, HCFA neither allowed for an open dialogue nor pursued matters in compliance with the APA. The resultant disaster is a testament to what can occur when preestablished processes are not followed.

NAHC has long operated itself as an organization with integrity and awareness that the real purpose of the Medicare program is to serve Medicare beneficiaries. While we will continue with this philosophy, it is our sincere hope that HCFA will readopt the same.

Conclusion

The National Association for Home Care has established a standard of zero tolerance for fraud, waste and abuse in serving home care patients. For every dollar lost to an offending party, a home care patient is adversely affected. The home care industry has worked strenuously to reenergize and reinforce the values which lead to the creation of home care. Our patients are our only true concern. What is appropriate and beneficial to home care patients is appropriate and beneficial to the home care industry. The surety bond requirement should be viewed as a tool to prevent fraud, waste, and abuse, not as a punitive measure arbitrarily applied against reputable home care providers. At the same time, preventative measures should be given higher priority.

Thank you for the opportunity to present the views of the National Association for Home Care. We look forward to working with the Subcommittee on this important matter. We are available to you at any time we can be of assistance.

U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

OFFICE OF CHIEF COUNSEL FOR ADVOCACY

APR 15 1998

Health Care Financing Administration
Department of Health and Human Services
Attn: HCFA-1152-FC
P.O. Box 26688
Baltimore, MD 21207-0488

[illegible] Regulatory Flexibility Act Requirements; Petition for [illegible] Final Rule on Surety Bond and Capitalization Requirements [illegible] Health Care Agencies, 63 Fed. Reg. 292 (January 5, [illegible]) Reg. 10,730 and 63 Fed. Reg. 10,732 (March 4, 1998); File Code HCFA-1152-FC.

Dear Dockets Management Clerk:

On January 5, 1998, the Heath Care Financing Administration (HCFA) published a final rule with comment period concerning surety bond and capitalization requirements for home health care agencies (HHAs). This regulation implements the surety bond requirement for such agencies established in the Balanced Budget Act of 1997 (BBA). The regulation also imposes additional minimum capitalization requirements on the agencies and includes an additional 15 percent surety bond requirements not contained in the BBA. The goal of the BBA and this final rule is to reduce Medicare/Medicaid fraud by regulating HHAs that do not or cannot reimburse Medicare/Medicaid for overpayments.

To address complaints by the surety bond industry and the HHA industry regarding the compliance deadline for obtaining surety bonds, HCFA published a final rule on March 4, 1998 deleting the February 27, 1998 effective date for all HHAs to furnish a surety bond. The new compliance date is on or about April 28, 1998, or 60 days after publication of the final rule.

In addition, to address complaints by the surety bond industry and members of the Senate Finance Committee regarding the potentially unlimited liability of sureties under the final rule, HCFA published a Notice of Intent to Amend Regulations on March 4, 1998 (concurrently with the final rule to extend the compliance date). The notice announces HCFA's intent to amend the final rule so as to limit the surety's liability under certain circumstances. It also establishes that a surety will only remain liable on a bond for an additional two years after the date an HHA leaves the Medicare/Medicaid program; and gives a surety the right to appeal an overpayment, civil money penalty or an assessment if the HHA fails to pursue its rights of appeal. HCFA claims that the changes will help smaller, reputable HHAs, like non-profit visiting nurse associations, to obtain surety bonds.

FEDERAL RECYCLING PROGRAM PRINTED ON RECYCLED PAPER

EXHIBIT
1

The Office of the Chief Counsel for Advocacy of the U.S. Small Business Administration was created in 1976 to represent the views and interests of small business in federal policy making activities.[1] The Chief Counsel participates in rulemakings when he deems it necessary to ensure proper representation of small business interests. In addition to these responsibilities, the Chief Counsel monitors compliance with the Regulatory Flexibility Act (RFA), and works with federal agencies to ensure that their rulemakings demonstrate an analysis of the impact that their decisions will have on small businesses.

The Chief Counsel has reviewed the final rules in the instant case and has determined that HCFA has not adequately analyzed the impact on small entities. This determination does not mean that regulating the problem of fraud and abuse is not an important public policy objective. Nor does it mean that small business interests supersede legitimate public policy objectives. Rather, the determination is based on the principle that public policy objectives must be achieved by utilizing recognized administrative procedures. The purpose of the procedures is not to place an unnecessary burden on federal regulatory agencies, but to ensure the promulgation of common sense regulations that do not unduly discourage or destroy competition in the marketplace.

The final rule is troubling for a number of reasons: 1) The proposal, although probably within HCFA's regulatory and statutory authority, goes far beyond the requirements contemplated by Congress when they enacted the BBA; 2) HCFA's good cause exception and waiver of the proposed rulemaking may be arbitrary and capricious under the Administrative Procedure Act (APA); and 3) Nearly all of the significant procedural and analytical requirements of the RFA were overlooked.

Action requested: Inasmuch as the rule is now final and in effect, the Chief Counsel of the Office of Advocacy herewith petitions the agency, pursuant to 5 U.S.C. § 553(e), to amend the final rule to exclude the provisions concerning the 15 percent bond requirement and the capitalization requirement until such time as a proper and adequate analysis can be prepared to determine the impact on small entities.

I. Legislative History and Intent

Prior to August 5, 1997, there were no provisions in the law pertaining to a surety bond requirement for home health agencies. Under the House bill (The Balanced Budget Act of 1997, H.R. 2015), there remained no provisions for the surety bond requirement. Under the Senate bill (as amended) (S. 947), a requirement was introduced to provide state Medicaid agencies with surety bonds in amounts not less than $50,000. Finally, in the conference agreement, the final bill was modified to require a surety bond of not less than $50,000, or such comparable surety bond as the Secretary may permit (applicable to home health care services furnished on or after January 1, 1998).[2] Congress, therefore, intended there to be a $50,000 or "comparable" bond, but did not intend the bond to be higher.

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[1] Regulatory Flexibility Act, 5 U.S.C. § 601, as amended by the Small Business Regulatory Enforcement Fairness Act, Pub. L. No. 104-121, 110 Stat. 866 (1996).

[2] See 143 Cong. Rec. H6253-6254 (daily ed. July 29, 1997).

The surety bond issue had not been the subject of public hearings, and some members of Congress expressed concern about the potential impact of the fraud and abuse provisions.

According to a floor statement by Senator Hatch, the fraud and abuse provisions found in the amended Senate version were actually based on provisions contained in the Administration's fraud and abuse legislation introduced earlier in 1997, and on which no hearings were held in the Senate. Senator Hatch was concerned that the fraud and abuse provisions might have "unintended consequences or implications that would penalize innocent parties who are following the letter of the law."[3] He further stated that, "As a general rule, we in the Congress should not act without the full and open benefit of hearings so that all parties have an opportunity to comment, and so that legislation can be modified as appropriate."[4] With regard to the surety bond requirement, it seems that the affected business community had no real opportunity to provide meaningful input or comment.

After the legislation was enacted, HCFA had little choice but to implement the surety bond requirement. However, the agency created additional bonding and capitalization requirements and incorporated them into the instant final rule.[5] Not only were law abiding home health agencies denied an opportunity to comment during the legislative process, they are now faced with additional burdensome requirements effective almost immediately—with no true recourse (since the agency waived the notice of proposed rulemaking and the 30-day interim effective date).

Congress clearly intended to eliminate or reduce waste and fraud in the Medicare/Medicaid system and to preserve quality patient care. The presumably unintended effects of the legislation and HCFA's final rule are that legitimate, law abiding home health agencies will be forced to file bankruptcy, go out of business or curtail their business operations significantly. Patient care will likely suffer when there are not enough home health agencies to meet increasing public demand in an aging population. Moreover, the resulting lack of market competition and bloating of the large, hospital-based and government-based home health agencies may lead to increased prices.

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[3] 143 CONG. REC. S6159 (daily ed. July 24, 1997) (statement of Sen. Hatch).

[4] *Id.* at S6159-60.

[5] Those requirements include basing the amount of the bond on a flat rate in combination with the $50,000 minimum bond. The flat rate is designated as 15 percent of the annual amount paid to the HHA by Medicare as reflected in the HHA's most recently accepted cost report. The other major requirement for new HHAs is for minimum capitalization. The amount of the reserve is to be determined by Medicare intermediaries based on the first year experience of other HHAs. First the intermediary determines an average cost per visit based on first-year cost report data for at least three HHAs that it serves that are comparable to the HHA seeking to enter the Medicare program. The average cost per visit is determined by dividing the sum of the total reported costs of care for all patients of the HHAs by the sum of their total visits. Then, the intermediary multiplies the average cost per visit by the projected number of visits for all patients (Medicare, Medicaid and all other patients) for the first three months of operation of the HHA asking to enter the program. HCFA also designates which funds count toward satisfying the capitalization requirement (--fifty percent of the funds required for capitalization must be non-borrowed funds). Medicare expects those funds to be available in cash or, in some cases, short term, highly liquid cash equivalents.

II. Waiver of Administrative Procedure

An agency is subject to the notice and comment requirements contained in 5 U.S.C. § 553 unless the agency rule is exempt from coverage of the APA, or the agency establishes "good cause" for not complying with the APA and waives notice and comment. When an agency waives the notice and comment procedures required by the APA, however, there should be compelling reasons therefor. In fact, courts have held that exceptions to APA procedures are to be "narrowly construed and only reluctantly countenanced." *New Jersey v. EPA*, 26 F.2d 1038, 1045 (D.C.Cir. 1980).

In the instant case, the agency waived both the notice and comment requirement and the requirement to allow a 30-day interim period prior to a rule's effective date. The agency based its "good cause" waiver on three factors: 1) Issuing a proposed rule would be impracticable because Congress mandated that the effective date for the surety bond requirement be January 1, 1998—five months after Congress passed the BBA of 1997; 2) Issuing a proposed rule is unnecessary with respect to Medicare regulations because there is a statutory exception when the implementation deadline is less than 150 days after enactment of the statute in which the deadline is contained; and 3) A delay in issuing the regulations would be contrary to the public interest.

First, with regard to the impracticability of issuing a proposed rule, as a general matter, "strict congressionally imposed deadlines, without more, by no means warrant invocation of the good cause exception." *Petry v. Block*, 737 F.2d 1193, 1203 (D.C.Cir. 1984). In addition, there is no good cause exception where "an agency unwilling to provide notice or an opportunity to comment could simply wait until the eve of a statutory . . . deadline, then raise up the 'good cause' banner and promulgate rules without following APA procedures." *Council of Southern Mountains, Inc. v. Donovan*, 653 F.2d 573, 581 (D.C.Cir. 1981).

By way of example, in *Petry v. Block*, the court concluded that the passage of a complex and extraordinary statute concerning changes in administrative reimbursements under the Child Care Food Program that imposed a 60-day deadline for the promulgation of interim rules justified the agency's invocation of the good cause exception. Also, in *Methodist Hospital of Sacramento v. Shalala*, 38 F.3d 1225 1236, (D.C. Cir. 1994), the court stated that the agency had good cause to waive notice and comment because Congress imposed a statutory deadline of about 4 1/2 months "to implement a complete and radical overhaul of the Medicare reimbursement system." (Emphasis added). Moreover, "[o]nce published, the interim rules took up 133 pages in the Federal Register: 55 pages of explanatory text; 37 pages of revised regulations, and 41 pages of new data tables." *Id.*

In the instant case, HCFA had five months to implement a relatively simple provision to require a $50,000 or comparable surety bond from home health agencies. After HCFA added additional bond requirements and capitalization requirements (never requested or contemplated by Congress), the regulation took up 63 pages in the Federal Register: 18

pages of explanatory text, 6 pages of revised regulations, and 39 pages of application documents. The final rule appeared in the Federal Register on January 5, 1998—four days after the mandatory effective date.

The Office of Advocacy opines that if HCFA had not included the additional requirements, which were not intended by Congress, and therefore not intended to be implemented within the five month window, there would have been ample time to follow proper notice and comment procedures. Based on the circumstances of this rulemaking and pointed case law, HCFA cannot rely on the impracticability argument to demonstrate that it had good cause to waive notice and comment.

Second, HCFA also based its good cause exception to notice and comment on the fact that they have the statutory authority to do so with regard to this particular type of rule. The agency states:

> "Issuing a proposed rule prior to issuing a final rule is also unnecessary with respect to the Medicare surety bond regulation because the Congress has provided that a Medicare rule need not be issued as a proposed rule before issuing a final rule if, as here, a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the enactment of the statute in which the deadline is contained."[4]

HCFA cannot rely on this statutory provision because the agency has gone way beyond their statutory mandate in issuing this final rule. Again, Congress only intended there to be a $50,000 or comparable surety bond. Therefore, only those provisions contemplated by Congress should be subject to the statute that permits HCFA to waive notice and comment when the deadline is less than 150 days.

Third, HCFA claims that a delay in implementing the final rule would be contrary to public policy. Quite the contrary---implementing the final rule as written would be contrary to public policy. The final rule imposes serious economic burdens on an industry already under increased scrutiny and financial hardship including a recent moratorium on entrants to the Medicare program and repeated audits.[5] HCFA has also announced its intention to

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[4] 63 Fed. Reg. at 308.

[5] In September 1997, President Clinton announced that the Department of Health and Human Services was declaring the first ever moratorium to stop new home health providers from entering the Medicare program. The moratorium was lifted in January after the instant final rules were published in the Federal Register. The Office of Advocacy received at least one call from an anxious home health agency just starting their business. The agency had completed the reams of paperwork and all the other necessary requirements for entering the Medicare program, but had to put everything on hold because of the 4-month moratorium—announced just days before their Medicare application would have been approved. Where is this business going to get three months reserve to demonstrate that their business is adequately capitalized? Unable to enter the Medicare program, how have they survived thus far (when you consider that 95% of home health patients are Medicare eligible)?

Another business contacted the Office of Advocacy to complain that their home health agency had been audited three times in one year under the Administration's "Operation Restore Trust."

include home health agencies in the enormously complicated prospective payment system now used by hospitals and physicians. As such, availability of home healthcare for those communities not served by giant hospital-based providers will surely decrease. This result seems contrary to the stated public policy objective of Congress and HCFA.

Finally, it should be noted that HCFA did insert a post-effective date comment period in the final rule. However, the fact that HCFA attached a comment period to the final rule is not a valid substitute for the normal provisions of the APA. The third circuit stated that:

> "[i]f a period for comments, after issuance of a rule, could cure a violation of the APA's requirements, an agency could negate at will the Congressional decision that notice and an opportunity for comment must precede promulgation. Provisions of prior notice and comment allows effective participation in the rulemaking process while the decision maker is still receptive to information and argument. After the final rule is issued, the petitioner must come hat-in-hand and run the risk that the decision maker is likely to resist change." *Sharon Steel Corp. v. EPA*, 597 F.2d 377, 381 (3rd Cir. 1979).

HCFA's waiver of administrative procedure would be less troubling if the rule were not so burdensome. By waiving notice and comment procedures, the agency conveniently removes itself from the obligation to carefully analyze and solicit input on the impact of the rule. Such an analysis could have yielded other, less burdensome alternatives that would have accomplished the agency's public policy objectives.

Since HCFA improperly waived notice and comment, the agency must comply with the Regulatory Flexibility Act.

III. Regulatory Flexibility Act Requirements

Even when a regulation is statutorily mandated, agencies are obligated by law to adhere to certain requirements prior to issuing the implementing regulations. Specifically, the RFA requires agencies to analyze the impact of proposed regulations on small entities and consider flexible regulatory alternatives that reduce the burden on small entities—without abandoning the agency's regulatory objectives. Agencies may forgo the analysis if they certify (either in the proposed or final rule) that the rule will not have a significant economic impact on a substantial number of small entities. Agency compliance with certain provisions of the RFA is judicially reviewable under section 611 of the RFA.

It is not clear from the instant rule whether HCFA has actually certified the rule pursuant to section 605(b) of the RFA or attempted a final regulatory flexibility analysis (FRFA) pursuant to section 604 of the RFA. In either case, the agency failed to comply with the requirements of the RFA.

HCFA expresses confusing "certification-like" statements throughout the text of the final rule.[8] However, the actual certification and statement of factual basis are not to be found in the final rule. If the agency was attempting to certify, then it did so erroneously for reasons discussed more fully below. On the other hand, perhaps HCFA did not intend to certify, but instead intended to prepare a FRFA. The agency did do some type of analysis: "we have prepared the following analysis, which in conjunction with other material provided in this preamble, constitutes an analysis under the [RFA]." 63 Fed. Reg. at 303. The problem with that declaration is that there is more than one type of analysis under the RFA. There is the preliminary assessment analysis which helps agencies determine whether to certify, and in the case of a final rule, there is a FRFA when an agency determines that certification is not appropriate. If HCFA was attempting a FRFA, then the FRFA was not adequate because it contained no analysis of alternatives to reduce the burden on small home health care providers. This, too, is more fully discussed below.

A. Certification

When an agency determines and certifies that a rule will not have a significant economic impact on a substantial number of small entities, then it is logical to assume that the agency has already performed some basic level of analysis to make that determination. ***Will a substantial number of small entities be impacted?*** In the instant case, the agency admits that all home health agencies will be affected. According to SBA's regulations, a small home health care agency is one whose annual receipts do not exceed $5 million, or one which is a not-for-profit organization.[9] Although the Office of Advocacy does not have data based on annual receipts, data is available based on number of employees. 1993 data obtained from the U.S. Bureau of the Census by the Office of Advocacy indicates that about 7% of home health care services (489 out of 6,928) have 500 or more employees and earn 51.2% of all annual receipts for the industry, 93% of home health care services (6,439 out of 6,928) have fewer than 500 employees and earn about 49% of all annual receipts for the industry, and 52.5% of home health care services (3,637 out of

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[8] Some of those statements include the following: "Because of the scope of this rule, all HHAs will be affected, but we do not expect that effect to be significant." 63 Fed. Reg. at 303. "We expect to have a 'significant impact' on an unknown number of such entities, effectively preventing some from repeating their past aberrant billing activities [but, t]he majority of HHAs will not be significantly affected by this rule." *Id.* "[A]ny possible impact that this [capitalization] requirement may have on HHAs entering the Medicare program is more than offset by savings to the Trust Funds in situations in which HHAs go out of business due to undercapitalization . . ." *Id.* at 308. "We are not preparing a rural impact statement [pursuant to section 1102(b) of the Social Security Act] since we have determined, and certify, that this rule would not have a significant impact on the operations of a substantial number of small rural hospitals." *Id.* "If a new HHA for some reason cannot raise the capital necessary to meet Medicare's [capitalization] requirement and, therefore, is not permitted to enter the Medicare program, that clearly has an impact on the HHA." *Id.*

[9] *See* 13 C.F.R. § 121.201. Based on Standard Industrial Classification code 8082, Home Health Care Services include home health care agencies and visiting nurse associations (establishments primarily engaged in providing skilled nursing or medical care in the home, under supervision of a physician. Establishments of registered or practical nurses engaged in the independent practice of their professions and nurses' registries are classified in another category. Similarly, establishments primarily engaged in selling, renting or leasing health care products for personal or household use are classified in another category).

6,928) have fewer than 20 employees and earn 6.3% of all annual receipts for the industry. Although it may be difficult to reconcile employment-based and receipt-based size standards, it is still fairly clear from the available data that a substantial number of small entities will be impacted by this final rule.

Will there be a significant economic impact? To determine whether the final rule is likely to have a significant economic impact, further analysis is required. It is not enough to claim that elimination of fraud and abuse in the Medicare/Medicaid system outweighs the need for further analysis. It is not enough to assume that only those agencies with "past aberrant billing activities" will be impacted. It is not enough to say that reducing a surety's liability means that there will not be a significant economic impact on home health agencies. The Office of Advocacy opines that the agency's "analysis" was doomed from the outset because of the agency's flawed assumptions about the number and type of small entities likely to be impacted, and about the cost of compliance.

Which small entities will be impacted? The agency did not take the basic and necessary step of adequately explaining why other small entities (presumably those whose billing practices are not "aberrant") will not be affected or whether small home health providers are even the primary offenders. At the least, the agency must consider the impact the bonding requirement will have on all small home health providers and not just the ones with "aberrant" billing practices. After all, the majority of home health agencies apparently do not have aberrant billing practices. HCFA presents evidence that, in 1996, Medicare overpayments were 7 percent of all claims paid to HHAs, and of that 7 percent, 14 percent remained uncollected by Medicare. Fourteen percent of 7 percent is .0098.[10] In other words, Medicare fails to collect overpayments less than one percent of the time. Despite this extremely low occurrence of failure to collect overpayments, HCFA deemed it necessary to place extremely costly and burdensome requirements on the entire industry. However, HCFA did not identify what percentage of the industry is contributing to the fraud problem, whether certain offenders were recidivist, or whether those offenders are primarily large or small.

