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MEDICARE HOME HEALTH SERVICES: NO SURETY IN THE FIGHT AGAINST FRAUD AND WASTE

EIGHTH REPORT

BY THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

OCTOBER 15, 1998.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
Washington, DC, October 15, 1998.

Hon. NEWT GINGRICH,
Speaker of the House of Representatives,
Washington, DC.

DEAR MR. SPEAKER: By direction of the Committee on Government Reform and Oversight, I submit herewith the committee's eighth report to the 105th Congress. The committee's report is based on a study conducted by its Subcommittee on Human Resources.

DAN BURTON,
Chairman.

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105TH CONGRESS, 2d Session } HOUSE OF REPRESENTATIVES { REPORT 105–821

MEDICARE HOME HEALTH SERVICES: NO SURETY IN THE FIGHT AGAINST FRAUD AND WASTE

OCTOBER 15, 1998.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. BURTON, from the Committee on Government Reform and Oversight, submitted the following

EIGHTH REPORT

On October 8, 1998, the Committee on Government Reform and Oversight approved and adopted a report entitled, "Medicare Home Health Services: No Surety in the Fight Against Fraud and Waste." The chairman was directed to transmit a copy to the Speaker of the House.

I. SUMMARY

A serious problem of waste, fraud, and abuse has been documented in the home health program. The General Accounting Office [GAO] "and others have reported on several occasions about the problems with Medicare's review of home health benefits."[1] Fraud in Medicare home health also threatens the quality of care as unqualified providers victimize beneficiaries and displace legitimate home health agencies.

Recent efforts by the Department of Health and Human Services' [HHS] Health Care Financing Administration [HCFA] to address the problem through administrative action and implementation of legislative requirements have been largely unsuccessful. While the overall Federal expenditures for home health care have diminished since late 1997,[2] there is little evidence vulnerabilities to waste, fraud, and abuse have been curtailed.

[1] "Medicare, Need to Hold Home Health Agencies More Accountable for Inappropriate Billings," (GAO/HEHS–97–108), U.S. General Accounting Office, June 1997, p. 2.

[2] *Medicare Home Health Agencies: Still No Surety Against Fraud and Abuse,* 105th Cong., 2d sess., July 22, 1998, Human Resources Subcommittee hearing, (prepared written statement of

Continued

There is also little consensus on the best approach to combat fraud in Medicare home health services. While it is generally agreed unscrupulous providers enter the Medicare program too easily, proposals to limit provider eligibility and strengthen program safeguards vary widely.

Congress included several home health reform measures in the Balanced Budget Act of 1997 [BBA]. Among those provisions were directives to require surety bonds from all home health providers and implementation of an interim payment system [IPS] as a precursor to a prospective payment schedule. The administration also took action September 15, 1997, announcing the implementation of a moratorium on new home health provider applicants, arguing this "time out" would allow the agency to put additional program safeguards in place, including capitalization and experience requirements for new applicants.[3]

However, under tight congressional implementation deadlines, and under pressure from the industry to lift the moratorium, HCFA's proposed final surety bond rule was rushed and poorly crafted, creating immediate controversy and requiring a March 15, 1998, announcement of forthcoming technical corrections. Those were published June 1, 1998.

The home health industry immediately took exception with HCFA's interpretation of the surety requirement, claiming it overstepped the congressional mandate by seeking to have bond liability cover all overpayments, not just those resulting from fraud and abuse. The industry also claimed HCFA failed to allow required public comment resulting in a twice-revised rule still so technically flawed that agencies would not be able to secure bonds due to cost, unrealistic underwriting standards, and owners' unwillingness to provide collateral or personal indemnification.

Adding to the home health industry's concern was the fact that the surety requirement, coupled with the IPS, created cash flow problems and other financial conditions that weakened many home health agencies. HCFA failed to anticipate the colliding consequences of simultaneous implementation of surety bonds and IPS, which resulted in increased industry opposition to both changes.