With regard to the capitalization requirement, HCFA states that, "An organization that is earnest in its attempt to be a financially sound provider of home health services under the Medicare program will already be properly capitalized without the need for Medicare to require such capitalization." This statement is basically true. However, the issue of adequate capitalization is relative and fungible because it is based on a number of factors like varying overhead costs, location, profit margins, competition in the area, etc. Surely some home health agencies cannot meet the capitalization requirements set by HCFA, but desire to be "earnest" in their efforts to be "sound providers". The capitalization requirement is a barrier to market entry for all new home health agencies and not just the ones who enter the market for purposes of defrauding Medicare. A careful look at the questions like the ones raised in this and the preceding paragraph would have yielded a

[10] In 1996, $14,357,504,894 was paid to HHAs, $1,061,157,961 was overpaid, and $153,628,056 was uncollected.

conclusion that the rule would have a significant economic impact on a substantial number of small businesses

Congress weighed in on the issue of impact after the final rule is published. Even members of Congress recognized that HCFA went beyond its mandate and imposed a significant economic burden on home health agencies. Specifically, a bi-partisan group of three senators from the Senate from the Senate Finance Committee, on January 26, 1998, asked HCFA to delay and modify the requirement that all home health agencies secure a surety bond. The Senators believed that home health agencies would not be able to obtain bonds by the original February 27 deadline. According to a recent news article, the senators reportedly wrote that:

> "HCFA has imposed conditions that go beyond the standard in the surety bond industry. Some of the biggest problems include cumulative liability, a short period of time in which to pay claims, and bond values of 15 percent of the previous year's Medicare revenues with no maximum, the letter said.
>
> 'The cumulative effect is that many surety companies are opting not to offer bonds to Medicare[home health agencies] at all,' the letter said. 'Those companies which are offering the bonds are doing so at a cost which is prohibitive, or with demands for collateral or personal guarantees that HHAs cannot provide.'
>
> The letter said Congress enacted the surety bond requirement to keep risky agencies out of the Medicare program. However, HCFA's rule seems to use the bonds as security for overpayments to providers, the letter said.
>
> 'We simply doubt that it is realistic to expect bonding companies to embrace a role as guarantors for overpayments from HCFA,' the senators wrote."[11]

It should be fairly obvious to HCFA, as it was to these members of Congress, that obtaining a $50,000/15 percent bond in addition to the 3-month reserve capitalization requirement (where there were no such requirements before) is likely to be prohibitively costly for small home health care providers—particularly new providers or providers operation only a few years that typically have few hard assets and relatively little credit.[12] Moreover, most home health patients are Medicare patients. If a home health agency is not Medicare certified, then it is very difficult to attract patients, and without patients, there is no opportunity to increase capital. There is already a requirement in many states (pursuant to "Operation Restore Trust") that home health agencies have a minimum number of patients prior to obtaining a Medicare license. How can these small home health agencies absorb losses on these ten patients (--possibly long term patients requiring multiple services several times per week--), never be reimbursed for services to these

---

[11] *Senators Ask HCFA to Delay Final Rule Requiring Surety Bonds of All Agencies*, BNA DAILY REPORT FOR EXECUTIVES, Jan. 27, 1998, at A-24.

[12] Small firms in service industries find it more difficult to obtain credit—where judgments in terms of character, markets, and cash flow are more likely to dominate—than in manufacturing industries, which typically have hard assets such as real property, equipment, and inventory. OFFICE OF ADVOCACY, U.S. SMALL BUSINESS ADMINISTRATION, THE STATE OF SMALL BUSINESS: A REPORT OF THE PRESIDENT (1995), at 36.

patients, and continue to raise capital? It's a vicious circle and there is a tremendous cumulative effect of all the various state and federal regulations. In any event, it seems that with only a cursory analysis and a little industry outreach, HCFA should have been able to determine that the final rule would have a significant economic impact on a substantial number of small entities. Therefore, under the RFA, HCFA should have prepared a final regulatory flexibility analysis with all the required elements for that analysis.

B. Final Regulatory Flexibility Analysis

The preparation of a FRFA may be delayed but not waived. Section 608(b) of the RFA reads:

> "Except as provided in section 605(b) [where an agency certifies that there will be no significant economic impact on a substantial number of small entities], an agency head may delay the completion of the requirements of section 604 of this title [regarding the preparation of FRFAs] for a period of not more than one hundred and eighty days after the date of publication in the Federal Register of a final rule by publishing in the Federal Register, not later than such date of publication, a written finding, with reasons therefor, that the final rule is being promulgated in response to an emergency that makes timely compliance with the provisions of section 604 of this title impracticable. If the agency has not prepared a final regulatory analysis pursuant to section 604 of this title within one hundred and eighty days from the date of publication of the final rule, such rule shall lapse and have no effect. Such rule shall not be repromulgated until a final regulatory flexibility analysis has been completed by the agency."

FRFAs may not be waived because they serve a vital function in the regulatory process. The preparation of a FRFA allows an agency to carefully tailor its regulations and avoid unnecessary and costly requirements while maintaining important public policy objectives. Without a careful analysis—which should include things like data, public comments and a full description of costs—agencies would be operating in a vacuum without sufficient information to develop suitable alternatives.

Since the agency did not issue a proposed rule, the agency had an obligation to consider carefully all of the significant comments regarding the impact of the final rule. After all, the agency was apparently unsure of the impact.[1] The congressional letter should have been some indication that there would be a significant economic impact and that further analysis was required. HCFA did extend the deadline for obtaining a surety bond for 60 days, and in some ways limited the liability of sureties. However, the agency did not change the bond or capitalization requirements, or explain why such changes were not feasible. Inasmuch as the agency failed to heed any of the comments regarding impact—even those from Congress—the comment period served no real function here.

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[1] Unsure of the actual impact, the agency specifically solicited comments on its assertions and assumptions. See 63 Fed. Reg. at 304.

The dearth of information regarding less costly alternatives is possibly the most serious defect in the analysis presented. To begin with, HCFA never demonstrated why the $50,000 bond was insufficient or would not accomplish the objective of discouraging bad actors from entering the Medicare program. The agency did not demonstrate why the 15 percent rule would not cause a significant economic impact—particularly when the $50,000 bond amount changed from a maximum level to a maximum level. There is no evidence that HCFA attempted to find less costly alternatives. Before heaping on additional regulations, would it not be prudent to first determine whether the programs and policies recently put in place by the Administration, and the prospective payment rules yet to come will work?

IV. Conclusion

Not everyone in the home health industry is a bad actor. More importantly, home health providers that cannot afford to comply with HCFA's regulations are not necessarily bad actors either. HCFA has twisted Congress' intent and changed the rule into a vehicle for punishing legitimate home health agencies and for securing overpayments by Medicare rather than a vehicle to discourage bad actors from entering the Medicare program. There must be a middle ground—a place where legitimate home health providers can survive and compete in the marketplace, and where fraud and abuse can be controlled. This final rule is not that place.

Therefore, the Office of Advocacy petitions HCFA to amend its final rule to remove the 15% bonding requirement and the capitalization requirement until such time as proper notice and comment procedures can be completed. Thank you for your prompt attention to this urgent matter. Please contact our office if we may assist you in your efforts to comply with the RFA on this or any other rule effecting small entities, 202-205-6533.

Sincerely,

Jere W. Glover
Chief Counsel for Advocacy

Shawne Carter McGibbon
Asst. Chief Counsel for Advocacy

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

7500 Security Boulevard
Baltimore, MD 21244

March 26, 1998

Mr. Michael Kinslow
National Association for Home Care
228 7th Street, S.E.
Washington, DC 20003

Dear Mr. Kinslow:

The following data is provided in response to your email request for information dated March 9, and our telephone conversation on March 23, 1998. Please note that the data for Intermediary Part A reconsideration requests and ALJ hearing requests is for home health and hospice care. Our data collection does not separate these entities. The data is for FY 1997 (Oct 96 thru Sep 97).

- Total number of HHA bills processed = 22,690,828
- Total number of HHA bills denied = 827,916
- Total number of HHA/Hospice reconsideration requests received = 53,252
- Total number of HHA/Hospice reconsideration requests processed = 55,356
- Total number of HHA/Hospice reconsideration determinations which resulted in increased payments (full or partial) = 19,335
- Total number of HHA/Hospice ALJ hearing requests received = 13,209
- Total number of HHA/Hospice ALJ hearing requests completed = 12,092
- Total number of HHA/Hospice ALJ hearing requests completed which resulted in increased payments (full or partial) = 8,911

NOTE: An appeal request (reconsideration and ALJ hearing) may involve one or more claims.

EXHIBIT
2

HCFA
MEDICARE + MEDICAID
Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244

September 17, 1997

Mr. Michael Kinslow
National Association for Home Care
228 7th Street, S E.
Washington, DC 20003

Dear Mr. Kinslow:

The following data is provided in response to your request for information on the percentage of reversals for home health care at the reconsideration level and the ALJ level for FY 96. Please note that the information is for home health agencies and hospice care. Our data collection does not separate these entities

Intermediary Part A Reconsideration Data, HHA/HOSP
Fiscal Year 1996 (Oct 95 thru Sep 96)

Total Reconsideration Requests Processed	48,537
Number with Increased Payments	18,962
Percentage of Reversals	39%

Intermediary Part A ALJ Hearings, HHA/HOSP
Fiscal Year 1996 (Oct 95 thru Sep 96)

Total ALJ Hearing Requests Completed	7,839
Number with Increased Payments	6,394
Percentage of Reversals	81.5%

If additional assistance is required, please contact me at (410) 786-7638.

Beverly J. Sgro
Division of Beneficiary Protections
Entitlement, Enrollment & Protections Group
Center for Beneficiary Services

...ancing Administratic

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

MAY 20 1996

Mr. Michael Kinslow
National Association for Home Care
228 7th Street, S E.
Washington, DC 20003

Dear Mr. Kinslow:

This office received your request for information on the percentage of reversals for home health care at the reconsideration level and the ALJ level. The following data is provided in response to your inquiry. Please note that the information is for home health agencies and hospice care. Our data collection does not separate these entities.

Intermediary Part A Reconsideration Data, HHA/HOSP
Fiscal Year 1995 (Oct 94 thru Sep 95)

Total Reconsideration Requests Processed	40,107
Number with Increased Payments	18,691
Percentage of Reversals	46.6%

Intermediary Part A ALJ Hearings, HHA/HOSP
Fiscal Year 1995 (Oct 94 thru Sep 95)

Total ALJ Hearing Requests Completed	5,508
Number with Increased Payments	4,440
Percentage of Reversals	80.6%

I hope the above information is helpful. If additional assistance is required, please contact Beverly Sgroi, of my staff, at (410) 786-7638.

Cheryl L. Slay
Manager, Appeals

HOMECARE™

NATIONAL ASSOCIATION FOR HOME CARE
519 C STREET, N.E., STANTON PARK
WASHINGTON, D.C. 20002-5809
(202) 547-7424, FAX (202) 547-3540

KAYE DANIELS
CHAIRMAN OF THE BOARD

VAL J. HALAMANDARIS
PRESIDENT

HONORABLE FRANK E. MOSS
SENIOR COUNSEL

STANLEY M. BRAND
GENERAL COUNSEL

August 22, 1995

The Honorable Newt Gingrich
Speaker of the House
U.S. House of Representatives
H-233 The Capitol
Washington, D.C. 20515

Dear Mr. Speaker:

I appreciated so much your generously giving of your time for me to interview you on August 7. It was a great honor and pleasure for me to be able to spend time with you. At that interview, you had asked that I give you some recommendations on behalf of the National Association for Home Care (NAHC) on how to prevent fraud and abuse in the industry. I share your deep concern about this issue, and have been proud that there has been a relatively low incidence of fraud and abuse in the industry to date. However, it is essential that we prevent any further occurrences.

The National Association for Home Care has developed specific recommendations on fraud and abuse that apply to the home care industry. In addition, NAHC has done extensive work with the Coalition of Health Associations United Against Fraud and Abuse, which is composed of organizations representing health care providers and suppliers, who want to work with Congress to eliminate fraud and abuse in the health care industry. Our recommendations are as follows:

PROPOSALS FOR HEALTH CARE INDUSTRY-WIDE FRAUD & ABUSE LEGISLATION

Fraud and abuse statutes must:

- Increase tools of enforcement against willful and criminal violations by giving regulators budgetary recognition and sufficient resources to enforce the law;

- Provide adequate and thorough education for providers, consumers, and payers to prevent violations;

- Protect Federal health care programs from unnecessary cost, utilization, and the failure to deliver appropriate levels of care;

EXHIBIT 3

- Be appropriate for the changing health care market; and
- Separate willful from technical violations.

We urge Congress to adopt the following proposals to help eliminate health care fraud and abuse.

I. Tools of Enforcement

A. Establishment of a new health care fraud statute in the criminal code. Providing penalties or fines, or both for willfully and knowingly executing a scheme to defraud a health plan in connection with the delivery of health care benefits, as well as for obtaining money or property under false pretenses from a health plan would help as a deterrent to fraud.

B. Provide for the creation of an Anti-Fraud and Abuse Collection Account. An account subject to the congressional appropriations process would provide the Office of Inspector General and the Federal Bureau of Investigation with the resources necessary to prosecute fraudulent provider and suppliers, and to provide guidance to those who seek to comply with the law.

C. Clarify Anti-Kickback Statute. The current anti-kickback statute is vague and not focused on fraudulent activity. By codifying the Hanlester Network vs. Shalala decision, the anti-kickback law would be ensured of applying to those who intentionally defraud the government. (In this case, the court ruled that "knowingly and willfully" committing a fraudulent act should be the basis of federal prosecution.) and clarification of a long-standing issue that an action is illegal if a "significant or substantial reason" for making a payment is to induce referrals.

D. Additional Enforcement Tools. In addition to criminal prosecution, regulators should be given the following enforcement tools to punish those found to commit a health care fraud offense:

1) Exclusion from Federal and State Health Care Program. Mandatory exclusion from state and federal health care programs to those convicted of a health care felony. Increase exclusion and apply it to an officer in an entity that has been convicted of a health care offense, if that officer is found to have "reason to know" that the crime was committed; and

2) Expand and increase existing monetary civil penalties. Expanding penalties would serve as an appropriate deterrent.

II. Health Care Fraud and Abuse Guidance

The vast majority of providers and suppliers seek to comply with the complex laws of Medicare and Medicaid. Much of the "noncompliance" should be resolved with education and guidance. The following provides mechanisms for further guidance to health care providers on the scope and applicability of the anti-fraud statutes.

A. Safe Harbors. Update existing safe harbors and create new ones.

B. Fraud Alerts. Establish a formal process for the request and issuance of special fraud alerts.

C. Advisory Opinions. Advisory opinions assist providers and others engaged in the delivery of health care to ensure that they remain in compliance with health care statutes and regulations.

III. Medicare Claims Processing

The General Accounting Office (GAO) in its report entitled "Medicare Claims-Commercial Technology Could Save Billions Lost to Billing Abuse" (May 1995) stated "Flawed payment policies, weak billing controls, and inconsistent program management have all contributed to Medicare's vulnerability to waste, fraud, and abuse." The following provisions would improve that process.

A. Medicare Transaction System (MTS). Downgrade the priority or terminate the development of the Medicare Transaction System.

B. Commercial Automatic Data Processing Equipment (ADPE). Require Medicare carriers to acquire commercially made Commercial Automatic Data Processing Equipment.

C. Reduce number of Medicare Carriers to ten. Upon implementation of the ADPE, HCFA should be required to study and report to Congress on reducing its 32 Medicare Part B carriers to 10 such as the Durable Medical Equipment Regional Carriers (DMERCs) that were reduced to four. This would help to foster better communication between HCFA and the Regional Carriers.

D. Contractor/Provider Relationships. Prohibit Medicare carriers and intermediaries from reviewing claims of provider organizations when the Medicare contractor has an investment in that organization.

E. Study Fraud and Abuse Under Managed Care. The rise in managed care brings new forms of fraud and abuse. For example, the government and beneficiaries may be defrauded through withholding necessary services. The Institute of Medicine should undertake a study on the types of fraud that it may encounter under managed care and to begin ways to detect and combat such fraud.

SPECIFIC HOME CARE FRAUD AND ABUSE RECOMMENDATIONS

A. Limit Use of Subcontract Care by Medicare Certified Home Health Agencies. Establish limits on Medicare-certified home health agencies' use of subcontract care for the dominant health care services, such as nursing or home health aide, which it may provide.

HOMECARE

B. Mandate Freedom of Choice Information as Part of the Discharge Planning Process or Consumer Information Resources. Hospitals, nursing homes, payors, and consumer groups (e.g. AAAs) should be required to give prospective home care patients full information about the availability of qualified Medicare certified home health agencies serving their area.

C. Provide Detailed and Appropriate Explanations of Benefits to Users of Home Care Services. Informing the user of the level of billing of a home health agency in a proper manner will allow beneficiaries to join in the enforcement effort.

D. Ban Assistance by Home Health Agencies to Physicians Regarding Physician Care Billing. Home Health agencies should be prohibited from providing record keeping and bill preparation services to physicians regarding the physicians billing for his/her care to Medicare patients.

E. Require Home Health Care Administrators to Meet a Standard of Certification and Accreditation. The last several years have seen unbridled growth in the rise of Medicare certified home health agencies. Inadequate standards are established for qualifications of home care administrators beyond those affecting the quality of care. Administrators should be certified relative to all standards of operation for a home health agency.

I hope that this information is helpful to you. Please let me know if I can be of further assistance. I look forward to working with you and thank you for your leadership on this vital issue.

With best regards,

Sincerely,

Val J. Halamandaris
President

Mr. SHAYS. Mr. Schneider.

Mr. SCHNEIDER. Thank you very much. Good morning.

Mr. Chairman and members of the committee, thank you very much for inviting me here to testify this morning regarding the surety bonds. I am the president and chief executive officer of the Visiting Nurse Association of Central Jersey, or VNACJ.

Our organization is a voluntary, nonprofit organization that has been serving the community with home-based and community-based services for over 85 years. As one of the largest freestanding, Medicare-certified home health agencies in the country, last year we provided 444,000 home visits to 12,000 Medicare beneficiaries.

My testimony today will focus on our agency as well as the experiences in New Jersey.

New Jersey providers, unfortunately, are in the unique position of being able to secure surety bonds more easily than the rest of the country. There are several reasons for this. However, the primary reason is that the majority of our agencies are nonprofit organizations that have longstanding reputations of efficiency and quality services in the community. As a result, I believe that the surety companies took into consideration the fact that we have been providing services for several decades, and even though we didn't have the assets that some of the other organizations had, we were able to secure the bonds.

In addition, most of the remaining agencies are hospital-based agencies that could utilize the assets of the hospitals to secure the bonds. However, there are still a few agencies in New Jersey that were unable to secure the bonds.

The success of New Jersey in securing the surety bonds has now created the other problem of what do we do with it now that we have it. Based upon the information received from member agencies by the Home Health Assembly of New Jersey, more than $200,000 was spent by the member agencies, and there are fewer than 60 agencies in the State. Those amounts have ranged from a few thousand dollars for the smaller agencies to over $50,000 for our agency, and at a time when New Jersey providers are suffering from cuts in reimbursement and laying off staff due to the interim payment system, we have essentially wasted valuable funds that could have been utilized for other purposes. Essentially, the scenario is similar to the interim payment system in that the agencies that have complied and been efficient are now paying the biggest price.

I do have a concern that the surety bond is not considered a reimbursable cost under the Medicare program. Our organization has limited net assets. The only opportunity for us to generate a surplus is either through excess investment income or charitable contributions.

In 1997, we had a very good year. On over $60 million of revenue we were able to generate an increase in net assets of $102,000. More than half of that increase in net assets had to be spent on surety bonds in 1998.

By setting the bond at 15 percent of Medicare revenues and making the cost nonreimbursable, Medicare is forcing the community-based providers to reallocate funds that would have otherwise been used for charity care, preventive services in the community or, in

1998, subsidizing the Medicare interim payment system. The financial burden on these agencies is creating a significant access problem for community health services throughout the country.

With regard to the moratorium which I was also asked to speak on, we have certificate of need in New Jersey, and as a result there is significant scrutiny on new entrants into the market. I do not believe that New Jersey experienced any problems with new entrants into the market. However, one of the problems of the moratorium was that you could not open or move a branch office. Which means that if you have a branch office which is either too small, too large, too expensive or not strategically located, you could not move the office, which makes it very inefficient for an organization's operations. Also, if the lease is being renewed, it puts the landlord in a very strong negotiating position when he knows that you can't move your branch office.

In closing, I would also like to thank Representative Pappas for sponsoring H.R. 3567 to change the interim payment system and for everybody who has spoken out regarding the interim payment system and has cosponsored a bill.

I do have in my formal presentation some recommendations for the future implementation of surety bonds as well as antifraud recommendations, and I would welcome the opportunity to work with the committee on any activities where they feel my expertise would be helpful.

Mr. SHAYS. The recommendations are found on page 7?

Mr. SCHNEIDER. It is on pages 3 and 4.

Mr. SHAYS. Thank you. I think we will come back to those in the questioning. Thank you very much. I appreciate the recommendations.

[The prepared statement of Mr. Schneider follows:]

TESTIMONY BEFORE THE SUBCOMMITTEE ON HUMAN RESOURCES
JULY 22, 1998

Schneider

Mr. Chairman and Members of the Subcommittee,

My name is Steven Schneider and I am the president and chief executive officer of the Visiting Nurse Association of Central Jersey (VNACJ). Thank you for the opportunity to provide testimony regarding the Health Care Financing Administration's (HCFA) efforts to implement the home health surety bond statutes.

VNACJ is a voluntary, nonprofit organization, providing home- and community-based services for more than 85 years. As one of the largest freestanding, Medicare-certified home health agencies in the country, VNACJ provided 444,000 home visits to 12,000 Medicare beneficiaries during 1997.

This testimony will discuss the implementation of surety bonds for home health agencies. A specific focus will be placed on the experiences of VNACJ and providers throughout New Jersey regarding the availability of surety bonds, the impact of the surety bond retraction, and the burdens of the moratorium on new home health agencies. In addition, recommendations will be offered regarding the use of surety bonds as a viable tool in addressing waste, fraud and abuse, as well as other anti-fraud measures.

For home health agencies in New Jersey, 1998 has been an extremely difficult year. The interim payment system (IPS) has resulted in significant cuts in Medicare reimbursement through the reductions of the cost per visit limits and the implementation of new per-beneficiary limits. I would be remiss if I didn't take this opportunity to thank Representative Mike Pappas (R-NJ) for his support in sponsoring H.R. 3567, the "Medicare Home Health Equity Act." I would also like to thank all the members of the Committee who have cosponsored IPS reform legislation and have supported home health agencies and Medicare beneficiaries.

Implementation of Surety Bonds for Home Health Agencies

Congress passed the Balanced Budget Act of 1997 requiring home health agencies participating in the Medicare program to maintain a surety bond at a minimum of $50,000. The underlying reason for this requirement was a heightened sensitivity to a perceived increase in waste, fraud, and abuse within the Medicare home health benefit. As with any industry, as the market expands and the number of providers increases, the risks of abuses also increased. This is particularly true when the new entrants may not share the original values of the home care industry.

The purpose of the surety bond was to act as a screening device to prevent individuals and organizations that presented a high risk of abuse from participating in the Medicare program. However, the regulations positioned the surety bond to serve as insurance against the loss of any Medicare overpayments, regardless of the reason. As a result, the surety bond addressed the risk of financial loss to the Medicare program, not necessarily the risk of waste, fraud and abuse by providers.

Throughout the country, approximately 60% of home health agencies could not effectively or reasonably secure a surety bond. This occurred for a variety of reasons, including the insufficient net worth or collateral of the providers. Surety companies were also concerned with the financial viability of providers based on the low reimbursement rates under the interim payment system.

New Jersey providers are in the unique, and unfortunate, position of being more successful in securing surety bonds. The majority of New Jersey's providers are nonprofit organizations with long, stable and efficient histories. Most have been serving their communities for decades. The surety companies recognized the long standing existence of these financially solvent organizations, even though their net assets might not have been as significant as other providers. New Jersey also has several hospital-based agencies that can rely on the net assets of the hospital as a basis of securing a surety bond. However, some New Jersey providers, despite their excellent history, have still been unable to purchase surety bonds due to lack of accumulated assets or reserves.

New Jersey's success in securing surety bonds has now created the problem of obtaining refunds from the surety companies. Based upon information received from member agencies, the Home Health Assembly of New Jersey (HHANJ) estimates that well over $200,000 has been spent on the surety bonds mandated by HCFA this year. The costs range from a few thousand dollars for the smaller agencies to more than $50,000 for VNACJ.

At a time when New Jersey providers are suffering from cuts in reimbursement and laying off staff to respond to the interim payment system, they have wasted valuable funds in paying for surety bonds that are now no longer required. As a matter of fact, the scenario is similar to the interim payment system. Providers that complied with the requirements of the Medicare program are now suffering the most. Once again, the industry's most efficient agencies are paying the price.

Why isn't the cost of a surety bond that is required by Medicare considered a reimbursable cost under the Medicare program? VNACJ is a nonprofit organization with limited net assets. The only opportunity for generating surplus funds is through excess investment income or charitable contributions. In 1997, VNACJ had a very good year. On gross revenue of more than $60 million, VNACJ generated an increase in net assets of $102,000. More than half of that amount went to cover the $57,000 cost of the 1998 surety bond.

By setting the bond at 15% of Medicare revenues and making the cost of the surety bond a non-reimbursable expense, Medicare is forcing community-based providers to reallocate funds that would have otherwise gone to cover charity care, preventive health services, and, in 1998, to subsidize Medicare's interim payment system. The financial burden of an excessive surety bond results in a significant loss of access to community-based services throughout the country. It is imperative that the cost of a surety bond, or any amounts that are not refunded by the surety companies in 1998, be considered a reimbursable expense under Medicare.

Recommendations for the Future Implementation of Surety Bonds

HCFA recently retracted the surety bond requirements, with the new rules not effective until at least February 1999. Recommendations to be considered for the future implementation are as follows:

- Surety bonds should be limited to loss through fraud and abuse, not serve as insurance against all overpayments regardless of the reason.
- Surety bonds should be used to screen out inappropriate providers.
- Surety bonds should be limited to $50,000, with the ability to reduce the amount for smaller agencies. Requiring a surety bond for 15% of Medicare revenues is excessive and creates an unnecessary financial burden for providers.
- Surety bonds should be a reimbursable cost under the Medicare program.
- Surety bonds should be required for new entrants into the Medicare program or for providers with histories of fraud and abuse. Providers in good standing with Medicare that have demonstrated fiscal responsibility should be exempt from surety bonds. Following an appropriate probationary period, after demonstrating compliance, new agencies should also be exempt from surety bonds.
- Surety bonds should be the payment of last resort. Providers should be able to exhaust all available alternatives for repayment prior to the utilization of the surety bond.
- Surety bonds should not be required for new subunits or branch offices of existing providers.

Moratorium on New Home Health Agencies

In September 1997, President Clinton announced the imposition of a moratorium on new Medicare home health agencies. The purpose of the moratorium was to put a hold on new agencies until HCFA could implement additional safeguards against fraud and abuse. Such safeguards included revised Medicare program admission standards and the surety bond requirements.

The moratorium had minimal impact on curbing waste, fraud and abuse. The surety bond as implemented screens new organizations for financial viability and solvency. It does not serve as a screen for the potential fraud and abuse by the provider or its employees. In fact, new providers may be more successful in securing a surety bond because they bring no accumulated risk of liability under the Medicare program.

New Jersey maintains certificate of need requirements for home health agencies. As a result, new providers undergo significant scrutiny during the review process. The certificate of need process, with planned, orderly growth of home health providers is one of the major reasons New Jersey has experienced such favorable utilization rates in comparison to the rest of the country. Accordingly, the impact of the moratorium was not felt as significantly in New Jersey as in other states.

One of the burdens of the moratorium on existing providers was the inability to open or move a branch office location. For larger agencies covering expansive geography, a branch office provides for more efficient and effective delivery of care. Limiting an existing provider's ability to open or move a branch office results in a constraint that negatively impacts operations. For example, if a lease is expiring for an existing office site that might be too large, too small, too expensive or no longer strategically located, an agency could not relocate due to the moratorium. This not only leads to inefficiency, but also puts the landlord in a very strong bargaining position in negotiating a lease renewal. Any future moratorium should consider the needs and operational requirements of existing providers.

Other Anti-Fraud Recommendations

In addressing the issues of waste, fraud and abuse, it is important that preventive measures be given a higher priority. The following recommendations include practices and activities implemented by providers in an effort to proactively address the issues of waste, fraud and abuse, as well as selected initiatives that should be pursued by HCFA:

- Require screening and criminal background checks for all principals, executives and employees.
- Require the implementation of an internally developed corporate compliance plan that meets specific guidelines.
- Require providers to demonstrate competency in Medicare fiscal matters as well as home health service delivery.
- Implement a prospective payment system, eliminating cost reimbursement.
- Eliminate the interim payment system. IPS rewards the past inefficiencies and over utilization of certain providers, while creating a competitive disadvantage for the most cost effective providers.
- Identify the reasons for the significant regional variances in visits per beneficiary and costs per beneficiary.
- Determine the reason utilization increases when the percentage of for-profit agencies increases or the ratio of providers per beneficiary increases.

Conclusion

Thank you for inviting me to present testimony on the surety bond issue and provide some specific information regarding home care in New Jersey. I would be happy to address any questions the Members have regarding any of the matters I've discussed. I would also welcome the opportunity to work with the Subcommittee in the development of standards or the review of any issues relevant to the home health industry. Please do not hesitate to involve me if I can be of any assistance.

Mr. SHAYS. Mr. Richard.

Mr. RICHARD. Thank you for the opportunity to come and share with you today our experience at SUN Home Health Services.

I am Steve Richard. I have been the Chief Financial Officer at SUN Home Health Services for 17 years. I have what I think has been a unique opportunity to kind of grow up with the home health industry. I remember the days of copayments and limits on visits, and I remember those days not fondly, and appreciate the improvement we have made in the benefits in the last 17 years.

We do have a staff of 425 people that covers 15 counties from 11 offices in Central Pennsylvania. We have been in business as a freestanding home health agency for 30 years. We have no affiliation with a hospital. We have no affiliation with a health plan. So as a freestanding, traditional, nonprofit agency, we have only ourselves when it comes to assets.

We have been an industry leader, being accredited by JCAHO with commendation for the last 5 years. We have participated in the OASIS demonstration project that was funded by HCFA to develop measurable outcomes. Those standards are now being placed in the conditions of participation. In our testimony you will see a letter from the Center for Health Policy and Research commending the outcomes that we have achieved as a home health agency.

Having been what many would consider to be an excellent, squeaky-clean agency, we were in a position of having a very difficult time getting a bond. When it came to getting a bond, because of the prorated years, our fiscal year starts April 1, the first Medicare bond we needed was for the period of January 1 through March 31. We were able to finally acquire that bond the day before the deadline after contacting dozens of insurers and working with several agents.

The company that finally wrote that part-year bond we thought would be more than happy to write the whole year bond. What we found when we had to go back and get a bond for the fiscal year beginning April 1, a bond now that was over $1 million because of our Medicare payments, was that the company that had written the bond prior would not consider us because they had decided not to write any bonds of that size.

Going back into the market, we again worked with many agents and contacted dozens of insurance companies. As of the date when the home health surety bond regulations were pulled back, we had still not acquired a bond.

Mr. SHAYS. What was the cost?

Mr. RICHARD. The bond amount that we needed was in excess of $1 million.

Mr. SHAYS. How much did it cost?

Mr. RICHARD. $10,000 to $15,000, if we could have gotten it.

Mr. SHAYS. I did not have a perspective. Thank you.

Mr. RICHARD. We tried everything to get a bond. We sent personal résumés, personal financial statements to some companies. We sent appraisals of any property that we owned. We went out and we tried to talk with our legislators who knew us, tried to get references.

Having done all of those things, including we have a life insurance policy that a donor has named us as a beneficiary. It is a $1

million policy. It has no cash value. So we did everything humanly possible, and as of the time that the bond regulations were withdrawn, we still did not have a bond.

I would say that I think that there are several reasons that HCFA is so intent on the bonding regulations. One of those has to do with IPS. One of the things that I have become very convinced of is that the bonding regulations are extremely important because HCFA realizes that with the new interim payment system that there will be hundreds and maybe thousands of home health agencies that will go out of business. And so I think that is something that needs to be factored into this equation.

I also will tell you that the fact that the IPS system was in place was an impediment to us getting a bond. In the State of Pennsylvania, agencies have always traditionally been very cost efficient. Our per beneficiary limits in Pennsylvania are some of the lowest in the country, and when I went out to bond companies one of the questions that I was asked is, what is your IPS rate? And when I had to tell them that it was approximately half maybe of the national average, it did me no good in getting a bond.

I would have to agree with HCFA that there are bad apples out there. There needs to be ways to get rid of the bad apples. But one of the things that I do in my spare time is that I grow apples, and I store apples in my basement. And when the fruit flies start to come out, I know that I have a bad apple. And when I sort through my apples, I am very careful with the good apples because, once you bruise them, they are no good either. One of the things that is happening in this industry right now is that we are bruising and battering the good agencies along with the bad, and all we end up with is the type of mess that we have today.

Excuse me if I get a little impassioned, but this is my career and my agency that was being put down the tubes by this regulation.

Mr. SHAYS. We accept your version of passion.

Mr. RICHARD. Thank you.

Having said that, I do have some recommendations. I do think that we need stronger conditions of participation. We need to have stronger accreditation standards. We need to require compliance programs. We need to use outcome measurements. We need all of these things to help identify the good and the bad apples in the industry. And I will tell you that there are too many home health agencies out there, and I am in agreement that there are bad apples that need to be removed.

I do have some other specific suggestions that are in my testimony, and I am not going to go through all of those, but I think it is important for this committee to realize that I represent an agency that is seen as an industry leader in many ways, but because we were guilty, guilty of caring for our community, guilty of providing over $200,000 of uncompensated care annually, we did not have the financial assets to make a surety company comfortable with our situation.

Had I known these regulations were coming along, there were steps that could have been taken. We are taking steps now. We just launched or moved forward a very aggressive endowment program, trying to increase the assets that are in hand to be used as collateral and for financial collateral for this bond.

So I can assure you that we have done and are continuing to do everything that we can to get a bond, but the bonding regulations as they exist with the 15 percent limit do effect small businesses and they do effect nonprofits who have been out there providing care and not padding their bank accounts.

Mr. SHAYS. I thank you very much, and this has been very helpful testimony from all of you.

[The prepared statement of Mr. Richard follows:]

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July 23, 1998

Congressman Chris Shays
Chairman, House of Representative Government Reform & Oversight
Subcommittee on Human Resources
United States House of Representatives
Washington, DC 20510

Dear Chairman Shays and Subcommittee members,

Thank you for the opportunity to share our Medicare bond experiences. I am the Chief Financial Officer for SUN Home Health Services, a mid-sized, traditional Visiting Nurse Association serving a large portion of Central Pennsylvania for the last 30 years. Our staff of 425 employees providing service from 11 offices has built our reputation as a traditional not-for-profit VNA who has always done whatever was necessary to ensure care for all those in need in Central Pennsylvania. We are members of several National and State associations including the National Association of Homecare, Visiting Nurse Association of America, National Hospice Organization and Pennsylvania Association of Home Health Agencies.

We are one of 50 agencies selected nationwide to participate in the OASIS demonstration project, funded by HCFA through the Center for Health Policy and Research. This project has been ongoing for several years and is designed to measure patient care outcomes and set standards for all Medicare-certified home care providers in the coming months. We were selected because of our good provider reputation and demonstrated leadership in the industry. Our continued high quality and effective and efficient outcomes have been commended by the Center for Health Policy, and a recent letter from project director Dr. Peter Shaughnessy is enclosed.

The Joint Commission also documents our quality in our accreditation with commendation since 1994.

Because SUN Home Health is a community-based, not-for-profit provider we have always provided care to all in need regardless of their financial situation in lieu of building financial reserves. That community mission almost got us dismissed from the Medicare program because we did not have the financial asset base required to obtain the $1,000,000 plus bond that was required of us by July 31st.

Because our fiscal year begins April 1st the bonding regulations required us to get a Medicare bond for the three-month period of January through March. This required bond of approximately a quarter of a million dollars that was acquired just prior to the February 27th deadline after having been denied by several companies.

The fact that we were unable to acquire the full year bond for the fiscal year beginning April 1, 1998, was not because we had had Medicare deficiencies or had ever experienced overpayments. In fact, we have never had any significant issue of any kind with Medicare but simply lacked the financial assets desired by insurers to write the bond at the required dollar amount. Our very existence was threatened because we had taken our not-for-profit status and our community-mission seriously and had invested our resources in providing annually over $200,000 in uncompensated care and free community health education. In the 17 years I have served as CFO at SUN Home Health Services, we could have built a stronger asset base, however our mission was homecare, not the padding of corporate or personal bank accounts. The truth is that much of the homecare industry is a very capital poor industry with the exceptions of institutional based or some large proprietary organizations. The financial assets shown on financial statements do not ensure quality cost effective homecare services. Homecare programs are built around caring professional staff, not bricks and mortar, medical equipment or cash reserves.

During the months of April, May and June, we were presented to dozens of surety companies for coverage. Some companies declined because they were not willing to write any home health bonds in excess of a million dollars, as we required. Many other companies simply did not see us as a good credit risk upon review of our financial statements. A few companies at the time of the bonding delay in late June had not provided formal responses. We cannot say with any certainty that they would not have given us a bond but to that point they had not extended coverage even though we were doing our best to sell ourselves to them for coverage. We sent them appraisals of the one office we do own. We informed them of a life insurance policy naming SUN Home as the beneficiary. We sent them impressive resumes of our senior management staff in an attempt to document our home health expertise and personal integrity. None of these strategies resulted in a bond. We aggressively tried to get a bond and failed. We did not delay or wait to see what happened as the industry has been accused of. That strategy was never suggested to us nor would we ever take such a foolish risk to our patients and staff.

As a community based homecare provider we were and are committed to staying in business and caring for the thousands of patients we care for annually. We have taken steps to try to bolster our financial base including the launching of an endowment fund campaign to ensure that we can meet whatever future demands are placed upon homecare providers.

We do recognize that there are some bad apples in the industry and we commend HCFA for addressing the issue. I personally believe that there are agencies that should not be providing service. SUN Home also recognizes that change often creates winners and losers. However the bonding regulations and the current IPS payment system does little to discriminate the bad from the good and in many instances may actually penalize the cost-efficient, service-minded providers while rewarding the more expensive less efficient providers. We believe the current IPS structure is simply bad policy and needs Congress' immediate attention to avoid a national homecare crisis.

We would make the following suggestion to HCFA for improvement of its fraud and abuse campaign.

1. Further study the effects of bonds on small business entities before releasing new regulations.
2. Create capitalization and/or bonding requirements for new providers that would be relaxed or eliminated as the provider demonstrates their ability to serve patients and follow program guidelines.

3. Strengthen accreditation and Conditions of Participation guidelines.
4. Require corporate fraud and abuse compliance programs for all providers.
5. Continue to develop with industry input outcome measures that can be used to evaluate homecare agencies.
6. Correct IPS and move quickly to a PPS system that allows cost efficient agencies to be rewarded and places the appropriate financial constraints on high cost providers.
7. Lastly, I can't stress enough HCFA's need to work ***with*** the industry. The industry wants to eliminate any fraud and abuse as much as HCFA does. Working together as partners with a common goal will accomplish more than the current adversarial relationship.

Thank you again for the opportunity to share my perspective.

SUN Home Health Services and many quality home care providers across the United States remain committed to our patients and our communities. However we need your help to insure that our mission is not destroyed by bad healthcare policy at the national level. Thank you for your assistance in this home-care crisis.

Respectfully submitted,

Steven Richard

Steven Richard
Chief Financial Officer
SUN Home Health Services

The National Medicare Quality Assurance and Improvement Demonstration

June 26, 1998

Jane E. Hyde, COO
SUN Home Health Services, Inc.
61 Duke Street
Northumberland, PA 17857-0232

Dear Ms. Hyde,

The purpose of this letter is to acknowledge and compliment you on SUN Home Health Services' participation in the National Medicare Quality Assurance and Quality Improvement Demonstration since 1995. As you know, the purpose of this national demonstration program is to test and refine a methodology to evaluate and then improve the patient outcomes of home health care. This entails data collection on every adult patient, outcome reporting, and outcome enhancement. We at the University of Colorado who designed the approach and are administering the demonstration were extremely impressed that SUN Home Health Services lowered its hospitalization rate by over six percentage points within just one year after beginning participation in the demonstration – an indicator of potentially outstanding care and of dedication to positively impacting the well being of your patients.

This national demonstration project has been the precursor to and set the national standard for the soon-to-be-implemented approach Medicare is adopting to collecting Outcome and Assessment Information Set (OASIS) data and implementing a national approach to Outcome-Based Quality Improvement (OBQI) throughout the United States. SUN Home Health Services has played an important part in the demonstration by being one of the 50 original participating agencies, collecting and submitting data as required, and by developing and implementing pertinent quality improvement plans for SUN's targeted outcomes. Your agency's conscientious involvement in the demonstration reflects a clear and strong commitment to providing quality care to your patients.

Sincerely,

Peter W. Shaughnessy, Ph.D.
Professor and Director

Center for Health Policy Research · 1355 S. Colorado Blvd., Suite 306, Denver, Colorado 80222 · (303) 756-8350 Fax: (303) 759-8196

Mr. SHAYS. Ms. Quinn, you will finish up, and then we will take some questions.