This ill-fated foray into the highly complex arena of insurance underwriting ended when HCFA delayed its surety bond rule until at least February 15, 1999, under a June 26 agreement with Senators Bond (R–MO), Baucus (D–MT) and Grassley (R–IA). Under the agreement, the Senate Finance Committee will obtain a General Accounting Office report on the surety bond rules, HCFA will consult with the industry and Congress before revising or moving forward with the rule. HCFA will give at least 60 days notice before the rule takes effect. At the time of postponement, 4,000 home health agencies had purchased surety bonds. Although the bonds are no longer needed, the cost of the bonds is not reimbursable

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Penny Thompson, Director of Program Integrity, Health Care Financing Administration, p. 2) [At this writing the subcommittee's hearing had not yet been printed. Page numbers in this and subsequent references to statements for this hearing refers only to the individual prepared written statements held in subcommittee files.]

[3] U.S. Department of Health and Human Services, press release, *HHS Halts Certification of Home Health Agencies: New Regulations Will Fight Fraud and Abuse,* Sept. 15, 1997.

under HCFA regulations. Therefore, it appears those who complied with the regulation are likely to be adversely affected.

After a year of failed efforts, HCFA's fight against waste, fraud, and abuse in the home health industry remains stalled. Reform options available to HCFA a year ago remain, for the most part, unexplored, including: strengthening conditions of participation, mandating agency accreditation standards, requiring provider education certification, and requiring compliance plans and background checks on home health agency [HHA] personnel.

Findings in brief:

1. Progress in combating waste, fraud, and abuse in home health during the past year has been minimal.
2. HCFA failed to follow regular administrative rulemaking procedures in crafting the surety bond requirement.
3. As the result of limited enrollment standards, HCFA was not able to ensure the financial responsibility of Medicare home health providers.

Recommendations in brief:

1. HCFA should better use existing authority and resources to augment efforts to address waste, fraud, and abuse in the Medicare home health benefit program.
2. HCFA should follow the Administrative Procedures Act, permitting thorough and formal industry comments, as well as ensuring collaboration with experts and congressional committees in drafting regulations implementing novel and complex program requirements.
3. HCFA should pursue the use of existing statutory and regulatory authority to better assure the financial responsibility of home health agencies.

II. Background

Medicare's home health benefit is crucial to millions of beneficiaries, allowing them to receive skilled treatment of a specific illness or injury in their homes.[4] The care must be provided by certified home health agencies which may be freestanding or affiliated with another facility, such as a hospital. Part A, the hospital insurance program, covers inpatient hospital services, post-hospital care in skilled nursing homes, and care in patients' homes. Part B, the supplementary medical insurance program, covers primarily physician services but also a number of other services, including home health care for beneficiaries not covered under Part A. Most of Medicare's payments for home health care are made under Part A.

The Medicare law requires that home health agencies be certified to serve Medicare beneficiaries.[5] Agencies obtain certification by meeting specific mandated requirements, known as conditions of participation [COPs]. These requirements cover an agency's qualifications and capacity to perform administrative functions such as appropriate recordkeeping, medical records confidentiality, as well as the delivery of skilled nursing services. In addition, starting

[4] 42 U.S.C. Sec. 1395(x) (Social Security Act of 1965 as amended).
[5] Ibid.

January 1, 1998, prospective home health agencies must meet minimum capitalization requirements to ensure they have sufficient funds on hand to operate responsibly. Also, agencies must have treated at least 10 patients before they are allowed to enter the Medicare program as a care giver.[6]

In administering the program, the Health Care Financing Administration typically contracts with State public health agencies to conduct certification and recertification surveys of home health agencies. If HHAs are found to be out of compliance with Medicare COPs, they are provided an opportunity to develop a corrective action plan to avert termination from the program. If the State agency and HCFA approve the plan, the home health agency can continue to participate in Medicare as long as the corrective plan is followed.

To qualify for home health care, beneficiaries must be homebound, be under the care of a physician and need part-time or intermittent skilled nursing care, physical therapy, speech language pathology services, or have a continuing need for occupational therapy.[7] The physician must certify that medical care in the home is necessary and develop a plan of care reflecting the patient's needs. If these requirements are met, Medicare will pay for skilled nursing care on a part-time or intermittent basis.

In 1989, as the result of a court case, revised HCFA guidelines broadened coverage policies for skilled nursing care which resulted in more visits per week and greater duration of eligibility.[8] There was an increase in nonmedical supportive and personal care assistance when needed by the chronically ill. In addition, as a result of legislative changes, copayments or deductibles for home health care are no longer required except for medical supplies and durable medical equipment.

Medicare's home health benefit has become the program's fastest growing benefit, generating a great deal of concern about the rising cost of the program. Spending increased from $2.6 billion in 1989 to $17.2 billion in 1997 and is expected to reach $21 billion by the year 2000, reflecting a rate of growth of 35 percent and accounting for nearly 9 percent of the total Medicare spending. By one estimate, spending for home health services could surpass $30 billion by 2002.[9]

During this same period the number of beneficiaries receiving home health care doubled from 2 million to 4 million, the average number of visits per beneficiary more than doubled, and the number of home health agencies has increased from approximately 5,800 in 1989 to 10,500 at the beginning of 1998.[10]

The growth in the Medicare home health benefits is due to several factors, including:

1) a court decision in late 1988 obligated HCFA to interpret more liberally Medicare's eligibility and coverage criteria, resulting in beneficiaries more easily obtaining home health cov-

[6] See *supra* note 2, p. 7.
[7] See *supra* note 4.
[8] *Duggan* v. *Bowen,* 691 F. Supp, 1487 (DDC 1988).
[9] *Jackpot! Gaming the Home Health Care System,* 105th Cong., 1st sess., p. 49 (1997) ("Special Committee on Aging hearing, No. 8") (statement of George Grob, Deputy Inspector General, U.S. Department of Health and Human Services).
[10] See *supra* note 2, p. 3.

erage, increasing the number of allowed visits per week and duration of eligibility, expanded eligibility to persons who have ongoing medical problems that require personal care assistance associated more with long-term care rather than acute care;[11]

2) claims processing policies resulting in high denial rates for home health care were relaxed by the 1989 HCFA guideline revisions;

3) the growing trend of discharging patients more quickly to their homes or providing care in other less expensive settings due to incentives contained within the Medicare hospital prospective payment system;

4) technological advances which have made it possible to provide an increased level of care in the home;

5) increased supply of services because of the expanding number of agencies participating in Medicare;

6) cost-based reimbursement that lacks the incentives to ensure care was provided efficiently, and encourages the maximization of the number of visits per beneficiary;

7) the general aging of a population which enjoys increased longevity; and,

8) for many, home is the preferred setting for care.[12]

THE EXTENT OF WASTE, FRAUD, AND ABUSE IN HOME HEALTH

In addition to changing demographics, medical advances, and liberalized benefits, recent studies by the HHS Inspector General and the General Accounting Office document that a significant amount of spending growth is due to waste, fraud, and abuse.[13] These studies point to the need to better manage the program, ensure claims review, and have better payment safeguards in place.

In two recent studies, the OIG concluded approximately 40 percent of the home health claims were likely inappropriate due to provision of unnecessary services, patients not truly homebound, inadequate physician authorization, or inadequate supporting documentation.[14] In addition, as many as 25 percent of the agencies in certain States were likely problem providers. These reports were conducted after a state-wide audit in Florida in 1995 indicated a 20 percent error rate for payments that did not meet Medicare guidelines. Expanding their anti-fraud activities, HHS initiated Operation Restore Trust in late 1995, continuing on with the work they started in their review of Florida home health. The focus of ORT was to reduce waste, fraud, and abuse in home health, nursing home services and durable medical equipment in five States—California, New York, Florida, Texas, and Illinois.[15] These States

[11] See *supra* note 1, p. 3.