Ms. QUINN. Thank you, and thank you for the opportunity to participate.

York Hospital is a nonprofit community hospital in the southern seacoast area of Maine. It has 79 beds. It has had a long-standing reputation in the community, since 1904, of providing community services, inpatient, outpatient and home services in a very creative way.

About 3 years ago, we started providing home care in a non-traditional way, just by continuing the care that the patients would receive in the hospital where the inpatient nurses would go out and see the patients at home to make sure that the discharge planning and the medication teaching and such were appropriate for that patient.

Well, the State of Maine had regulations about licensing and required us to get licensed as a home health agency in the State, and because of those regulations the hospital decided to get a certification as a Medicare provider. At that point in time, we invested a lot of money and resources and then, when the moratorium was enacted, we were stopped dead in our tracks.

Mr. SHAYS. When you say a lot of money? Give me a perspective?

Ms. QUINN. Over a quarter of a million dollars, not including the time of the employees.

Mr. SHAYS. That is a lot of money.

Ms. QUINN. I have been asked to testify about the impact of the moratorium and also the surety bond, because we happen to be an agency that is hospital-based. And as Steve mentioned, if you are connected to an organization with assets, it is pretty easy to get a bond. And we were able to secure a bond with one phone call to one broker to one surety company, and it cost us $500 for a $50,000 bond. We don't have a history of Medicare payments and revenues in the home care program, so we didn't have 15 percent of the revenue, but if we had, I can assure you it would have been very onerous.

The moratorium itself probably stopped us from being able to service our patients in the way that York Hospital likes to service the community. We believe, as Bill mentioned, about caring, and that is the reason that we are in the business.

If anybody were to examine my head or the people who made the decision at York Hospital to start a home health agency in this environment, they would have said we are crazy. But we are not doing it because we are trying to have Medicare pay us a lot of money. We are doing it because our hospital has a patient vision which includes putting the patient first. We don't just say it, we do it, and it makes sense in our continuum of care.

So the moratorium prevented us from doing that, and it prevented our patients from getting access to that continuum of care for at least a 6-month period.

Once you get the momentum and start a home health agency, I don't know if any of you have started a business before with the kinds of regulations that we have, but it takes an awful lot of time and planning. If you get stopped in the middle, it is almost like starting all over again.

I think that the surety bond regulations that came out after the moratorium or some of the new regulations in terms of making home health agencies go through a new application process, our agency was the first in the State of Maine to go through the new application process with the new requirements. We were required to see 10 patients and demonstrate that we could provide care to 10 patients before the State would survey us.

In my experience of 20 years of home care, and I started in New York State, and I will let Mr. Towns know that there is a New York person here, I have been in home care for 18 years and a nurse for 20 years. There have been in the New England area where I have worked State licensing and certification procedures. I don't understand why you weren't able to get an answer to your question about what things can be done to enforce the regulations and to get the bad players out because there are things in place.

If you have to be licensed in your State or if you have States with certificate of needs, there are hoops that you have to jump through. You can't say, I want to be a provider, fill out an application and start providing home care. I can speak more to that later, but I don't understand why you couldn't get an answer to that.

Because in my experience with the process of medical review, when you submit your claims, with the process of focused medical review, if the claims that you submit have too many errors, and in the process of your initial State survey and your annual State surveys, where the State surveyor comes in and looks at whether you are meeting the conditions of participation of the program in which there are qualifications for the administrator, the director of nursing, qualifications for staff, qualifications for home health aides and supervision, and on and on and on, I don't understand why these things can't be utilized to enforce the program. And why are we wasting money, excuse me, in new programs and new regulations when we don't just look at the systems that we have?

Look at the good players. Look at the States with the good reputations and the agencies with good reputations. Look at the systems that are in place that are working, and let's make them work in other areas, and let's focus on the bad apples or the fraudulent people or the waste, but let's not try to reinvent the system.

[The prepared statement of Ms. Quinn follows:]

QUINN

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July 18, 1998

105th Congress of the United States
House of Representatives
Committee on Government Reform and Oversight
Subcommittee on Human Resources
The Honorable Christopher Shays, Connecticut
Chairman
Room B-372 Rayburn Building
Washington, DC 20515

RE: The Hearing on "Medicare Home Health Agencies; Still No Surety Against Fraud and Abuse"

Dear Mr. Chairman:

Thank you for the invitation to testify at the hearing scheduled for Wednesday, July 22, 1998. It is an honor to have been selected.

In response to your request for information, I am providing the following:

- this cover letter, including the disclosure statement regarding receipt of federal grants and contracts;
- my curriculum vitae;
- the testimony;
- copies of two patient surveys and comments;
- copies of two local newspaper articles about our Home Care program;
- a York Hospital brochure; and
- a brochure about York Hospital Home Care.

DISCLOSURE STATEMENT : York Hospital Home Care was initially licensed by the State of Maine on October 2, 1997, and approved as a Home Health Agency in compliance with Medicare requirements effective April 17, 1998. York Hospital Home Care has not received any federal grants, subgrants, contracts, or subcontracts during the current fiscal year or either of the two previous fiscal years.

In closing I would like to thank you, again, for this opportunity and honor. I look forward to meeting with you and sharing York Hospital Home Care's experiences with the subcommittee members. Please contact us should you have any further requests.

Sincerely,

Jayne Freedman Quinn BSN, RN

Jayne Freedman Quinn, BSN, RN
Home Care Coordinator

cc: Tom Allen, Representative
John Baldacci, Representative
Susan Collins, Senator
Olympia Snowe, Senator

JAYNE FREEDMAN QUINN, BSN, RN, CMA
P.O.Box 6656
Portsmouth, NH 03802
(603) 431-9367

EDUCATION: BSN, University of Rochester, May 1979

EXPERIENCE:

Home Care Coordinator, York Hospital, York, Maine, 10/20/97 - present. Responsible for creating and establishing the hospital's Certified Home Health Agency, including administrative, clinical, fiscal, regulatory and operational aspects.

Case Manager/Staff Nurse, Columbia/HCA Portsmouth Regional Home Care (formerly Portsmouth Regional Visiting Nurses and Hospice), Portsmouth, New Hampshire, 11/13/95 - 10/09/97. Visiting Nurse responsible for coordination and primary care delivery of all home health services.

Vice President and Director of Nursing, Nantucket Cottage Hospital, Nantucket, Massachusetts, 8/6/90 - 5/26/95. Responsible for management and administrative functions (clinical, fiscal, operational) for the Nursing Service Department, Community and Home Health Department, Hospice, Anesthesia, Pharmacy, Materials Management, Adult Community Day Center and the proprietary subsidiary of the hospital, Cottage Care Unlimited, Inc.. These functions included budget preparation and administration, personnel responsibilities, policy and procedure development and implementation both for individual departments and Hospital-wide systems, strategic planning, total quality improvement program development and implementation, and clinical program development for inpatient, outpatient and community services. Served as Administrator of the Hospital in the absence of the President. Attained and maintained JCAHO accreditation for the Home Health Department and Private Duty Agency.

Training Specialist, Allen Associates, Inc., (AAI) Wakefield, Massachusetts, 1/90 - 8/90. Responsible for installation and training of AAI's management information system for home health agencies and mental health centers. Activities involved lectures, presentations, consulting, documentation, quality control, and development.

Independent Contractor, Visiting Nurse Service of Southern Maine, York, Maine, 9/89 - 1/90. Provided direct care and coordinated services.

Associate, InterQual, Incorporated, North Hampton, New Hampshire, 9/88 - 9/89. Consultant to health care providers for quality assurance, utilization review and risk management programs. Experience included direct consulting, assessment and implementation of quality management programs, faculty for national educational seminars, development and publications.

Medicare Administrator/Regional Director, Special Care Home Health Services, Woburn, Massachusetts, 4/86 - 9/88. Executive Director of the Certified Division with responsibilities focused on clinical, administrative, regulatory, and fiscal operations. General Manager of five of the ten Branch Offices in the Private Division directing marketing and sales, service, personnel, purchasing, collections, development and expansion, and budget.

Patient Care Coordinator, Samaritan Hospital, Troy, New York, 7/84 - 12/85. Responsible for administrative and clinical operation of the medical surgical units (168 beds, 180 employees).

Patient Service Manager, Visiting Nurse Service of New York, New York City, New York, 2/83 -7/84. **Public Health Nurse**, 9/80 - 2/83. Coordinated comprehensive health care for patients in a community setting.

Primary Nurse, University of Rochester, Strong Memorial Hospital, Rochester, New York, 6/79 - 8/80. Responsibilities included primary care delivery to medical/surgical patients, assessing and monitoring cardiac patients on telemetry, conducting research and serving as a peritoneal dialysis resource nurse.

RELATED INFORMATION:

Professional Organizations: American Nurses Association; Home Care Alliance of Maine (Board of Directors 1997 - present); New Hampshire Nurses Association; Portsmouth Regional Health Support Associates (Board of Directors 1997 - present).

Nursing Registration: Maine; Massachusetts; New Hampshire; New York.

Certification: American Nurses Association Certification in Nursing Administration (C.N.A.), since 1986 (current through the year 2000).

TESTIMONY

July 18, 1998

105th Congress of the United States
House of Representatives
Committee on Government Reform and Oversight
Subcommittee on Human Resources
The Honorable Christopher Shays, Chairman
Room B-372 Rayburn Building
Washington, DC 20515

Dear Mr. Chairman:

This testimony is submitted to the House Subcommittee on Human Resources, with oversight responsibilities for the Department of Health and Human Services, for the hearing titled "Medicare Home Health Agencies: Still No Surety Against Fraud and Abuse" scheduled for Wednesday, July 22, 1998 at 10:00 a.m. in the Rayburn House Office Building. York Hospital Home Care has been asked to share our experiences related to the surety bond issue, the earlier moratorium implemented by HCFA on new home health applicants, and the effect these two actions have had on efforts to fight waste, fraud and abuse in home health.

Our testimony reflects the recounting of our adventure in starting a home health agency in York, Maine, and addresses the following topics :

1. **York Hospital's experience in providing care to the community and the reason we sought to offer home care in the first place;**

2. **York Hospital Home Care's experience with the September 15, 1997 HCFA imposed moratorium, including financial and access problems as a result of the moratorium;**

3. **York Hospital Home Care's efforts to secure a surety bond; and**

4. **Antifraud recommendations that we believe may help to ensure fewer problems of waste, fraud and abuse in the home health industry.**

We do not pretend to be experts with regard to the specific numbers and statistics about fraud and abuse in home health care agencies that all sides seem to be reporting and disputing; you have

several other witnesses to speak to those points. However we believe you selected York Hospital Home Care simply because of our individual and collective experience in actually delivering home health care to patients in our community, and in maneuvering through the innumerable regulatory hoops along the way. At any rate, here is our story.

1. York Hospital's experience in providing care to the community and the reason we sought to offer home care in the first place:

York Hospital has been serving the southern Maine seacoast area since 1904. We are a 79 bed non-profit community hospital with a wide range of services from birthing to skilled nursing. We are unique in that we consider the desires and needs of our patients first and strive to meet them. Our documented testimonials from patients, their families and friends will substantiate our ability to accomplish this.

About nine years ago, we developed a model of care for our expectant mothers that extends through discovery of pregnancy, to delivery, and includes home visits for the first five years of the child's life. Hospital based nurses initially meet the expectant mother in the physician's office; this starts the relationship. These nurses will be providing all preparation courses as well as care during the delivery and recovery. They develop a relationship with the mother and family that continues throughout the prenatal course on through delivery and return to home. A pediatric nurse then begins a relationship and follows the infant and family throughout the first five years of life with focus on growth and developmental stages of the child during this period.

This program has been such a success that we realized how important a continuum of care is for every patient, regardless of age. In March of 1995 we implemented a plan for reorganization that focused on putting the maximum amount of resources in areas that touch the patient. We did away with the various "layers" of people that our patients must meet and deal with. Following entrance into the hospital, a patient will be cared for by nurses who work as a team organized by community. We call these teams paths and list them by the communities of York, Wells, Kittery and Eliot. "Path" stands for "Patient Approach To Health" and is further explained in York Hospital's patient vision statement.

YORK HOSPITAL
PATIENT VISION

THROUGH THE PATIENT'S EYES
Caring, Listening, Satisfying... One by One

At York Hospital, each one of us is devoted to satisfying the needs and expectations of every patient by:

- **deeply caring about and understanding each patient's unique needs and concerns.**
- **meeting each patient's expectations by providing value through their eyes.**
- **responding to each patient with clear information, personal attention and respect.**
- **allowing patients to make their own decisions about their treatment and care.**
- **nurturing an enduring relationship with each patient and their family that begins prior to their hospital experience and continues after they return home.**

Our unique spirit of dedication to patient satisfaction sets us apart. It is the promise on which our current patients rely, to which new patients are attracted and by which each one of us lives.

We share this vision statement with all of our patients when they receive care at York Hospital. At discharge from the hospital the patient will always receive a follow-up call and up to three home visits by one of their path nurses. At this time, the nurse is evaluating the patient in their own environment, assessing their understanding of their medications, and other instructional activities. This is done at no charge to the patient.

Other services such as telephone calls to patients following a visit to a specialty area like Emergency Care, Physical Therapy, Cardiology, Surgery, or Special Procedures, are all part of our patient program. We have a TeleNurse Program that provides medical advice 24 hours a day, every day of the week for anyone who calls in with questions on health and/or treatment options. This service is available to those who reside anywhere in our area and even beyond, through our toll-free number. We offer free transportation to patients and their families to come to the hospital, to return home, to physician offices, and other off-site healthcare facilities. We have a home meal delivery program in our service area and also a delivery service from our retail pharmacy. There is a nominal charge of $2.00 for this service.

For three years we have been working on a comprehensive home care program. As previously stated, we feel this is a vital part of our total patient care commitment. We know our patients and feel we can best serve them in attaining a quality of life that is optimal for the patient and the family. When the State of Maine required us to obtain a state license as a home care agency because of our path discharge visit program, we learned that we needed to implement many of the same structures, policies, procedures and operations of a Medicare certified Home Health Agency. So York Hospital elected to retain the unique Discharge Visit Program as a Maine-licensed home care provider that is not Medicare certified, and to start a new Home Health Agency that would participate in the Medicare program.

2. York Hospital Home Care's experience with the September 15, 1997 HCFA imposed moratorium, including financial and access problems as a result of the moratorium;

We began in earnest in January of 1997 by hiring a consultant to set up the initial plan, budget, policies, procedures, education and application process. Many activities were initiated during this period including ordering supplies, furniture, computer hardware and software; setting up space, scheduling computer development, education and implementation; expense of time, resources, and commitments. On August 1, 1997, the application for Maine state licensure was submitted as the first step in establishing a new Medicare certified Home Health Agency. The state survey was then scheduled for October 2, 1997. I accepted the position of Home Care Coordinator on September 12, 1997, with a start date of October 20. And then the moratorium hit.

Needless to say, we were devastated. We felt that York Hospital had initiated the application process prior to the September 15 date, but our appeals to HCFA were unsuccessful in obtaining an exception to the moratorium. York Hospital received a January 6, 1998 letter from Robert Streimer, Director of Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, HCFA in response to our request for exception to the moratorium. We were informed that the September 15, 1997 initiative also included (I am quoting directly from his letter):

> **"New Requirements.** HHAs will be required to undergo recertification for Medicare every 3 years. As part of the continuing enrollment process, agencies must submit an independent audit of their records and practices. In addition, agencies will have to supply information about related businesses they own, and meet capitalization requirements for 3 to 6 months of operation. HHAs will also be required to serve a minimum number of patients prior to seeking Medicare certification."

So, for that period of the moratorium, until it was lifted on January 13, 1998, York Hospital could not go forward. Generally speaking, we estimate approximately a 6 - 8 month delay in operational functions due to the moratorium. In fact, the impact was tremendous:

- Because of the "new requirements" established when the moratorium was lifted, we were required to complete the new HCFA 855 application, including information about related businesses of the Hospital, the individual officers of our Board of Directors, and the senior management. Being the first to use this application resulted in additional time and resource delays (the State and Fiscal Intermediary were also new to the application, which resulted in time issues there. I must comment , however, on the excellent response and assistance we received from the staff at the Maine State Division of Licensing and Certification, and Associated Hospital Service of Maine, in completing the process).
- In addition, we were required to provide services to at least 10 patients and maintain an active census of 7 patients before the state could conduct the initial survey site visit. None of these services were billable because we were not certified as yet; but we could not become certified, until we demonstrated we could serve the "minimum number of patients". Prior to September 15, 1997, that number was 1 patient.
- The initial survey was also changed from a mutually scheduled date, to an unannounced site visit, as a result of these "new requirements".

- Although we were officially certified effective April 17, 1998, we have yet to bill for any services due to the delay in installation of the computer system. This presents a tremendous cash-flow problem, because we are providing services, paying staff, paying for supplies and other operational expenses.
- The computer process which included training, installation, development , parallel run and "go live" date was originally scheduled from October of 1997 to a "go live" date of June 1, 1998. Because of the moratorium, we could not even reschedule the starting time until April of 1998, with a projected "go live" date of October or November, 1998. This resulted in a six month delay, at least.
- Patients have been denied access to our continuum of care because of the moratorium. We estimate that period of denied access to be approximately 6 months.
- We are currently providing service at only 50% of the projected level for this time period. We estimate a loss of revenue of approximately $325,000 by the end of our current fiscal year (FYE 06/30/1999). This represents a 27% loss in revenue to our program because of the moratorium delays.
- We were required to secure surety bonds as part of the initial application process due to the publication of the surety bond regulations when the moratorium was lifted. See the next topic for information about that process.

3. **York Hospital Home Care's efforts to secure a surety bond:**

- York Hospital Home Care was successful in securing three $50,000 security bonds for Medicare, term 01/01/98 - 06/30/98; Medicaid, term (01/01/98 - 12/31/98); and Medicare, renewal term 07/01/98 - 06/30/99. The cost was $500 each, a total of $1,500. These costs, although required for participation in the Medicare program, are not currently considered reimbursable by Medicare or Medicaid.
- Because York Hospital Home Care is part of York Hospital, we were able to make one phone call to our agent, who made contact with one surety company (on the list of federally approved surety companies) to secure the bonds.
- Some of the conditions of the bonds are:
    1. A Medicare overpayment for which the Principal and Surety are liable under this Bond is an "unpaid claim," (as defined in 42 C.F.R. section 489.60 on the date the Surety executes this Bond) arising out of payment for home health services which both becomes "unpaid" and for which HCFA first demands payment from the Surety, during the term of this Bond.
    2. A civil penalty for which the Principal and Surety are liable under this Bond is an "unpaid civil money penalty or assessment" (as defined in 42 C.F.R. section 489.60 on the date the Surety executes this Bond) in connection with home health services which both becomes "unpaid" and for which HCFA first demands payment from the surety, during the term of this Bond.
    3. HCFA shall promptly notify the Surety of any claims or civil money penalties or assessments which it asserts against or imposes on the Principal during the term of this Bond.

4. The total aggregate maximum liability of the Surety under this Bond, including interest, is the Penal Sum stated above without regard to the number or amount of unpaid claims and the number or amount of unpaid civil money penalties or assessments asserted against or imposed upon the Principal.
5. The Additional Requirements set forth in 42 C.F.R. section 489.66 on the date the Surety executes this Bond are hereby incorporated by reference and are binding on the Principal and Surety to the same extent as if set out verbatim herein.
6. HCFA is the sole Obligee of this Bond, and no action may be brought on it by, or for the use or benefit of, any person or entity other than HCFA or its fiscal intermediaries.

- Because of the recent suspension of the surety bond requirement, we are attempting to cancel the second Medicare bond we purchased, and recover the $500.

4. Antifraud recommendations that we believe may help to ensure fewer problems of waste, fraud and abuse in the home health industry.

Many of the "new requirements" for initial applications and recertification appear to be sound and reasonable in their effort to prevent waste, fraud and abuse. However, I am extremely concerned about the use of the surety bond under the current regulations. In addition, the moratorium only caused a painful and costly delay in our obtaining Medicare certification as a Home Health Agency. I do not believe it has anything to do with preventing waste, fraud and abuse , and should not be a tool to utilize in the future.

But why waste our precious resources adding new conditions, processes and regulations in fighting fraud and abuse, when we have good systems in place in some states and regions that appear to do that job already? I am speaking about the individual state licensing and certification programs, with multiple and complex tools in place. The New England region, and the state of Maine in particular do not appear to have these horrific problems that continue to be sensationalized and applied to the Home Health industry as a whole. Yet, we are being punished, driven out of business and persecuted by these McCarthy-like tactics that are evident in the Wedge surveys, HCFA mandates like sequential billing, and a general attitude of "WE" versus "THEY".