[12] Statement for the record of National Association for Home Care, Special Committee on Aging hearing, No. 8, July 28, 1997, pp. 203–04.

[13] *Medicare Home Health,* 105th Cong., 1st sess., p. 8 (1997) ("Oversight and Investigations Subcommittee hearing, No. 64") (statement of June Gibbs Brown, Inspector General of U.S. Department of Health and Human Services).

[14] *Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas,* Office of Inspector General, U.S. Department of Health and Human Services, July 1997, p. 13.

[15] Statement of George Grob, Deputy Inspector General, U.S. Department of Health and Human Services, Human Resources Subcommittee hearing, July 22, 1998, pp. 1–2 (in subcommittee files). Note: These States were selected due to growth in the volume and value of home health claims and the suspicion the growth was in some measure attributable to fraud

Continued

"account for close to 35 percent of the Nation's Medicare beneficiaries and program expenditures." [16]

Responding to the OIG's reported 1997 finding that 40 percent of the home health claims may be a result of waste, fraud, and abuse, the witness representing the home health industry in the subcommittee's July 22, 1998, hearing stated, "We heard [the OIG] 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." [17]

In earlier work, the OIG recommended HCFA develop and implement additional program safeguards that would strengthen their ability to identify problem providers and prevent potential problem providers from entering the program. They recommended a moratorium on new entrants to stem further losses to the Medicare trust fund.[18] HCFA did not concur with the moratorium proposal in the 1997 draft report, pointing to pending legislative proposals to strengthen the home health program. The OIG withdrew the recommendation. The OIG did recommend HCFA take administrative action, or seek legislative authority, to:

1) require surety bonds of new and existing home health agencies;

2) require user fees to cover the cost of certifications, comprehensive reviews and recertification;

3) require HHA principals to have prior health care service experience;

4) develop a data bank of owners, principals, and related organizations;

5) require that agency principals and owners provide their Social Security and Employer Identification numbers prior to certification;

6) require that home health agencies demonstrate fiscal soundness prior to certification;

7) deny certification to owners and principals of current or defunct agencies who are not financially responsible and trustworthy; and,

8) preclude the discharge of Medicare debts through bankruptcy.

At a hearing entitled "Jackpot: Gaming the Home Health Care System," HHS's Deputy Inspector General said:

> I am here to talk about Medicare's home health benefit. This is an extremely valuable program, one that provides much needed medical care for elderly and disabled individuals in the place that most of them want to be—in their homes. Sadly, I must tell you—in fact I must emphasize—that this program is out of control. . . . The problems of

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or abuse. However not all questionable claims are fraudulent. In order to assure correct payment and appropriate patient records, Medicare does require correct documentation in the delivery of Medicare services. It is the documentation that justifies the payment. If documentation is incomplete, either due to oversight or an effort to submit fraudulent claims, Medicare, through its contractors can withhold payment until all supporting information is provided.

[16] Ibid., p. 3.

[17] Testimony of William A. Dombi, VP for Law, National Association for Home Care, (July 22, 1998), Human Resources Subcommittee hearing transcript, p. 75 (in subcommittee files).

[18] *Home Health: Problem Providers and Their Impact on Medicare,* Office of Inspector General, U.S. Department of Health and Human Services, July 1997, p. iii; see also HCFA response, p. 4.

> waste, fraud and abuse associated with the home health benefit are well known. We in the Office of Inspector General have reported on these problems frequently in the last several years through a large body of work including audits, investigations, inspections, and congressional testimony. We are not alone in this assessment. The General Accounting Office has also issued important reports on this subject.[19]

The Senate Aging Committee, in summarizing their July 28 hearing, reported, "Home health has become an 'economic jackpot' for unscrupulous providers gaming the system at the expense of both taxpayers and future Medicare beneficiaries. This hearing addressed the inadequate controls and rising costs characteristics of the home health care system."[20]

On October 29, 1997, appearing before the House Commerce Committee's Subcommittee on Oversight and Investigations, the HHS Inspector General testified that home health "is a $20 billion program that grew too fast with an inherently vulnerable payment structure and inadequate controls. The result has been annual losses to the Medicare program of billions in misspent dollars."[21]

Acknowledging that some of the growth in home health is appropriate and in response to demographics, new technology and liberalized benefits, the OIG statement continued:

> However, the basic design of the program and lack of effective program controls opened the way to waste, fraud and abuse. Reports issued by the Office of Inspector General (OIG) and others have repeatedly documented how fraud, waste, and abuse contribute significantly to the high growth of home health expenditures.[22]

Testifying before the House Government Reform and Oversight Committee's Subcommittee on Human Resources on July 22, 1998, the HHS Deputy Inspector General stated in written testimony:

> Over the last several years, we alerted the Congress and policy officials about our concerns. In fact, Inspector 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.[23]

In this same statement, the OIG's testimony called attention to the fact there continues to be a serious problem of home health providers leaving the program while still owing millions of dollars to Medicare:

> 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 Medi-

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[19] See *supra* note 9, p. 48.

[20] *Jackpot! Gaming the Home Health Care System, July 28, 1997,* Senate Special Committee on Aging's Web site. (http://www.senate.gov/~aging/hr6sum.htm).

[21] See *supra* note 13, p. 8.

[22] Ibid.

[23] See *supra* note 15, p. 1.

> care 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.[24]

HCFA provided similar data in testimony before the Subcommittee on Human Resources, acknowledging there are agencies that default on their obligations to the programs and fail to repay Medicare or Medicaid. HCFA's statistics indicate that from 1993 to 1996 home health agencies left the Medicare program owing more than $154 million to the program.[25] It should be noted that HCFA regulations allow the agency to refer these legal claims to the Department of Justice for collection. It is unclear whether HCFA availed itself of that remedy.

The OIG added:

> 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 loses due to the activities of exploitive [sic] home health agencies.[26]

In their many studies and reports on the home health program, the General Accounting Office reached many of the same conclusions. In a report to Congress in March 1996, GAO stated:

> Although we have been reporting on program weaknesses over the last 15 years, controls over the Medicare home health benefit remain essentially non-existent. Few home health claims are subject to medical review and most claims are paid without question. Further, because (1) few on-site coverage audits are done, (2) beneficiaries are rarely visited by intermediaries, and (3) physicians have limited involvement in home health care, verifying whether the beneficiaries receiving home care truly qualify for the

[24] Ibid., p. 4.
[25] See *supra* note 2, p. 4.
[26] See *supra* note 15, p. 6.

> benefit, need the care being delivered, or are even receiving the services billed to Medicare is nearly impossible.[27]

In a report the following year, GAO wrote that while utilization of home health care was expanding, there were insufficient program controls in place for HCFA to detect and prevent inappropriate payments. "We and others have reported on several occasions about the problems with Medicare's review of home health benefits. . . . Yet, in spite of the need for increased scrutiny indicated by these reports and by the growth in home health expenditures, Medicare's review of home health claims decreased in the 1990s."[28]

As funding for claims review was reduced, the number of home health agencies increased by more than a third, and the volume of home health claims being processed had more than tripled.[29]

In July 1997 testimony before the Senate Aging Committee, GAO responded to questions as to whether the rapid growth in home health agencies had been effectively managed and whether HCFA ensures home health agencies in the program comply with Medicare's conditions of participation. GAO stated:

> . . . we are finding that Medicare's survey and certification process imposes few requirements on HHAs seeking to serve Medicare patients and bill the Medicare program. The certification of an HHA as a Medicare provider is based on an initial survey that takes place so soon after the agency begins operation that there is little assurance that the HHA is providing or is capable of providing quality care. Moreover, once certified, HHAs are unlikely to be terminated from the program or otherwise penalized, even when they have been repeatedly cited for not meeting Medicare's conditions of participation and for providing substandard care.[30]