Where is the patient in all of this?

Instead of reacting, we need to work together to strengthen the systems we already have in place that are working. When there is evidence of actual fraud and abuse there should be severe consequences, including fines, criminal prosecution and elimination from the Medicare program, when appropriate. But if there are unintentional errors due to human mistakes, do not call this fraud and abuse.

In closing, it seems important to remind everyone that what we are really trying to do is provide the right care and services to the patients without bankrupting the Medicare program. Hopefully, the prospective payment system for home care will help address the financial aspect. As for the patient care issue, we all need to embrace the vision of York Hospital and "Patient Approach To Health".

Personally, I have been a Registered Nurse for twenty years, working in the Home Care industry for most of that time, in a variety of settings. First and foremost, however, is my devotion to nursing and focus on patient care. I wanted to become a nurse to take care of people. Over the past twenty years, I believe that I have been able to do that, but more time seems to be focusing on everything but patient care. At least at York Hospital and York Hospital Home Care, I am part of a team of people who have demonstrated that an organization can be successful by doing the right thing as we care for people, "THROUGH THE PATIENT'S EYES: Caring, Listening, Satisfying... One by One".

I hope this has been helpful as you continue with your analysis of these issues. Thank you for the opportunity to participate.

Sincerely,

Jayne Freedman Quinn BSN RN

Jayne Freedman Quinn, BSN, RN
Home Care Coordinator

YORK HOSPITAL
HOME CARE SURVEY

Thank you for choosing York Hospital's Home Care. It is important to us that we have met your needs and wishes. Please take a few moments to complete and return this brief survey. Thank you for your feedback.

WHICH SERVICES DID YOU RECEIVE?
Please check each that apply.

- ☒ Nurse
- ☒ Certified Nursing Assistant/Home Health Aide
- ☐ Personal Care Attendant
- ☐ Social Worker
- ☐ Occupational Therapist
- ☐ Speech Therapist
- ☐ Physical Therapist

PATIENT CARE- (Did we meet your expectations?)

- Were visits kept as scheduled? ☑ Yes ☐ No
- Did we provide the services that you expected? ☑ Yes ☐ Somewhat ☐ No
- Were your care providers knowledgeable about healthcare? ☑ Very ☐ Somewhat ☐ No
- Were your care providers courteous and professional? ☐ Very ☐ Somewhat ☐ No
- Were you pleased with your involvement in the planning of your care? ☑ Very ☐ Somewhat ☐ No
- Would you recommend us to a friend? ☑ Definitely ☐ Maybe ☐ No
- Overall, were you pleased with the service? ☑ Very ☐ Somewhat ☐ Dissatisfied

COMMENTS: Jayne + Elizabeth were so caring and professional! This was a first for me - Home nursing care. They let me know in advance when to expect them. They listened to my concerns and were so helpful! Very observant - Gentle and explained everything to me - I appreciate this service as much. They were Wonderful! I was sorry to see this ending! Thanks to all!

(Please turn to other side.)

May we call you to discuss your response? ☑ Yes ☐ No If Yes, see below.

Name: Marie E. Smith Telephone Number: (603) 436-1175

Convenient time to call: afternoon

Address: 180 Willard Ave Portsmouth NH 03801-5064

If you are happy with the service you received, please tell your friends about York Hospital Home Care.
All of our home care specialists are licensed in the states of Maine and New Hampshire.
York Hospital Home Care is a Medicare certified home health agency.

PORTSMOUTH NH 03801 PM 28 MAY 1998

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York Hospital
Home Care Survey

- Registered Nurses
- Home Health Aides
- Physical Therapists
- Speech Language Pathologists
- Occupational Therapists
- Medical Social Workers
- Certified Nurse Assistants
- Homemakers
- Companions
- Personal Care Attendants

HOME CARE OKAY

YORK HOSPITAL
HOME CARE SURVEY

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WHICH SERVICES DID YOU RECEIVE?
Please check each that apply.

- ☑ Nurse
- ☑ Certified Nursing Assistant/Home Health Aide
- ☐ Personal Care Attendant
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- Would you recommend us to a friend? ☑ Definitely ☐ Maybe ☐ No
- Overall, were you pleased with the service? ☑ Very ☐ Somewhat ☐ Dissatisfied

COMMENTS: This is a wonderful service. I am a widow with only one child who does not live in York. I have no other relatives. The services was wonderful.
Thank You
Vivian K. Hall

(Please turn to other side.)

May we call you to discuss your response? ☑ Yes ☐ No If Yes, see below.

Name: Vivian K Hall Telephone Number: 207-363-4027

Convenient time to call: Before noon or after five P.M.

Address: P.O. Box 275 York, Me. 03909 (mailing add.)

Physical address: 170 Old Post Rd. York, Me. 03909

If you are happy with the service you received, please tell your friends about York Hospital Home Care.
All of our home care specialists are licensed in the states of Maine and New Hampshire.
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York Hospital Home Care

York Hospital
Home Care Survey

- Registered Nurses
- Home Health Aides
- Physical Therapists
- Speech Language Pathologists
- Occupational Therapists
- Medical Social Workers
- Certified Nurse Assistants
- Homemakers
- Companions
- Personal Attendants

York Hospital takes a unique pathway to in-home health ca[illegible]

By Nicole Gauthier
Staff Writer

YORK — Following along with its Patient's Approach To Health (PATH) vision, York Hospital has created a home care program to fit the many needs of its patients.

Similar to a visiting nurse association, York Hospital Home Care provides licensed specialists to assist patients who still have medical and emotional needs following a stay at the acute care facility.

"No matter how great the hospital experience, everyone is happy to get home after an illness or injury,' said Jayne Quinn, the program's director. "But sometimes that adjustment requires additional help. Or perhaps someone's had a real life-changing injury. These are instances where YHHC can be of help."

Quinn gave the example of a stroke victim whose body has been half paralyzed. That patient, while well enough to return home, may need physical therapy to learn to walk again, occupational therapy to learn how to work in the kitchen again, nursing visits to teach about medication and, in some cases, a counselor to help with depression brought on by the illness.

Among the professionals available for home care are registered nurses, home health aides, physical therapists, speech/language pathologists, occupational therapists, medical social workers, certified nurse assistants, homemakers, companions and personal care attendants. Every effort will be made to ensure that patients of the hospital receive continued [illegible] from the same health care professionals that aided them during their hospital stay, Quinn said.

The program is not limited [illegible] York Hospital patients, how[illegible] It will accept referrals from [illegible] one living in the area.

"Our nurses visit patients at the home, free of charge, up to [illegible] times after their discharge [illegible] light of that, we thought [illegible] also have these same nurses [illegible] and therapists continue to [illegible] patient in the home? [illegible] does it offer consis[illegible] that's something you can't [illegible] the director said.

Interested residents can [illegible] York Hospital Home [illegible] (207)351-2194, or to[illegible] 800-564-3321. They can [illegible] the unit through the York Ho[illegible]

Portsmouth Herald 6-5-98

York Hospital is now offering home care

By Danalyn Adams

There's no place like home.... Dorothy thinks so and so does York resident Eva Wendell, 85, who is recovering from a bad spill on a patch of winter ice.

"I'm very happy. I'm satisfied with it. People are very nice."

Wendell is referring to the new York Hospital home care program, which was officially launched this month. Offering visits and extended medical care in the home by licensed specialists, home care was developed to provide a comfortable life at home for those who need additional support.

"York Hospital home care was developed in response to our patients who constantly remarked, 'I wish I could get the same great care at home as I get here at the hospital,'" said Jud Knox, president of York Hospital.

Last Thursday morning, registered nurse Elizabeth Layton, who has years of experience in adult health home care, called on Wendell at Yorkshire Commons, where she lives alone. "A lot of our job is teaching," said Layton, as she proceeded to take her patient's blood pressure, listen to

■ Care, see page 32

YORKSHIRE COMMONS RESIDENT Eva Wendell, 85, in good spirits while recovering from a bad spill on a patch of winter ice, engages in a pleasant conversation with York Hospital home care nurse Elizabeth Layton, as she takes her blood pressure and performs a number of other home care services. The home care program was officially launched this month and offers visits and extended medical care by experienced, licensed home care specialists. More than 30 patients already receive regular care by the staff and there is room for many more. Wendell is appreciative of the fine, attentive care she receives [illegible] and thinks the people are nice who come [illegible]

Cheryle Moore-Smith

Care

continued from page 1

her heart and lungs, ask about any ailments and recommend a daily regimen of deep breathing.

Retrieving a tray of pill bottles from the kitchen, Layton began to organize the 14 varieties into daily doses. "I'm glad you're here doing [this] for me," Wendell commented with gratitude, her ankle healed from the break in March, but her back pain still a chronic problem.

Layton has visited Wendell for almost a month and a half, gradually decreasing the number of weekly visits as she noticed her gaining strength and growing more independent.

"Eva's 100 percent better than when I first saw her [in the hospital]," said Layton. "I think she's doing well and I probably won't have to visit much longer."

Home care services are available to everyone, regardless of whether they were a patient at York Hospital.

If an individual has been a patient of the hospital, however, one of the goals of the program is to create a feeling of continuity for patients and that includes continued care by the same people. In most instances, familiar faces will make follow-up visits to the home as home care providers, the backbone of the PATH program.

PATH stands for Patient's Approach To Health and embodies the philosophy of York Hospital: looking at everything through the patient's eyes. Each PATH, or patient area, is named after a nearby town — York, Kittery, Eliot, Wells — and nurses and other hospital staff members are typically placed in their particular hometown, as are patients.

Home care nurse Maggie Murphy thinks the continuity of post-hospital care is second to none. "It reduces stress, you get better faster in your own home, you eat better, sleep better, think more clearly, breathe your own germs and it even saves money. The program is a professional challenge for me and it is really satisfying."

All of the home care specialists are licensed in the states of Maine and New Hampshire, and the program is a Medicare-certified home health agency, similar to any visiting nurses association.

Home care provides registered nurses, home-health aides, physical therapists, speech-language pathologists, occupational therapists, medical social workers, certified nurse assistants, homemakers (assist with shopping, meals), personal care attendants and companions.

The program also provides a wide variety of services, from routine home care to IV therapy, care of the terminally ill and trauma victims, blood draws, high-risk pregnancy and infant care, nutrition counseling, rehabilitation and social work services, among others.

"No matter how great the hospital experience, everyone is happy to get home after an [illegible] or injury," said Jayne Free[illegible] Quinn, R.N. and coordinator [illegible] the home care program. "And [illegible] was the next logical step [illegible] PATH already in place."

Quinn has more than [illegible] decades of nursing exper[illegible] throughout New [illegible] Massachusetts, New Ham[illegible] and Maine. Experience [illegible] from home, acute and clinical [illegible] to administration. From this perspective, she says with conviction: "This is the first hospital I've worked in where they say the patients come first and they do. The surveys that have been returned by our first few patients are really positive. Human beings answer each phone call [illegible] the program and a nurse is on [illegible] 24 hours a day, seven days a week."

All of the home care nurses [illegible] staff have years of experience [illegible] the field, added Quinn. Curr[illegible] the program cares for [illegible] patients and has the capa[illegible] many more.

As Layton left Wendell's [illegible] last week, after providing [illegible] home care services with [illegible] smile and pleasant demeanor [illegible] emphasized that the program [illegible] "really focused on the needs of [illegible] patient." Just ask Wendell.

"Everyone who's been here [illegible] been nice. I like having people here."

York Hospital home care can [illegible] reached directly by calling [illegible] 351-2194, or, toll-free, 877-[illegible] 3321.

Mr. SHAYS. Let me just have an assessment of our panel here a second.

Ms. Schubert, you basically represent the Surety Association, so you can speak to the whole issue of the products that you provide and so on.

Mr. Koniers, you are basically a supplier of equipment, medical equipment under Medicare?

Mr. KONIERS. Correct.

Mr. SHAYS. Mr. Dombi, you basically represent the association of home health care providers, the basic—not the nurses, but the businesses that provide the services?

Mr. DOMBI. The not-for-profits, for-profits, hospital based, all of the above.

Mr. SHAYS. Ms. Quinn, you are a hospital providing services?

Ms. QUINN. Hospital-based certified home health agency.

Mr. SHAYS. So you represent a bigger player in this process. You are connected to an institution that provides other services?

Ms. QUINN. Correct.

Mr. SHAYS. Mr. Richard, you are providing a service. I have no sense of your size.

Mr. RICHARD. We have a $12 million budget.

Mr. SHAYS. That is not insignificant. How would you be ranked among your peers, large or small?

Mr. RICHARD. I would say medium to large agency.

Mr. SHAYS. I think that is fair.

Mr. Schneider, you again represent an association on a State level but not for the businesses themselves but nurses who provide these services?

Mr. SCHNEIDER. No, I am actually from a provider, the Visiting Nurse Association of Central Jersey.

Mr. SHAYS. You are a provider.

Mr. SCHNEIDER. Nonprofit, freestanding.

Mr. SHAYS. So we have a pretty good mix of witnesses here.

You started us off, Ms. Schubert, and made the suggestion that the surety bond would be more likely to guarantee protection against fraud and abuse than financial reimbursement? You were moving in that direction?

Ms. SCHUBERT. Toward the end of my time, yes.

Mr. SHAYS. That is one of the bottom lines?

Ms. SCHUBERT. There is certainly a continuum. Certainly the position of most of our members is that it is up to the obligee to determine what kind of bond they want. You tell us the type of bond you want, and we will do what we can to provide that bond if possible.

Mr. SHAYS. I understand, and the government is stepping in and we mandated a protection that they may not have wanted. But what I am hearing you say and what I am really getting a feeling from all of our witnesses is that it obviously is going to be different for members of your association to determine whether they want to get into the marketplace of providing financial guarantees and having to deal with a system that sometimes isn't understood by the participants.

In other words, I would think that it would be very difficult to put a cost to a bond that is placing financial guarantees. I would

think that it would be very difficult and I would think that you would get into a lot of value judgments with HCFA as to what should have been paid and what shouldn't have been paid.

And the example of the half a million dollars, was that yours, Mr. Dombi?

Mr. DOMBI. Yes.

Mr. SHAYS. That is a mouthful if you provided the service, and it seems to me you need a good Congressman to help you out on that bill with HCFA. Because it does seem that there must be more to the story. You need a good advocate on that one.

Sorry for rambling here.

One of the things that I am gaining from this is that maybe we should be looking at not just the faith performance bond to start with and decide whether we want to move beyond that. What is the reaction of all of you here? A short response, yes, no.

Mr. KONIERS. We agree with NAMES that perhaps a surety bond gains you entry into the Medicare program but certainly there are other vehicles in place today such as accreditation, licensure and certification that are excellent tools in monitoring the providers in the system, as some of our other witnesses had mentioned quite well.

Mr. SHAYS. If you were going to have a surety bond. You make the argument that you don't need a surety bond?

Mr. KONIERS. As you gain history within the system and become qualified and certified under other private sector vehicles, such as JCAHO or CHAP accreditation.

Mr. SHAYS. Right. Anyone else want to comment on this?

Ms. SCHUBERT. The surety bond requirement should be in addition to what you are talking about, in addition to certification. But you have to keep in mind the second piece of surety bonds. If we are wrong, then the claims and losses will be paid by the surety, which this other program will not address.

Mr. SHAYS. First off, the product wasn't being offered to the extent it should have been; and I understand why. But if you don't have many players offering the service, you are not going to get a very competitive price?

Ms. SCHUBERT. Mr. Chairman, I don't know that we know that. There are at least 54 companies that have written——

Mr. SHAYS. I know that some had trouble getting this.

Ms. SCHUBERT. Certainly.

Mr. SHAYS. That says to me that it is difficult. For—it was difficult to know—there was not a large list of people that they could go to to get these bonds, it appears—you can dispute it later—from the testimony that we have had.

Yes, Ms. Quinn.

Ms. QUINN. The efforts that the surety company might have to go through to evaluate whether or not the candidate is a good risk is a process of shifting the burden of oversight from HCFA to a surety bond company. I think we should spend the money that we have on the services that we have now and make them work right. I think it is deterring us from the real problem.

Mr. SHAYS. I had a Baptist Church behind me that was lobbying against surety bonds and I am hearing this voice in one ear from

one of my staff and one of Mr. Towns' staff, but I did not think that a $10,000 to $15,000 cost was a significant cost.

Mr. RICHARD. In our situation, the cost was not an issue. We were prepared to pay the cost, 1½ to 1 percent, whatever that may be. Our situation was that it simply was not available.

And what has been said here today and in talking with surety companies, they will tell you that we look at the credibility and the integrity of the agency and the owners and the management. And that is OK. But you can have a stellar agency as far as credibility. If you do not have financial assets, it still is not an insurable risk for that surety company.

Beyond that, I think HCFA is looking at the bonds as not only an issue of fighting fraud and abuse but also to preserve the Medicare trust fund, to preserve overpayments that are not recouped, and they are looking at it from a very financial perspective. They want to be able to recoup overpayments, which I must tell you takes on a new light with the interim payment system.

Overpayments are a guarantee. They will happen. They are happening and will continue to happen as long as that system is in place.

Mr. SHAYS. I am going to come back, but let me give Mr. Towns the floor. But before I do, I gather—I am going to summarize what I think I am hearing you say, and then I want anyone to jump in, anyone here.

That if you were going to have a surety bond, it would clearly be one over faith versus financial, but you are not advocating any bonds. Let me understand, among the five who may be purchasers of these, obviously if you are the association you want to sell them. But, Mr. Koniers, what is your position on surety bonds?

Mr. KONIERS. Our position is that a minimum surety bond requirement of $50,000 may be reasonable, but that over time, as you become accredited, certified and/or licensed and you do have a history behind you, that that surety bond requirement be waived.

Mr. SHAYS. So, basically, a history of good service should make it less likely for you to have one?

Mr. KONIERS. Exactly.

Mr. DOMBI. Mr. Chairman, our position would be of similar nature to Mr. Koniers, a faith bond focused in on fraud and abuse for a period necessary to demonstrate good-faith operation. But we would have to agree with Ms. Quinn. Much of what goes into that analysis should continue to be done by HCFA, rather than having to spend money taking it from charity care to support that kind of a cost by a private organization.

Ms. QUINN. I don't think that we should have a bond but, if we did, I think the cost should be covered as part of our reimbursement for Medicare services.

Mr. SHAYS. You would, obviously, go for the faith versus the financial?

Ms. QUINN. Yes.

Mr. SHAYS. Mr. Richard.

Mr. RICHARD. I certainly question the bond's effectiveness in accomplishing what HCFA set out to do. A minimum bond for new entrants may make some sense in terms of solidifying the requirements to get into the program.

Mr. SCHNEIDER. Going last, I will say that I agree with everything that they have said, and the cost should be a cost-reimbursable expense, and it should be kept to a minimum.

Mr. SHAYS. Mr. Richard, we were talking about Mr. Kanjorski, who is a very seasoned Member of Congress. We are happy to have you participate in this dialog.

Mr. KANJORSKI. Thank you.

Mr. TOWNS. Thank you, Mr. Chairman.

Ms. Schubert, the type of bond that they are asking for, isn't that sort of unusual in the business? Is that traditional for the industry? This is basically—isn't this new, the type that they are asking for?

Ms. SCHUBERT. To specifically repay overpayments, that is not something that we have done before. A financial guarantee is a typical surety bond, but you have to remember there are hundreds of kinds of surety bonds. This bond is unusual only in the sense that it has never been applied to the home health agency business before. It is a much more difficult bond to obtain than other types of surety bonds.

Mr. TOWNS. I am concerned about the capitalization requirements, and I have not been convinced that it has a lot to do with the delivery of service in terms. Can the panel explain the difference between capitalization and effective service delivery? Can you help me with this? I am struggling.

Mr. DOMBI. If there is a connection, it relates to the ability of the agency to make it the first several months before payment is made by the Medicare program and there already had been a capitalization requirement. Because no home care agency could open its doors to Medicare patients without having sufficient funds to meet payroll and pay the rent for several months, because that is how many months it would take before payment started coming from the program already.

If you have sufficient——

Mr. TOWNS. Timely payment would actually solve that problem?

Mr. DOMBI. If you have sufficient resources to do that, then your agency remains stable.

The difficulty with the capitalization requirement is that it didn't look at what resources. It restricted the resources. It had to be no more than one-half of the amount in a credit line, and the rest had to be personally controlled liquid assets, and that makes a big difference in your ability to operate your home health care agency and to open the doors.

But capitalization—as Ms. Quinn stated in her testimony, they capitalized by over a quarter of a million dollars before they opened the door, because that is what it took for startup costs.

Mr. RICHARD. And the home health industry is not a capital-asset-intensive organization. We are a very staff-intensive organization. It is people, human resources that make home health agencies go.

Mr. TOWNS. So, in other words, if the payment comes, then you don't have the problem. That is the point that I am trying to understand.

We talk about fraud. We talk about all of this. And it seems to me, if you raised this, that you are asking people to do other things

to come into the business. I look at all aspects of fraud, where you get somebody to put money in and then you come in. I think the back door is something that we should try to do everything that we can to stop, and I think sometimes when we call ourselves fixing something we are actually tearing it down.

Ms. QUINN. It is not unreasonable, I think, to make a contract with a provider and expect that provider to be in business a year after you make a contract with them. So any business needs to be able to have some kind of business plan, and if that means initial capitalization, that is not unreasonable. But, about payment, the way that the system is designed is to look at claims and review them and give payment after that fact.

Recently, there have been new payment requirements, something called sequential billing. If you submit a bill for the care you gave me and there is a question, you cannot submit claims for any subsequent month thereafter. You still have to deliver care. Because if you don't deliver care to me, then it is abandonment. There are all of these things that are so complicated in the system.

What is happening, people are looking at the little pieces and they are trying to make decisions as to the little pieces, and it is making it worse. It is making it onerous to the providers. It is making it difficult for people to give good care to the patients, and it is a mess.

Mr. TOWNS. Thank you very much.

I am concerned about the fraud example used to justify the use of bonds. Would any of the witnesses like to comment on the differences between the program in Florida and the Federal rules proposed by HCFA?

Mr. DOMBI. Perhaps I can offer you some insights.

Florida was the first to date and, outside of Medicare, the only bonding requirement for home health services. It also applied to durable medical equipment suppliers.

With respect to home health agencies, it applied only for the first year of operation for a new home health agency unless its track record was tainted along the way.

Existing agencies in the State of Florida did not require a bond requirement. It was also set at a minimum of $50,000. It appears that they are using it as a faith bond, although the authority may be there for using it beyond that into the overpayment realm, and I understand that they are looking at that once again in the State of Florida.

It had limited impact from the home health agency side on home health services, because the State also has a certificate of need process, which is all of the hoops that Ms. Quinn referred to that you have to jump through. The government has to say that there is a need for your home health agency in your State, and that process costs you several hundred thousand dollars just to secure that CON.

So the people getting into home health services in Florida were screened significantly to begin with, and a $50,000 additional bond requirement was not going to be that significant to them because they had shown their commitment already.

Ms. SCHUBERT. This is one of the most important issues pending, since I understand Congress looked at Florida as a good example

to come up with a surety bond requirement. The law as written in Florida is very different than the implementation of the program. The program worked as implemented. The program as written was for a 1-year, new entrants requirement. As implemented, the Medicare agency in Florida required bonds from everybody, and that was a very important point, and we were told that there was a significant impact. I don't have any numbers on what the impact was for home health agencies.

The law also does allow for the repayment of overpayments under the bond, and as implemented it was implemented as an antifraud bond instead. Very important points. If the committee or subcommittee is interested in the same kind of a program as Florida, it is important to model it on what worked versus what was actually drafted and on the books.

Thank you.

Mr. TOWNS. Let me ask this. I believe that the reason this rule ran into trouble was because it was enacted without public hearings or an opportunity of the affected people, the providers, to comment on the issue. During the rulemaking process, what efforts were made to bring in home health care or even surety bond agencies? Any effort?

Mr. DOMBI. I would like to say that our organization was highly successful in getting entry into HCFA discussion on surety bonds because that is my job to be there, to consult with them, and present information to them.

The way our testimony characterized it, we were heard but not listened to. That we had phone calls returned. We had meetings with HCFA, but I swear it was the same as talking to an empty room, and the results showed throughout on that.

It became a very frustrating experience for us because we couldn't produce for our constituents in that way. But what became more alarming than anything else was the increasing and perhaps habitual use of the waiver standard for waiving public notice and comment in advance of a rule becoming final.

I have not seen HCFA in the last 20 years move in the direction that they have in the last 1 or 2 years to waive the APA and Regulatory Flexibility Act requirements to the degree that they have now with the excuse that they continue to use which is we are running out of time. We have a congressional deadline we must meet.

In this bond rule it was signed into law on August 7, 1997. On January 5, a final rule with an opportunity for comment was published. It did not need to take that long to develop that rule, and it did not need to take it into a final, waived, public-comment stage. We have yet to see any response to the comments which we did submit after the final rule was implemented. And, as I mentioned earlier, we have no promises that they will comply with the APA on the third visit to this rule once again, and we may be back before this committee with a third crisis where 60 percent of home care agencies can't find bonds that make sense to secure and access to services are once again in jeopardy.

Mr. KONIERS. In the medical equipment industry, we had an opportunity to meet with HCFA once; and, frankly, they did not take our advice with respect to the 15 percent rule; and we thought that that was very much injurious to our industry.

Mr. DOMBI. One more thing. We have asked this question 100 times of HCFA officials and still don't have an answer. Why is it that they came out with a proposed rule for the DME bond and a final rule for home health agencies?

The DME bond is still in a proposed stage. We don't know when the final rule will see the light of day. We are going into the third iteration of a final rule on home health with never an opportunity to review a proposed one.

Ms. SCHUBERT. As soon as the Balanced Budget Act was passed, we started providing HCFA as much information as possible. I will tell you that the rule that came out in January bore little resemblance to any of the information that we had provided.

After that time, they have been very cooperative. This is not to say that they didn't work with us beforehand, but in my opinion they determined what they wanted and they wrote a rule to get what they wanted, despite what anybody else had told them at the time.

Since then, they have been very cooperative in listening to the effect of the regulations and trying to make technical corrections, and now of course are moving forward. I think the GAO study will be significantly helpful in assisting them in writing a rule that maybe makes more sense.

Mr. TOWNS. I am out of time, but Ms. Quinn?

Ms. QUINN. They never asked me.

Mr. RICHARD. Me neither.

Mr. SCHNEIDER. No.

Mr. TOWNS. I yield back. You have been very helpful.

Mr. SHAYS. Mr. Kanjorski, you have the floor.

Mr. KANJORSKI. Thank you.

Let me see if I can break it down, because I spent an awful lot of time in my District. It seems to me that what happened is that the Congress, in its wisdom—I say that with quotes—saw this huge increase in home health care and, automatically, that means that there is great fraud, mismanagement and abuse. Because any time an expenditure goes up significantly, I think government and bureaucrats and the press tend to say there must be abuse there when, in fact, it all occurred to a large extent by our cost containment in the hospital field, that is, to get people out to lower cost care, and in Pennsylvania generally because of our tremendous senior citizen population. It actually saved a great deal of money by having effective home health care as opposed to hospitalization and nursing home care, but the numbers went up.

Certainly the hospital costs would have gone up significantly higher if the people would have been hospitalized instead of being put in home care, but, nevertheless, the home care portion of the budget went up.

So the agency looked at this, and from the top down, rather than extracting information from the bottom up, saw the bond requirement as a quick fix, and I think they made some fundamental errors, and I want to address that.

I see a distinct difference between for-profit and nonprofit organizations. There is certainly a greater incentive to commit fraud and abuse if it is for-profit, if you are going to keep it. I don't know many Catholic charities or Jewish community centers or Lutheran

homes that are nonprofits that are going to try and cheat the government since there is no benefit derived unless there is embezzlement occurring by the people, and that is a highly unusual set of circumstances.

So I think there is a need to separate the profits and the nonprofits and, to a large extent, separate the areas of the country involved. Growing areas of the country where for-profits are running in to provide services in what otherwise is a vacuum or a void are dangerous.

Florida is a perfect example of that. The extreme growth in population. People coming from all over the country, rather than having a community mind-set, and providers rushing in to fill the vacuum that exists in the senior population down there.

Pennsylvania with a steady population, with a strong community orientation, it is very difficult in Pennsylvania to commit a fraud because everybody in town knows about it and you are soon out of business.

The bond requirement it seems to me not to be the worst in the world, but the way that it was handled is poor. What I suggested in meeting with my folks, and I know that we have association people here, I can't really understand why there has not been an aggressiveness by associations, private associations that represent nonprofits particularly and those that represent for-profits, that you find the vehicle to provide the surety system involved, rather than just going to the professional marketplace.

Now, the professional marketplace has a role here, but it is as a secondary insurer. The primary filtering system that would occur by the association to put money together sufficient to cover the real risk factor involved, and what I want to ask is, what is the experience—and I will start with you, Mr. Richard—in Pennsylvania? What kind of fraud and abuse have we had in the home health care field which gives us some idea what kind of protection the Federal taxpayer needs?

Mr. RICHARD. Fraud and abuse has been geographic, and I think there has been a difference based on profit and nonprofit, and Pennsylvania has been very minimal. In Pennsylvania, most of the care is provided by traditional nonprofit visiting nurse associations that have been around in business for a lot of years.

I would say that we have had some bad apples. One particular bad apple which has been put away at this point remained in business for a long time even though providers within Pennsylvania were yelling and telling HCFA, here is a bad apple, you need to do something.

Mr. KANJORSKI. Is that profit or nonprofit?

Mr. RICHARD. It was a proprietary agency. I am not aware of any nonprofits in Pennsylvania investigated for fraud and abuse issues.

I read somewhere that the overpayments is only two-tenths of 1 percent.

Mr. KANJORSKI. I asked the question, why don't you all get together and just form your own insurance capacity? We have seen that happen in public housing and municipal workmen compensation and self-insuring, because of the specialty of the area, where they come together very quickly and particularly in nonprofits.

Mr. RICHARD. Given time——

Mr. SHAYS. Will the gentleman yield? This is a dialog we had before you came. The one challenge is that sometimes in a nonprofit, you find that the employees pay themselves more and they consume the profit in salaries, and you end up with a nonprofit almost becoming an employee-owned operation.

Mr. KANJORSKI. Sometimes does it appear to be nonprofit but the operators treat it as a for-profit?

Mr. SHAYS. I think our Inspector General was clear in pointing out that most of the fraud was in the startup entrepreneurial profit side. So, there may be a leaning toward that side, but I don't want to—we will extend the debate on the efficiencies of nonprofits and whether they truly keep costs down and so on, so we will have an interesting dialog on that as well.

Mr. KANJORSKI. I found in the meetings that I had with many nonprofits, because that is what we have, almost a personal reaction to it. They are questioning our integrity. Organizations like Visiting Nurse Association came in, Catholic organizations came in and said, what is this? We have been doing it for 20, 30, 40 years, and suddenly our government says we are so irresponsible we need to come up with a $1 million bond.

I encouraged them to do their own self-insurance. It is not a punishing feature that the government wants to have some fund to look at there. And, in reality, it would be self-policing if the associations did their own surety bonds because they wouldn't give a surety bond to an irresponsible organization. They would keep tabs on them as to what is happening and going on.

Now the for-profit organization is a great fear, it seems to me, because it can be started with little assets and little recourse if the people do commit fraud and abuse. I am not sure what we should do, but, on the other hand, we shouldn't make it a test to keep irresponsible people out.

Quite frankly, as an entrepreneurial thing, I don't see that great of a profit. If you are going to commit fraud and that is your intention, there are many other areas you can go into to commit fraud and make great profit, if you are a fraudulent entrepreneur, than home health care. That is a difficult field, and particularly dealing with Federal prosecution and audits and everything else.

Mr. SHAYS. If the gentleman will yield again. I am really happy to continue, so I am not going to take his time, but we have been meeting this morning. We are going from $3 billion to $4 billion to $18 billion in a span of less than 5 years; and the Inspector General's report, obviously, we will have to dissect a little more; but we are looking at numbers between 20 and 40 percent mispayment or overpayment. We are not talking about 1 or 2 percent. That is what is really shocking.

Mr. KANJORSKI. Then you have to look at what the overpayment is about.

For instance, in a district like mine, we have people that are diabetic and both the husband and wife are in their 80's and there is need for insulin and blood testing, and they may live 30–40 miles away from a hospital or laboratory where they can get the test done. And it is determined now that blood testing on its own is not, for diabetes, a sufficient cost for the home health care provider to come in, and so they are literally cutting it off.

You have an elderly couple that doesn't belong in a hospital or nursing home situation but without proper laboratory tests to determine their blood level and diabetic conditions. It is just a matter of time with that disease that you are now going to have kidney failure or malfunction, blindness or heart disease, some radical, very expensive cost analysis.

Now, you know, there is a certain sensitivity that arises with home health providers, and some have picked up those costs on their own. Even though they are not getting compensated to provide those services, they just see the necessity for it.

But, ultimately, that is what was happening over the last 4 or 5 years. Rather than that senior citizen staying in the hospital or being admitted to a nursing home to get laboratory care and medication provided to them, they are now removed to a home health setting atmosphere at maybe one-tenth the cost. So you are not seeing the savings on the side that they haven't assumed. You are seeing the cost of providing the service.

But, long term, we have a healthier, less costly population being treated. And if we just look at the numbers—now, I will agree there is abuse in the system. Don't get me wrong. But I think it is targeted to regions, and it is targeted to who is getting into the field to do it. Some people have seen opportunities for abuse.

Mr. SHAYS. Would the gentleman yield? I don't know how long it would take to discover it, but I think there are two issues that we probably would want to look at, and that is the efficiency of profit versus nonprofit and the abuse based on fraud and the abuse based on allocation of resources.

The other area that you bring up as well is, when we do call it overpayment? Is it overpayment that individuals would concur was not going to the agency but going to beneficiaries who really needed the service? That is still wrong because it is not according to the law, but it is a different kind of overpayment or mispayment. And I think it would be helpful to see if it hasn't been done, and if it hasn't we should ask the Inspector General to isolate the kinds of abuses that are taking place, because those are very valid points.

Mr. KANJORSKI. And the regions, Mr. Chairman.

Mr. SHAYS. And the regions. I think that they already have some of that, but in the case of their four hospitals, they took the four States, they took the four biggest States where the biggest increase is, Illinois, California, Texas and Florida.

Mr. KANJORSKI. And Pennsylvania is among those.

Mr. SHAYS. No.

Mr. KANJORSKI. Mr. Chairman, I want to point out that Mr. Richard's organization——

Mr. SHAYS. Sure, you have the floor.

Mr. KANJORSKI [continuing]. Has been identified as one of the most efficient, effective providers of health care. And it's interesting that——

Mr. SHAYS. It just so happens that it's in Pennsylvania.

Mr. KANJORSKI. It is and on the limits of my district, not quite in my district, but the fact that he has difficulty when his organization has been a model organization, for example, across the country of how to provide service that he can't get a bond. It's pretty clear that the average organization couldn't, could not hope to. And it

just seems to me that maybe we can find a middle ground to assist some of these associations.

Now, I happen to believe that—I know the chairman is not on the Banking Committee, but we had the same problem in manufacturers' housing about 10 years ago. And it was a question of how government was going to regulate it and see what we could do. And what we finally came up with is—I think the chairman, being on that side of the aisle, will appreciate my suggestion—is that regulatory control, is it should be first attempted to be imposed by the private sector.

And it seems to me that we ought to find some way to encourage the home health care people particularly to come up with this solution to how it works, so they have to put a great deal of input on the surety bonds.

I don't think we should say absolutely surety bonds are bad, they're terrible and they should be done away with, because they're a way of filtering out the bad actor.

But we had the home—the manufacturers' housing industry do their self-policing, their own standards, their own models, stamps of approval. And we've had an improvement—incalculable improvement over the last 10 years and a very low cost without a government agency getting involved and passing regulations. The industry did it itself.

Now, what we have to just find for this industry, it just seems to me, is a way of getting the secondary market or secondary insurer involved. So there's not a great deal of difficulty, and they probably could self-fund. If they did self-fund, they would also self-police.

And you would have—Mr. Richard may have preferred they knew there was a bad actor out there and they're yapping among themselves, there's a bad actor, maybe even talking to the agency. But if there was a risk involved to the insurance fund for all, there would be more of a likelihood of a direct report and charges made within the private sector.

Mr. TOWNS. Mr. Chairman, I yield to my colleague and friend, but I also think there's another piece to the fact that I think HCFA has to assume some responsibility, which means that it might be—have a cost effect in the beginning and the front end. Because what I see now is going to happen if we don't watch, that the IG is going to end up with all the money; and I think we have to careful about that. I think HCFA has to assume some of the responsibility up front in terms of screening and certifying and to do the kinds of things that need to be done to—that's one way to get a lot of folks out.

You know, I think the bond is one thing, but I think that you can't eliminate HCFA's responsibility as well; and I think that that's very, very important.

Mr. KANJORSKI. Well, and I agree with you. And I'm suggesting, you know, if you want HCFA to be the health police agency, it's going to be very expensive, very difficult and probably these providers would prefer not to have that, because it's going to be more costly.

What I'm suggesting is we try and use the private sector, profit and nonprofit, to try and bring up the standards, bring up the in-

spections, have the bells and whistles go off when there's something wrong.

Let me give you an example of something, Mr. Towns, that I ran across in my district. I was struck why we couldn't use Pap smear tests. We had no laboratory that was providing it. And I went to the Medical Association and discovered that the cost in my district for a Pap smear was somewhere between $12 and $15 at various hospitals, some of which were some of the foremost hospitals in the country. But all the providers found a Texas laboratory that did it for $5. And they just literally ate up Pennsylvania Pap smears. Everything went to Texas.

Now, just a year ago, we discovered that the reason they were so successful in doing this is they didn't do the Pap smears. They merely pushed a button on the computer and sent a letter back, negative finding, and $5 that's not very expensive. So they were able to undercut the market.

But what it proved is we didn't have adequate inspection out there, either on the Federal or the various State or interState levels, to pick up on that type of product. We did away and destroyed the laboratories. Our laboratories closed down that could have done this, in the confines of Pennsylvania, because they couldn't compete. But nobody went to the next step to ask the question, how in the hell are they competing for $5 when somebody else is charging 100, 150, 200 percent more? That's a highly unusual thing.

That is happening in the health care field. And just because we pass some rule or regulation, including a bond, if somebody can come in the home health care field and put a $1 million bond overnight and do all kinds of things, that doesn't guarantee you're going to have a good operator. You may just have a very sophisticated operator that has figured out how he's going to really bang the system and bang it hard and get out.

We haven't improved anything. We just created one way to take out real, honest-to-God, merciful givers of health care and we've encouraged sometimes involved felonious thinking organizations that are going to be into the field.

Mr. SHAYS. I'm almost attempted to allow the witnesses to ask us some questions since we've been having a little dialog now.

Let me ask—first, I'm going to have our staff take all of your recommendations and put them in a grid form and just see where you have parallel recommendations, and then we will see where you don't agree. And we may be back to you to have you expand or elaborate on those recommendations, because I think we will attempt to incorporate some of your recommendations, if not in a formal report, in a letter that Mr. Towns and I and the other committees members might send to HCFA as a possibility. Because we want to weigh in quickly. And I don't know if we want to have this delayed too long.

Is there any last comment that any of you want to make? A brief comment? I welcome each of you just to get it into—just as long as you didn't get Mr. Kanjorski back into this dialog. Don't look at him when you talk. You just make your comment.

Mr. KONIERS. A former Pennsylvanian, we had a landmark case in Bridgeport, CT, about a year ago with a DME company that entered the marketplace billing Medicare and Medicaid and certainly

became a very fraudulent company. They weren't around that long. And we now know that the system works, because the perpetrators are now in jail.

I will tell you that, again based on my perspective, that if there was accreditation and licensure required by either the private sector or something having to do with a mechanism set in place with the State of Connecticut, this would have absolutely never happened.

Mr. SHAYS. Let me just say that any additional recommendations you all want to make you can send to our committee, fax it, e-mail it, whatever, in the next day or 2 or next 3 days. We will try to incorporate that into our——

Ms. Schubert, any comment you want to make?

Ms. SCHUBERT. Just very briefly. Most everyone else has talked about the 15 percent requirement. If I can just make a comment on the $50,000 minimum. I'm very concerned, our association is very concerned, about small businesses, and the disparate impact that the $50,000 has on very small HHAs. And so if you're going to look at the 15 percent, I would request that you also look at the $50,000 and how that impacts the very small HHAs and their ability to get a bond.

Mr. SHAYS. So some variation for a small agency.

Mr. Dombi.

Mr. DOMBI. In terms of the agency that came up for-profit, not-for-profit and issues of risks there, the more common factor that has been found is whether it's a new home or old home health agency. The tendency is that the new agencies are for-profit, but we find more that the new agency is the high-utilization agency, is the high-cost agency, and, more often than not, the new agency or the new owner of an agency is the agency that finds itself subject to oversight and prosecution in the end. So we would suggest focusing in on that rather than for-profit and not-for-profit.

Mr. SHAYS. Ms. Quinn.

Ms. QUINN. I would just like to say on the regulation issue, again try not to create, reinvent the wheel and look at what we have in place. I think there's a lot of systems in place that work in a lot of places.

I don't know any home health agency—a person in the home health industry that would go to Connecticut and try to open up a home health agency with the intent to be fraudulent, because the regulations there are just enormous. And it's got a reputation, as well as the other States in New England.

Mr. SHAYS. It varies from State to State, as you pointed out.