GAO's testimony went on to say, "The fact that the law allows this ease of entry into Medicare has probably contributed to the rapid growth in the number of Medicare-certified HHAs; it has also allowed some questionable agencies to participate in the program."[31]

Testifying before the House Commerce Committee's Subcommittee on Oversight and Investigations on October 17, 1997, GAO stated that in order to ensure maximum success of the BBA home health changes, HCFA:

> . . . has considerable discretion in implementing the law which in turn means the agency has much work to do within a limited time period. HCFA's action, both in designing a PPS and in implementing enhanced program controls to assure that unscrupulous providers cannot readily 'game' the system, will determine to a large extent how successful the legislation will be in curbing past abu-

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[27] "Medicare: Home Health Utilization Expands While Program Controls Deteriorate," (GAO/HEHS–96–16) U.S. General Accounting Office, March 1996, pp. 2–3.

[28] See *supra* note 1, p. 2.

[29] Ibid., p. 5.

[30] Statement of Leslie G. Aronovitz, Associate Director, Health Financing and Systems Issues, Health, Education, and Human Services Division, U.S. General Accounting Office, Select Committee on Aging hearing, No. 8, July 28, 1977, p. 134.

[31] Ibid., p. 138.

> sive billing practices and slowing the rapid growth in spending for this benefit.[32]

In December 3, 1997, correspondence to Members of Congress, GAO stated:

> Medicare's size, complexity, and rapid growth make it an attractive target for fraud and abuse. Efforts by the Health Care Financing Administration (HCFA), the agency responsible for administering the program, to improve program safeguards have not been adequate to prevent substantial losses, in part because the resources available to avoid inappropriate payments have shrunk relative to the program's size and in part because some tools have been underutilized or not deployed as effectively as possible.[33]

During the last 6 years, the funding level for HCFA's administrative activities has been reduced.[34] Because of budget constraints, rapid program growth and shifting priorities, the review of claims and related medical documentation and site audits of providers' records are inadequate to keep up with the dramatic increases in Medicare home health activity. As a result, providers have only a slim chance of having claims, year end cost reports, or the actual provision of services carefully scrutinized by Medicare.

Ten years ago HCFA audited over 60 percent of home health claims, but ironically as the program grew, the number of claims reviewed decreased substantially.

> By 1995, however, when payment safeguard funding for Part A medical review had substantially declined (from $61 million in 1989 to $33 million in 1995), the intermediaries' claims review target had been lowered to 3.2 percent for all Part A claims (or even lower, depending on available resources) to a required minimum of 1 percent. During this same period, the number of home health agencies participating in Medicare increased by more than a third, and the volume of home health claims processed more than tripled.[35]

During this same time, home health claims increased from 5.5 million in 1989 to 16.6 million claims in 1994. The number of home health claims grew to 18 million in 1995, 19 million in 1996 and 1997. This figure is expected to remain at 19 million in 1998, due in part to changes brought about by implementation of IPS. The September 15, 1997, announcement by HCFA that they will begin reviewing more claims—250,000 up from 200,000—reflects a minimal response. As noted by HCFA in their July 22, 1998, testimony before the Subcommittee on Human Resources, the agency's increase in audits represented an increase of 25 percent.[36] Neverthe-

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[32] Statement of William Scanlon, Director, Health Financing and Systems Issues, Health, Education, and Human Services Division, U.S. General Accounting Office, Oversight and Investigations Subcommittee hearing, No. 64, p. 17.

[33] Letter from William J. Scanlon, Director, Health Financing and Systems Issues, (GAO/HEHS–98–59R) U.S. General Accounting Office to Senator Thomas A. Daschle, et al., Dec. 3, 1997, p. 2. (in subcommittee files).

[34] See *supra* note 1, p. 2.

[35] Ibid., p. 5.

[36] See *supra* note 2, p. 2.

less, it is only 1 percent of the expected home health claims in 1998.