Ms. QUINN. Yes.

Mr. SHAYS. Mr. Richard.

Mr. RICHARD. The only comment I would make, I think it's very clear that the home health agencies have as much at stake in all of this discussion as anyone, and I would encourage HCFA to look at home health agencies as a part of this process and that somehow we need to get passed the adversarial relationship that is involved in this process, as well as some other issues, in order that we can work these things out. Because if we don't work them out, the truth of the matter is that when we get together again some time in the future, you're going to have half the agencies to represent.

Mr. SHAYS. Thank you. It's the first time that Mr. Towns didn't say, and when I'm chairman.

Mr. Schneider.

Mr. SCHNEIDER. OK, I would just like to touch on the one point where you mentioned that the industry had gone from $4 billion in 1990 to $18 billion, and even though you told me not to look at him, Mr. Kanjorski did bring up a lot of factors as to why that happened, and probably the majority of it is for very good reason——

Mr. SHAYS. I agree with that.

Mr. SCHNEIDER [continuing]. And saving a lot of dollars in the total health care system. And I wouldn't want that to be lost.

And also one of the comments that was made about the percent of overpayments and denials, I think that, again, those have to be looked at, net of the appeals, and what actually was the net amount of the overpayments.

Mr. SHAYS. I think your net point is well taken, because it could be just 5 percent rather than 100 percent of the billing.

I would just comment that with the Florida 18, what concerns me is that we don't wait 3 years and find we're wrestling with a $100 billion problem. That's my biggest concern.

Mr. SCHNEIDER. Correct.

Just one final issue with regard to the utilization rates. I did do an analysis, which I will be glad to fax to the staff, but based upon looking at experiences of various States, if you look at the increase in number of agencies per beneficiary, you'll see a definite increase in utilization.

And to pick up on what Mr. Dombi said, if you look at the percentage of proprietary agencies as a ratio of the total—and again it may just be the new agencies, because most of the new agencies are proprietary, not necessarily saying that proprieties are bad—if you do look at those two factors and those two comparisons, you'll see a definite increase in utilization and increase in per beneficiary costs as those two numbers increase.

[The information referred to follows:]

INTERIM PAYMENT SYSTEM (IPS) FOR MEDICARE HOME HEALTH SERVICES

EXECUTIVE SUMMARY

New Jersey's elderly and disabled are facing a crisis as a result of changes in the Medicare home health benefit imposed by the Balanced Budget Act of 1997. The new interim payment system (IPS) will reduce payments to all home health agencies in all states, far below the current levels. There are many states in which the cost to Medicare has clearly been inflated by the delivery of excessive and unnecessary services. The agencies in these states are in a position to absorb the new cuts in reimbursement, as there will certainly be room to reduce utilization. New Jersey, on the other hand, which has managed its services in an efficient, conservative and cost effective manner, with utilization rates significantly lower than the national average, cannot sustain any further cuts to an already lean home health provider system.

New Jersey's home health agencies will be forced to reduce services provided to the Medicare beneficiaries. The state's nonprofit agencies do not have large financial reserves or alternative means of support. They do not receive any state funding for charity care. They cannot absorb reductions in reimbursement without reducing the levels of service. All agencies in New Jersey will struggle to survive under the provisions of IPS; some will close their doors.

New Jersey has maintained certificate of need (CN) regulations for home health care, fostering the planned, orderly growth of Medicare-certified agencies. Utilizing the CN process, New Jersey has been able to avoid significant increases in the cost of care, the unwarranted duplication of services and the proliferation of unreliable providers with questionable standards of quality.

Based upon 1994 Medicare home health utilization data published by the U.S. Department of Health and Human Services, New Jersey ranks as the fourth lowest state at **39.7** visits per patient per year (see attached statisitical summary). The national average is **65.6** visits. The five highest ranking states are Louisiana (**125.8**), Tennessee (**116.4**), Mississippi (**113.5**), Alabama (**113.4**) and Oklahoma (**105.7**). Of the nine regions nationwide, the Middle Atlantic, which includes New Jersey, New York and Pennsylvania, has the lowest utilization rate at **43.0**. The two highest ranking regions are the East South Central (**105.7**) and the West South Central (**102.1**).

The new per beneficiary limits under IPS are based upon a blend of 75% agency-specific utilization and 25% regional average utilization. It is clear that certain states, those that have abused the Medicare home health benefit in the past, will weather the storm, probably without their residents even noticing that a change is taking place. However, because New Jersey's providers have been prudent and diligent in the provision of home health services, its residents will suffer. At a time when patients are being discharged from hospitals with higher levels of acuity than ever before, agencies are being required to reduce utilization. In New Jersey, the likely result of IPS will be an increased rate of hospital and nursing home admissions, which will be more costly to the taxpayer.

The new per beneficiary limits do not take into consideration the introduction of any new services for Medicare patients, such as medical supplies or rehabilitative therapies. Home health agencies that have introduced these services since 1993 must operate within the constraints of limits calculated excluding the costs of the new programs. Other detrimental provisions of the new law include a reduction of the cost per visit limits by approximately 15%, the requirement of a surety bond for 1998 with no provision for reimbursement of the associated costs, and the elimination of the periodic interim payment (PIP) system for Medicare home health services after October 1, 1999.

The major thrust behind IPS is the rapid growth in home health services and heightened sensitivity to fraud and abuse. The government must make cuts to Medicare, clamping down on fraud and abuse, tightening controls and avoiding payments for inappropriate services. However, a blanket approach to resolving the problems of over utilization is not appropriate. Consideration must be given to the value of agencies with a history of cost effective and quality care. New Jersey's system of home health services could serve as a model for reform.

INTERIM PAYMENT SYSTEM (IPS) FOR MEDICARE HOME HEALTH SERVICES

STATISTICAL SUMMARY - 1994

Rank	State / Region	1994 Visits/ Person	1994 Costs/ Person	9/94 Medicare Pop	1/95 All HHA	1/95 VNA	1/95 Off/ Comb	1/95 Fac-Based	1/95 Other	1/95 % Other	HHA/ Pop	8/97 All HHA	8/97 VNA	8/97 Off/ Comb	8/97 Fac-Based	8/97 Other	8/97 % Other
1	Maryland	37.1	$2,859	591	74	2	19	20	33	45%	13	80	5	22	13	40	50%
2	Minnesota	37.8	$2,518	623	239	2	86	85	66	28%	38	269	2	90	97	80	30%
3	Washington	38.4	$3,951	671	61	8	5	26	22	36%	9	69	7	2	33	27	39%
4	South Dakota	39.7	$2,402	116	37	1	1	26	9	24%	32	57	1		41	15	26%
	New Jersey	39.7	$2,702	1,158	53	22	8	18	5	9%	5	57	22	6	21	8	14%
	Oregon	39.7	$3,188	460	81	3	6	44	28	35%	18	90	6	4	50	30	33%
7	Nebraska	40.9	$2,566	247	66	4	2	45	15	23%	27	87	1	3	62	21	24%
8	Hawaii	41.0	$3,549	146	26		5	11	10	38%	18	28		7	11	10	36%
9	North Dakota	41.5	$2,380	102	33		4	23	6	18%	32	36		3	27	6	17%
10	Wisconsin	41.6	$2,586	753	172	14	45	45	68	40%	23	179	12	42	41	84	47%
11	District of Columbia	42.1	$3,462	79	19	1	1	3	14	74%	24	21	2	1	3	15	71%
12	Pennsylvania	43.0	$2,899	2,055	323	48		93	182	56%	16	382	42	2	99	239	63%
13	Delaware	43.4	$2,478	98	19	2		5	12	63%	19	21	2	2	4	13	62%
	Alaska	43.4	$4,336	317	21			10	11	52%	7	26		1	13	12	46%
15	New York	44.6	$3,334	2,618	213	28	55	92	38	18%	8	229	28	56	98	47	21%
16	Michigan	44.7	$3,285	1,329	178	15	31	33	99	56%	13	236	20	26	57	133	56%
17	California	46.1	$4,705	3,582	640	53	61	154	372	58%	18	860	64	70	179	547	64%
18	Iowa	46.4	$2,280	472	178	10	71	58	39	22%	38	213	10	68	73	62	29%
19	Virginia	49.0	$3,168	781	204	3	41	69	91	45%	26	234	4	32	76	122	52%
20	Missouri	49.5	$3,161	823	236	9	26	95	106	45%	29	275	8	33	97	137	50%
21	Ohio	50.7	$3,014	1,646	358	29	47	91	191	53%	22	468	36	59	114	259	55%
22	West Virginia	51.0	$2,819	325	67	2	22	21	22	33%	21	90	1	22	32	35	39%
23	Montana	51.6	$3,052	128	52		9	33	10	19%	41	61		12	41	8	13%
24	Illinois	51.9	$3,386	1,606	320	24	45	95	156	49%	20	384	16	34	116	218	57%
25	Idaho	54.2	$3,347	146	56	3	5	28	20	36%	38	77	3	12	35	27	35%
26	Kansas	55.8	$3,486	380	166	3	34	67	62	37%	44	228	3	29	90	106	46%
27	New Mexico	56.0	$3,355	205	80	15	5	17	43	54%	39	109	12	1	22	74	68%
28	Arizona	56.2	$3,932	577	97	2	34	21	40	41%	17	134	1	35	29	69	51%
29	New Hampshire	56.8	$2,823	152	39	28	2	5	4	10%	26	46	27	3	6	10	22%
30	North Carolina	57.3	$3,287	999	149	1	53	30	65	44%	15	160	2	47	50	61	38%
31	Colorado	59.8	$4,091	409	158	6	14	44	94	59%	39	200	6	12	48	134	67%
32	Rhode Island	60.7	$3,753	166	20	8	2	2	8	40%	12	28	10	2	4	12	43%
33	Vermont	61.4	$2,635	81	13	13				0%	16	13	13				0%
34	Maine	64.1	$3,365	199	29	11		2	16	55%	15	50	13	3	6	28	56%
35	Kentucky	64.8	$3,369	575	107	2	29	41	35	33%	19	109		24	46	39	36%
	NATIONAL AVERAGE																
36	South Carolina	66.8	$3,764	495	66	1	15	13	37	56%	13	82	2	16	30	34	41%

INTERIM PAYMENT SYSTEM (IPS) FOR MEDICARE HOME HEALTH SERVICES

STATISTICAL SUMMARY - 1994

Rank	State / Region	1994 Visits/ Person	1994 Costs/ Person	9/94 Medicare Pop	1/95 All HHA	1/95 VNA	1/95 Off/ Comb	1/95 Fac-Based	1/95 Other	1/95 % Other	HHA/ Pop	8/97 All HHA	8/97 VNA	8/97 Off/ Comb	8/97 Fac-Based	8/97 Other	8/97 % Other
37	Nevada	68.1	$4,466	182	42		22	9	11	26%	23	53		10	13	30	57%
38	Indiana	72.5	$4,000	813	214	19	9	65	121	57%	26	296	18	19	83	176	59%
39	Connecticut	72.9	$4,367	497	115	52	10	8	45	39%	23	113	46	7	7	53	47%
40	Florida	75.9	$4,595	2,554	313	17	34	102	160	51%	12	387	17	31	161	178	46%
41	Arkansas	76.0	$3,586	416	204	1	78	82	43	21%	49	206		77	83	46	22%
42	Wyoming	77.0	$4,309	57	55		26	22	7	13%	96	65		26	24	15	23%
43	Massachusetts	87.0	$4,328	923	172	79	10	16	67	39%	19	203	74	8	35	86	42%
44	Texas	97.4	$5,977	2,023	996	11	9	222	754	76%	49	1,850	12	17	265	1,556	84%
45	Utah	98.4	$5,481	182	66	1	20	32	13	20%	36	91	2	41	40	8	9%
46	Georgia	102.1	$5,215	811	82	6	4	21	51	62%	10	102	6	4	35	57	56%
47	Oklahoma	105.7	$6,035	479	243	2		90	151	62%	51	371	2		95	274	74%
48	Alabama	113.4	$5,107	630	173	2	73	68	30	17%	27	182	2	71	82	27	15%
49	Mississippi	113.5	$5,316	390	77	1	31	23	22	29%	20	70		19	29	22	31%
50	Tennessee	116.4	$6,508	753	238	2	43	59	134	56%	32	240	2	38	76	124	52%
51	Louisiana	125.8	$6,700	572	430	1	24	67	338	79%	75	521	3	37	74	407	78%
	National Average & Total	65.6	$3,987	36,392	8,070	567	1,176	2,351	3,976	49%	22	10,438	565	1,186	2,866	5,821	56%

STATE SUMMARIES

Rank	State	Weighted Average 1994 Visits/ Person	Weighted Average 1994 Costs/ Person	9/94 Medicare Pop	1/95 All HHA	1/95 VNA	1/95 Off/ Comb	1/95 Fac-Based	1/95 Other	1/95 % Other	HHA/ Pop	8/97 All HHA	8/97 VNA	8/97 Off/ Comb	8/97 Fac-Based	8/97 Other	8/97 % Other
1-10	First Ten	39.4	$2,902	4,867	842	56	181	343	262	31%	17	952	56	179	396	321	34%
11-20	Second Ten	45.4	$3,616	12,154	2,031	169	286	612	964	47%	17	2,497	180	291	699	1,327	53%
21-30	Third Ten	53.4	$3,275	6,164	1,384	107	256	408	613	44%	22	1,757	101	254	535	867	49%
31-40	Fourth Ten	71.0	$4,179	5,971	1,077	129	135	286	527	49%	18	1,331	125	124	398	684	51%
41-51	Last Eleven	102.3	$5,523	7,236	2,736	106	318	702	1,610	59%	38	3,901	103	338	838	2,622	67%
1-13	First Thirteen	40.5	$2,902	7,099	1,203	107	182	444	470	39%	17	1,376	102	184	502	588	43%
14-26	Second Thirteen	47.7	$3,603	14,153	2,689	179	447	846	1,217	45%	19	3,381	193	454	1,021	1,713	51%
27-39	Third Thirteen	63.5	$3,717	5,350	1,129	158	195	257	519	46%	21	1,393	150	179	344	720	52%
40-51	Last Twelve	95.4	$5,281	9,790	3,049	123	352	804	1,770	58%	31	4,288	120	369	999	2,800	65%
1-17	First Seventeen	43.0	$3,474	14,945	2,255	203	329	733	990	44%	15	2,727	214	337	849	1,327	49%
18-34	Second Seventeen	53.0	$3,246	9,095	2,222	167	410	678	967	44%	24	2,770	165	404	839	1,362	49%
35-51	Last Seventeen	90.0	$4,998	12,352	3,593	197	437	940	2,019	56%	29	4,941	186	445	1,178	3,132	63%

INTERIM PAYMENT SYSTEM (IPS) FOR MEDICARE HOME HEALTH SERVICES

STATISTICAL SUMMARY - 1994

Rank	State / Region	1994 Visits/ Person	1994 Costs/ Person	9/94 Medicare Pop	1/95 All HHA	1/95 VNA	1/95 Off/ Comb	1/95 Fac-Based	1/95 Other	1/95 % Other	HHA/ Pop	8/97 All HHA	8/97 VNA	8/97 Off/ Comb	8/97 Fac-Based	8/97 Other	8/97 % Other
1	Middle Atlantic Region (NJ, NY, PA)	43.0	$3,031	5,831	589	98	63	203	225	38%	10	668	92	64	218	294	44%
2	Pacific Region (AK, CA, HI, OR, WA)	44.5	$3,862	5,176	829	64	77	245	443	53%	16	1,073	77	84	286	626	58%
3	West North Central Region (IA, KS, MN, MO, NE, ND, SD)	46.9	$2,871	2,763	955	29	224	399	303	32%	35	1,165	25	226	487	427	37%
4	East North Central Region (IL, IN, MI, OH, WI)	51.5	$3,272	6,147	1,242	101	177	329	635	51%	20	1,563	102	180	411	870	56%
5	Mountain Region (AZ, CO, ID, MT, NV, NM, UT, WY)	63.7	$4,050	1,886	606	27	135	206	238	39%	32	790	24	149	252	365	46%
6	South Atlantic Region (DE, DC, FL, GA, MD, NC, SC, VA, WV)	69.1	$4,066	6,733	993	35	189	284	485	49%	15	1,177	41	177	404	555	47%
7	New England Region (CT, ME, MA, NH, RI, VT)	76.4	$4,023	2,018	388	191	24	33	140	36%	19	453	183	23	58	189	42%
8	West South Central Region (AR, LA, OK, TX)	102.1	$5,877	3,490	1,873	15	111	461	1,286	69%	54	2,948	17	131	517	2,283	77%
9	East South Central Region (AL, KY, MS, TN)	105.7	$5,329	2,348	595	7	176	191	221	37%	25	601	4	152	233	212	35%

REGION SUMMARIES

Rank	State	Weighted Average 1994 Visits/ Person	Weighted Average 1994 Costs/ Person	9/94 Medicare Pop	1/95 All HHA	1/95 VNA	1/95 Off/ Comb	1/95 Fac-Based	1/95 Other	1/95 % Other	HHA/ Pop	8/97 All HHA	8/97 VNA	8/97 Off/ Comb	8/97 Fac-Based	8/97 Other	8/97 % Other
1-3	First Three Regions	44.3	$3,311	13,770	2,373	191	364	847	971	41%	17	2,906	194	374	991	1,347	46%
4-6	Second Three Regions	61.1	$3,733	14,766	2,841	163	501	819	1,358	48%	19	3,530	167	506	1,067	1,790	51%
7-9	Last Three Regions	96.6	$5,237	7,856	2,856	213	311	685	1,647	58%	36	4,002	204	306	808	2,684	67%

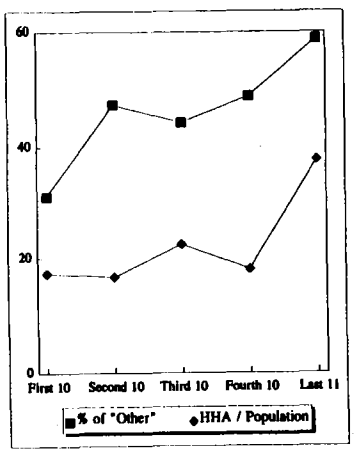
Notes: "All HHA" means all home health agencies.
"VNA" means visiting nurse associations.
"Off/Comb" means governmental or combined governmental / voluntary.
"Fac-Based" means facility-based agencies, including hospitals, rehab facilities and skilled nursing facilities.
"Other" means proprietary or private not-for-profit.
"% Other" represents the ratio of Other agencies to total agencies.
"HHA/Pop" shows the number of agencies per hundred thousand Medicare beneficiaries.
"Weighted Average" is weighted based upon the total Medicare population residing in each state.

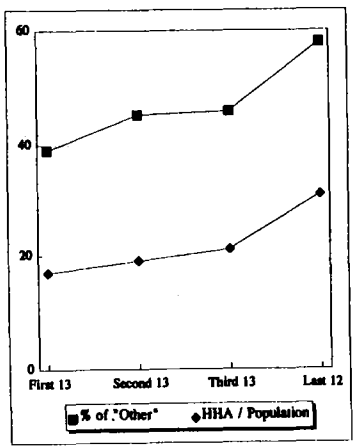
INTERIM PAYMENT SYSTEM (IPS) FOR MEDICARE HOME HEALTH SERVICES

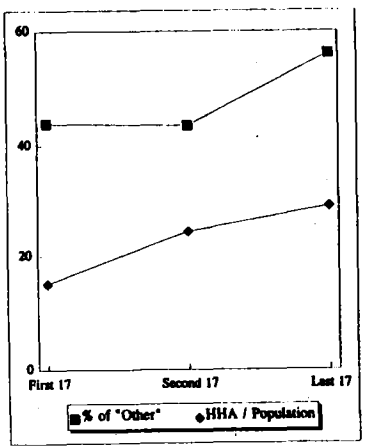
STATISTICAL SUMMARY - 1994

Rank	State / Region	1994 Visits/ Person	1994 Costs/ Person	9/94 Medicare Pop	1/95 All HHA	1/95 VNA	1/95 Off/ Comb	1/95 Fac-Based	1/95 Other	1/95 % Other	HHA/ Pop	8/97 All HHA	8/97 VNA	8/97 Off/ Comb	8/97 Fac-Based	8/97 Other	8/97 % Other
	National Average & Total	65.6	$3,987	145,568	32,280	2,268	4,704	9,404	15,904	49%	22	41,752	2,260	4,744	11,464	23,284	56%
	95 to 97 Change											2,368	(2)	10	515	1,845	78%
												29%	-0%	1%	22%	46%	

GRAPHS OF STATE SUMMARIES







Notes: Visit and cost data taken from a publication by the National Association for Home Care (NAHC) that quotes a source:
HCFA, Medicare and Medicaid Statistical Supplement 1996
Medicare Population data (in thousands) taken from NAHC Report # 638 that quotes a source:
U.S. Department of Commerce
Home Health Agency data taken from articles in "Home Health Line" that quote a source:
OSCAR reports, HCFA Office of Survey and Certification

Mr. SHAYS. You've got the last word.

Thank you very much. You all were very helpful, and we appreciate it. And we're going to try to weigh in I think before we write a formal report and see if we can write a letter based on the hearings and the testimony today. Thanks so much.

This hearing is closed.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

DAVID M. McINTOSH
2D DISTRICT, INDIANA

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SUBCOMMITTEE CHAIRMAN
NATIONAL ECONOMIC GROWTH, NATURAL RESOURCES AND REGULATORY AFFAIRS

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STATEMENT OF REP. DAVID McINTOSH

HUMAN RESOURCES SUBCOMMITTEE HEARING
ON HCFA SURETY BOND REQUIREMENT
JULY 22, 1998

Under the Balanced Budget Act of 1997, home health agencies are required to secure surety bonds of at least $50,000 to participate in Medicare and/or Medicaid. Unfortunately, HCFA went well beyond the will of Congress by issuing regulations that stated that the bond amount for home health agencies had to be the greater of $50,000 or 15% of the home care agency's previous year's Medicare revenues, with no ceiling.

This blatant disregard of Congress' instructions is simply not acceptable. It is an unconstitutional usurpation of Congress' legitimate authority. I demand that HCFA state unequivocally that it will reverse its earlier ruling and abide by the Congress' directions as it is required to do under the Constitution. If it doesn't, the future of quality, affordable home health care is in jeopardy for millions of elderly Americans.

HCFA's draconian regulations are sure to drive honest home-health providers out-of-business. This will unnecessarily expose millions of seniors to inadequate health care. In my state of Indiana, the effects of HCFA's assault on home health are already being felt. Many Hoosier agencies are going out of business and many more are on the brink. This must end and balance must be restored to this debate.

I must also mention that this is a small business issue as well. Most home health providers are family -run small businesses, which are the real engine of our economy. Small business is also under assault here. In fact, the Small Business Administration recently concluded that the HCFA's illegal regulations are sure to cost thousands of small businesses heavily and small home-health agencies are going to be run out of business in droves in the near future if HCFA is allowed to have its way.

Therefore, I unequivocally insist that HCFA rewrite the January 5 regulations to bring the bond program back to its original intent. The surety bond amount should be no greater than $50,000. Bonds should be imposed in the first year only for honest home-health providers. Moreover, surety companies should be required to include only reasonable personal guarantee requirement on good providers. Finally, HCFA should make the cost of the bonds a Medicare-covered expense.

THIS MAILING WAS PREPARED, PUBLISHED, AND MAILED AT TAXPAYER EXPENSE
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Medicare Home Health Agencies:
Still No Surety Against Fraud and Abuse

Statement of
the American Insurance Association
to the
Subcommittee on Human Resources
Of the House Committee on Government Reform and Oversight

July 22, 1998

The American Insurance Association ("AIA") is a non-profit national trade association representing over three hundred major insurance companies, most of which issue surety bonds, along with property and casualty insurance.

We would like to thank the House Committee on Government Reform and Oversight Subcommittee on Human Resources for addressing the important issue of the new surety bond requirement for certain Medicare and Medicaid providers mandated by the Balanced Budget Act of 1997 ("BBA") and the equally important issue of the efforts of the Health Care Financing Administration ("HCFA") to implement the surety bond mandate.

From the beginning, AIA has supported the efforts of Congress and HCFA to combat fraud, waste and abuse in the Medicare and Medicaid systems. In fact, staff from AIA met with the sponsors of the surety bond requirement in the BBA to assist them in this endeavor. We were pleased to see that Congress had once again recognized surety bonds as a valuable prequalification mechanism for entities being paid with tax dollars. AIA felt at the time and continues to believe that a surety bond is an excellent tool to assist in the fight against fraud in the Medicare and Medicaid systems.

Once the BBA surety bond mandate was enacted, staff members from AIA began extensive discussions with staff from HCFA to attempt to provide technical assistance to them as they wrote regulations to implement the directive of Congress. Our assistance was offered due to our expertise in the field of surety bonds. While AIA had had little previous experience with the Medicare or Medicaid programs, bonds for this type of an obligation were not unheard of. We believed at that time that we could assist HCFA as it drafted bond regulations that both furthered the intent of Congress and provided a viable market for the bonds.

Over the many months since those first discussions, the bond regulations have taken a number of turns. Since HCFA determined that the bond should

ensure repayment of overpayments, essentially a financial guarantee obligation, AIA worked with HCFA to attempt to draft regulations to make such a bond requirement as reasonable as possible. If HCFA ultimately determines that the bond should guaranty a different obligation, AIA would be happy to provide technical assistance to HCFA's staff as they draft regulations to implement that requirement.

It appears that the drafters of the bond requirement and regulations did not anticipate the effect of a financial guarantee-type surety bond on all businesses. Two things particularly have affected the availability of these bonds for small HHAs: the type of obligation, i.e., financial guarantee; and the requirement that the bond be in an amount of not less than $50,000 each for both Medicare obligations and Medicaid obligations. These two factors may have combined to make the implementation of the bond requirement problematic for some small businesses. However, that is very difficult to determine at this point.

When the BBA mandating this new surety bond requirement first was enacted, many surety companies geared up to enter this new market. When the January regulations were published, however, the regulations contained many problematic provisions which forced companies to reverse their decisions. Through significant discussions between the surety industry and HCFA, HCFA determined that certain technical corrections to the regulations would assist in making this bond more available, while still preserving the protections HCFA desired. A notice of intent to make those changes was published in March, and the actual changes were made in June. Between March and June many surety companies individually determined that, based on the regulatory changes anticipated in June, they would be able to be a viable market for these bonds. Companies established entire departments devoted to this new product and marketed it aggressively. As the date by which bonds were required to be filed approached, more and more HHAs obtained bonds. It is AIA's understanding that by June 11, 1998, 41% of all HHAs required to obtain bonds had filed them with a fiscal intermediary. Prior to publication of the June regulations, 33% already had obtained bonds.

It is AIA's belief that, if the date to provide bonds had not been suspended indefinitely, a significant percentage of the HHAs required to obtain bonds would have filed them by the July 31st deadline. Surety companies were writing these bonds as defined by the June regulations, and many companies were willing to continue writing these bonds, for both large and small HHAs. However, these bonds would be underwritten as a financial guarantee ensuring the repayment of overpayments.

It is our understanding that many HHAs are uncomfortable with signing the personal indemnity agreement often required to obtain an overpayment bond. This is not because they have doubt in their own honesty or intent to comply with the requirements of HCFA, but rather because they are concerned that, under

the interim payment system, overpayments are virtually ensured; and they may not know in time to be able to pay HCFA back. Since these HHA owners currently are not personally liable to HCFA for these overpayments, they do not want to take on that obligation to a surety company. However, due to the nature of suretyship, personal indemnity is a very common underwriting tool.

Under a surety bond, the principal, in this case the HHA, remains primarily liable for the obligation; while the surety is secondarily liable. Thus, if the surety pays the obligee (HCFA or the state Medicaid agency) its losses, it is entitled to recover those losses from the HHA, which is primarily liable. Since many of these HHAs provide only services reimbursed by Medicare or Medicaid, and the HHA is not entitled to make a profit on those services, the HHA itself does not have the capital to repay the surety. In cases like this in all areas of suretyship, for all types of surety bonds, a surety often will ask for the personal indemnity of the owner of the business or perhaps the posting of collateral.

It is imperative to understand that these two underwriting tools are part and parcel of the surety industry and often are the only tools that will allow certain bond applicants to obtain those bonds required to stay in business. Sureties often require and rely on personal indemnity in order to issue a bond. For certain bond applicants, collateralization is the only tool that permits a surety to issue the bond necessary for the applicant to stay in business. Elimination of these two underwriting tools would interfere with the traditional underwriting process and dramatically reduce the availability of bonds.

We have been told by representatives of HHAs that many HHA owners would not have the same reluctance to sign a personal indemnity agreement or post collateral if they were guaranteeing their own honesty and compliance with licensing requirements rather than the return of overpayments under the HCFA system.

This situation clearly needs to be addressed as expeditiously as possible. A different type of bond obligation, in other words, a bond that guaranteed against the dishonesty or fraud of the HHA, should allow HHAs a much better opportunity to provide the bond on terms with which they would be more comfortable.

The recent agreement between HCFA and the Senate Committee on Finance suspends indefinitely the July 31 compliance date by which HHAs must submit a surety bond. At the same time the Committee on Finance plans to request the General Accounting Office ("GAO") to conduct a study on surety bonds and HHAs. While we are heartened by the intent to include GAO in this issue, we do have some concern about bonds which already have been written for and purchased by providers. Although the existing rules allow surety bonds to be canceled, it is unclear what liability the surety will have on canceled bonds for the time during which they were in affect. Only if the obligee on the bond,

HCFA or the state Medicaid agency, provides a full release of the bond can the surety be sure that no claim might be made on that bond. If the bond were released, then any question of a prorated return of premium or release of collateral would be governed by applicable state law. This issue must be addressed as soon as possible.

It is our understanding that the discussions in Congress surrounding the proposal of the surety bond requirement in the BBA centered on an existing similar requirement by the State of Florida Agency for Health Care Administration ("Florida Agency"). As implemented, that requirement assisted Florida in weeding out many fraudulent providers. It is important to note that the implementation of that requirement in the field was not identical to the written requirement. As successfully implemented, the requirement was as follows:

1. The bond required was essentially a faithful performance bond. As implemented, the Florida Agency never used this bond to guaranty repayment of overpayments. Rather, it was used to guaranty against fraud or dishonesty of the provider.

2. The bond was required for all providers.

3. The bond was required to be continuous and was required until the Medicaid provider agreement expired.

4. The bond amount was $50,000, and it clarified that the aggregate liability of the surety was $50,000.

A similar requirement could be created for the federal bond mandate. AIA would be very pleased to work with Congress and HCFA in drafting a surety bond requirement that would fulfill the intent of Congress for surety bonds to fight against fraud and dishonesty in the Medicare and Medicaid programs.

Again, we applaud you for your efforts in examining the effort to implement the surety bond mandate of the BBA, and AIA stands ready to assist Congress and HCFA in this endeavor. We would be very pleased to further discuss these issues with you.

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July 21, 1998

The Honorable Christopher Shays
Chairman
Subcommittee on Human Resources
Committee on Government Reform and Oversight
U. S. House of Representatives
B-372 Rayburn House Office Building
Washington, DC 20515

RE: Medicare Home Health Agencies:
Still No Surety Against Fraud and Abuse
Statement of the National Association of Surety Bond Producers

Dear Chairman Shays,

The National Association of Surety Bond Producers (NASBP) is a trade association of independent agencies and brokerages which specialize in surety bonding and insurance for business and industry. NASBP's 500 member firms – most of which are small, closely held businesses – serve as agents or brokers for virtually all of the companies currently writing surety bonds in the United States. We submit this letter as our statement for the record of the Subcommittee's hearing on July 22, 1998.

Regarding the surety bond requirement for home health agencies participating in the Medicare and Medicaid programs, NASBP fully concurs with the statement submitted to your Subcommittee by The Surety Association of America (SAA). SAA members are by and large the surety companies represented by NASBP member firms.

NASBP representatives met with HCFA officials in October, 1997, to assist them in understanding how surety bonds could work to rid the Medicare system of fraud and abuse. For the most part, HCFA officials chose not to heed the surety industry's advice and recommendations and instead promulgated in January, 1998, a very onerous financial guarantee bond that was to cover overpayments routinely a part of HCFA's reimbursement system. As SAA explained in their statement, this initial rule contained several provisions that made underwriting of this bond very difficult.

The "technical corrections" that HCFA made in their June 1, 1998, revisions of the bonding rule did allow a viable market to develop for these bonds. However, the requirement still was for a financial guarantee-type bond for which it would be difficult for some smaller, undercapitalized home health agencies to qualify.

NASBP

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NASBP believes that Congress's intent in passing the surety bond provisions of the Balanced Budget Act of 1997 was to use the surety bonding process – particularly sureties' prequalification of Medicare/Medicaid providers – as a tool to uncover and eliminate fraud and abuse. We think that surety bonds can be provided that will address this goal. It would be a surety bond that guaranteed against dishonesty and fraud of the HHA. This kind of an anti-fraud bond will be one for which reputable HHAs will more easily qualify on terms with which they will be more comfortable.

We further concur with SAA's suggestion that HHA's be required to provide only one surety bond to cover their participation in both the Medicare and Medicaid programs.

NASBP applauds the Subcommittee for addressing this important issue and we stand ready to work with the Subcommittee as well as with the General Accounting Office and HCFA to develop a revised rule for surety bonding that will accomplish Congress's intent without placing undue hardship on the nation's smaller home health agencies.

Sincerely,

J. Martin Huber
Executive Vice President

cc: Lynn M. Schubert, President
The Surety Association of America

FOR THE RECORD

Statement
of the
American Hospital Association
for the
Subcommittee on Human Resoureces
of the
Government Reform and Oversight Committee
U.S. House of Representatives
on Medicare Home Health Agencies

July 22, 1998

The American Hospital Association (AHA) represents 5,000 hospitals, health systems and networks, about half of which operate home health agencies (HHAs). On behalf of these home health agencies, the AHA was very pleased that HCFA agreed to suspend the surety bond requirements in response to a variety of concerns expressed by providers, insurers, and Congress.

The AHA strongly supports the federal commitment to curb fraud and abuse in the delivery of home health services, but we believe HCFA exceeded congressional intent in a number of areas in promulgating its surety bond rules. We submitted formal comments to HCFA on these rules and the following is a synopsis of the AHA's positions.

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The across-the-board requirement for surety bonds for all but government-operated agencies ignores the successful track records of a large majority of agencies in good standing with the Medicare program. The AHA believes that HCFA has the authority to develop waiver standards; in fact, the rule published in January 1998 solicited comments on appropriate criteria for waivers. **The AHA recommends that any agency in good standing that has demonstrated ongoing compliance with Medicare program requirements should be eligible for a waiver.** Alternatively, the AHA believes that it is reasonable to include a provision that would allow hospital-based agencies to be exempt from holding a separate bond if the hospital already holds other bonds that meet the requirements of the rule.

Section 4312 of the Balanced Budget Act of 1997 (BBA) included a requirement that home health agencies, among other providers, purchase a $50,000 surety bond on an annual basis. HCFA's rule, however, sets the amount at $50,000 or 15 percent of the HHA's Medicare and Medicaid revenues, whichever is greater. **The AHA recommends that HCFA reduce the bond requirement to the $50,000 amount legislated by Congress and recommends that home health agencies providing services under both Medicare and Medicaid be required to obtain only one bond in the amount of $50,000.**

The AHA also has concerns about the potential for HCFA to use surety bond instruments as a means to recoup program monies without first pursuing appropriate administrative recoupment processes. **The AHA recommends that objective and reasonable standards for repayment arrangements be established and that agencies be given the opportunity to make restitution for any overpayments before the surety company is required to pay. All administrative appeals should be exhausted, including judicial review, before any penalties or assessments are levied.**

The AHA agrees with the Small Business Administration's counsel that HCFA under-estimated the financial effects of the surety bond rule on smaller HHAs, many of which are operated by AHA members in rural areas and often represent the only source of home health services in a large geographic area.

While we were encouraged that some of the original requirements were modified in the June 1, 1998 reissuance of the surety bond rule, HCFA's changes **addressed the concerns of the bond market but not the providers.** The AHA again urged HCFA to carefully consider requiring a single bond of $50,000 for both Medicare and Medicaid program participation, granting exceptions to HHAs that have exemplary records with the programs, and exploring use of other financial guarantee instruments in lieu of surety bonds, as HCFA indicated it would do.

Finally, while the AHA is pleased to see the reports that HCFA is again withdrawing the surety bond rule, HCFA has not yet published an official *Federal Register* notice confirming the agency's intent and clarifying surety and provider responsibilities and recourse from these financial obligations.

A *Federal Register* notice is necessary to clarify surety liability. Bond sellers must be released from further liability in order to cancel existing bonds. And, providers must have recourse to get refunds on the purchase of bonds. Since the rule was first published in January 1998, many HHAs, acting in good faith, have incurred considerable expense in securing bonds, including pledging personal collateral, only to find out that they have made an unnecessary and costly expenditure, and now at best, may be able to recoup prorated premiums for the remainder of calendar year 1998. While we recognize that the BBA mandated the surety bond requirement on home health agencies, HCFA's exceeding the statutory authority has diverted operating funds from patient care services to respond to costly, but ever-changing government directives.

The AHA urges Congress to direct HCFA to issue an official notice in the *Federal Register* that will allow providers to recoup monies spent for bonds no longer required during 1998.

Statement
of the
American Orthotic and Prosthetic Association
Submitted to
The House Committee on Government Reform and Oversight
for the July 22, 1998
Human Resources Subcommittee
Oversight Hearing
on
Medicare Home Health Programs

The American Orthotic and Prosthetic Association (AOPA) is pleased to submit this statement on the issue of surety bond requirements for the record of the July 22, 1998 Oversight Hearing on Medicare Home Health Programs.

The American Orthotic and Prosthetic Association represents nearly 1,900 orthotic and prosthetic patient care facilities, manufacturers, and suppliers. O&P suppliers do not simply "supply" products, they deliver a complex set of health care services that include patient assessment, custom fabrication and fitting of artificial limbs and orthopedic braces for specific patient needs. They also provide significant training evaluation, and follow-up care as a part of the rehabilitation process.

Section 4312(a) of the Balanced Budget Act of 1997 (BBA '97), Pub. L. 105-33, which was enacted on August 5, 1997, amended section 1834(a) of the Social Security Act by adding a new paragraph (16). That new paragraph requires the Secretary, as a condition of providing for the issuance or renewal of a provider number for a **DME supplier** for purposes of payment under the Medicare statute, to provide the Secretary, on a continuing basis, with a surety bond. Section 1834(a)(16), as amended by section 4312 (c) of the BBA '97, further provides that the Secretary may, at the Secretary's discretion, impose a surety bond on some or all providers or suppliers who furnish items or services under Medicare Part B other than physicians or other providers.

In its proposed rule for additional supplier standards, HCFA, recognizing the unique custom nature of orthotics and prosthetics, requested specific comment on the advisability of exercising its authority to impose a surety bond on all suppliers of orthotics and prosthetics to the same extent as required for DME suppliers.

AOPA's comments on the proposed rule reflected its belief that HCFA certainly has a legitimate concern regarding the existence of false providers and the problems associated with recoupment of monies incorrectly paid to such entities. Surety bonds are one way to deal with this situation and would probably by effective in most cases.

Recent recommendations by the HHS OIG regarding the desirability of stricter standards on who can bill for orthotics serves to emphasize that a problem exists that must be dealt with. AOPA feels that it is highly desirable to put some restrictions on the types of providers who can bill for custom orthotic and prosthetic care, thus greatly lessening the probability for erroneous billings.

It is also clear from recent activity by the OIG in Florida, as a part of Operation Restore Trust, that there is a problem with suppliers obtaining Medicare provider numbers when they are not legitimate businesses. The operation of such entities not only endangers patient safety and provides poor patient care, but also besmirches the name of the many legitimate providers who do their best to operate in a legitimate manner.

AOPA strongly recommends that the provision of custom O&P devices be limited to facilities that are accredited by, or practitioners certified by, the American Board for Certification in Orthotics and Prosthetics (ABC). One of the benefits of this approach is that HCFA would be assured that custom services would be provided either by, or under the supervision of, practitioners certified by ABC.

AOPA has offered this alternative to surety bonds for the O&P field because the facility accreditation program of ABC ensures that facilities really do exist, through on-site inspections and an extensive documentation requirement. For this reason, we feel it would be very appropriate for HCFA to not only allow such accreditation to equal meeting the supplier standards, but also to take the place of a surety bond. If however, a facility were not accredited by ABC, it could still qualify for a provider number by satisfying all of the standards and obtaining an appropriate bond.

Accepting ABC accreditation would therefore meet HCFA's needs regarding verifying that a business exists and meets patient care and documentation standards (in some cases more rigorous that the proposed standards), while at the same time relieving HCFA or the DMERCs of having to perform on-site audits and still allow non-accredited facilities a way to qualify. Thus HCFA and/or the DMERC could be spend more time on other program integrity issues.

Conclusion

For all of the above reasons, we feel it would be in the best interest of patients, the Medicare program, and O&P facilities, to:

- **allow accreditation by the ABC to serve as the equivalent of meeting the Medicare provider standards, and**
- **limit the provision of custom orthotic and prosthetic care to ABC accredited facilities**

AOPA welcomes the opportunity to work with the Committee and HCFA to eliminate waste, fraud and abuse in the health system and to ensure that Medicare is paying the correct price for care provided to its beneficiaries.

Thank you.

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