In this same July 22 hearing before the House Government Reform and Oversight Committee's Subcommittee on Human Resources, HCFA's Program Integrity Director acknowledged the serious weaknesses in the home health program, and the failure to respond adequately.

> 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.[37]

After congressional hearings and extensive media attention, the administration responded to the findings of the July 1997 OIG reports. In what they called an "unprecedented" action, the Department of Health and Human Services, in conjunction with the White House, implemented a moratorium on the entry of any new home health agencies into the Medicare program on September 15, 1997, and announced more claims reviews, and audits. The administration was taking "aim at fraud" according to Secretary Shalala.[38]

1997 BALANCED BUDGET ACT ANTI-FRAUD AND ABUSE PROVISIONS

To address the continuing problems of waste, fraud, and abuse in the home health program, the Congress proposed several changes to the home health program, contained in the Balanced Budget Act of 1997:

1) a mandatory surety bond for home health and DME providers in the amount of at least $50,000;

2) an interim payment system for home health services with payment rates based on prior year (1994) cost data;

3) development of a prospective payment system for home health services, to be effective on or after October 1, 1999;

4) payment based on the location of the beneficiary rather than location of the home health agency;

5) modification of the Part A home health benefit for individuals enrolled under Part B;

6) clarification of part-time or intermittent nursing care;

7) an HHS study of the criteria in determining home bound status;

8) development of standards for home health claims denials;

9) prohibition of home health services based solely on drawing blood (venipuncture); and,

10) a report to Congress regarding home health cost containment.

As several of these changes were being implemented by HCFA, the industry took exception with the agency's interpretation of the requirements and launched an active lobbying effort to weaken

[37] Testimony of Penny Thompson, Director of Program Integrity, Health Care Financing Administration, U.S. Department of Health and Human Services, (July 22, 1998) Human Resources Subcommittee hearing transcript, p. 13 (in subcommittee files).

[38] See *supra* note 3.

them and persuade Congress of their potential harm to beneficiaries and the industry. The industry spent considerable effort opposing changes in delivery of venipuncture service, the new surety bond requirement and implementation of the interim payment system.[39]

THE BBA SURETY BOND REQUIREMENT

The BBA requires each home health agency and durable medical equipment supplier participating in Medicare and/or Medicaid to secure a surety bond of at least $50,000 on a continuing basis. After several meetings and correspondence with HCFA in an effort to provide technical assistance in drafting the new home health surety requirement, the surety industry found the January 5, 1998, HCFA regulations too restrictive.

Specifically, the surety industry wrote, "However, the regulations which were published on January 5, 1998, include provisions which the surety industry specifically told HCFA could create difficulties for many providers in obtaining bonds." The surety industry identified their concerns as ". . . the potential stacking or cumulative effect of annual bonds, and the long tail or open-endedness of the obligation of the bond. Among other issues, the industry also expressed concern that the regulations do not contain a cap on the maximum amount of the bond."[40]

The home health industry opposed the proposed final regulation, particularly the establishment of the bond amount beyond the $50,000, arguing HCFA exceeded congressional intent by requiring bonds covering the lesser of $50,000 or 15 percent of prior-year Medicare revenues. In an industry that is by-in-large limited in assets and capital, the ability of HHAs to produce needed collateral was limited, which jeopardized their ability to secure the surety bond required by the regulation.

Additionally, the home health industry (as well as the surety industry) objected that the proposed final regulation potentially exposed HHAs to bond liability for all overpayments, not just losses due to fraud and abuse. The surety provision contained no waiver mechanism for home health agencies that pose no risk to the Medicare program. It required separate surety bonds for Medicare and Medicaid, with an exception for small agencies whose combined Medicare, Medicaid revenue was less than $334,000.

Some HHAs argued:

1) surety bonds were meant only to serve as a deterrent to fly-by-night providers that pose a risk to the programs, not a source of recoupment for routine overpayments and reimbursement errors;

2) HCFA's bonding requirement was to be continuous, with no opportunity for agencies with good payment records to reduce or eliminate bond coverage;

[39] *News Release, NAHC Announces 10-point Plan to Stem Surety Bond Regulations,* NAHC website, (http://www.nahc.org/NAHC/NewsInfo/98nr/10ptplan.html).

[40] Letter from Martha L. Perkins, senior counsel, American Insurance Association and Lynn M. Schubert, president, the Surety Association of America to Val J. Halamandaris, president, National Association for Home Care, Jan. 15, 1998 (in subcommittee files).

3) HCFA set the value of the bond at the greater of $50,000 or 15 percent of the previous year's revenues from the Medicare and/or Medicaid programs;

4) the expense of the surety bond, made more costly by HCFA's unrealistic requirements for cumulative and perpetual liability, was not an expense reimbursable under Medicare or Medicaid; and,

5) the collateral and personal indemnification required by surety underwriters were too burdensome and risky.

The industry identified an aggressive plan of action to challenge the proposed home health surety bond. Their "10 Point Plan" to counter the surety bond requirement included legal action, lobbying, legislative remedies, White House intervention, and correspondence.[41]

The home health industry recommended HCFA reconsider the surety bond regulation and modify it for use as a screen for inappropriate providers, rather than as an insurance policy against all overpayments. They also took the position that HCFA should not implement or enforce the surety bond regulation until there was full compliance with the Administrative Procedures Act, permitting interested parties the opportunity to provide comment prior to any proposed rule being finalized.

The March 4, 1998, notice in the Federal Register indicating HCFA's plans to modify the January 5, 1998, regulation by setting clearer limits on sureties's liability and providing surety companies better appeal rights, did little to reassure the home health industry. They continued to object to HCFA's interpretation of the BBA surety requirement and proceeded with their active opposition.[42]

Members of Congress also raised questions about the surety bond regulation, questioning HCFA's interpretation of congressional intent, and departure from "the Florida model,"[43] a surety bond requirement the State of Florida implemented in 1995 to combat waste, fraud, and abuse in the State's Medicaid program. All new home health and durable medical equipment providers were required to obtain a bond in the amount of $50,000. Agencies in good standing with the Medicaid program, and that had participated for at least one year, were permitted to forego the requirement. The State did not track the size of home health agencies who left the program, nor whether the surety requirement had a disproportionate impact on women and minority owned agencies. The bond requirement, with several other anti-fraud initiatives, was successful in improving program integrity and reducing the number of problem providers through more rigorous enrollment and re-enrollment requirements.[44]

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[41] See *supra* note 39.

[42] "Problems with the Home Health Surety Bond Requirement and HCFA's Implementation Plan," Nation Association of Home Care Talking Points, March 1998 (in subcommittee files).

[43] Letter from Representative Pete Stark to Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services, Feb. 12, 1998 (in subcommittee files); letter from Representative Karen L. Thurman to Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services, Jan. 28, 1998 (in subcommittee files).

[44] *Comparability of Federal and Florida Bond and Financial Ability Requirements for Medicaid Home Health Agencies,* Florida Agency for Health Care Administration, Feb. 23, 1998 (in subcommittee files).

THE BBA INTERIM PAYMENT SYSTEM AND THE IMPACT ON SURETY BONDS

The BBA changes home health reimbursements from an open-ended cost-based system to an interim payment system that capped costs based on historical data. It was implemented to reduce costs, curtail opportunities for over-service abuses, and to facilitate the transition to a home health prospective payment system [PPS]. Reduced IPS payment rates from Medicare affect HHA cash flow and overall financial viability. Those factors make it more difficult or more expensive for agencies to obtain surety bond coverage.

Members, as well as witnesses, at the subcommittee's July 22 hearing expressed concerns about the interim payment system and its effect on HHAs' ability to secure security bonds. The home health industry and surety industry noted that IPS would probably result in more overpayments, necessitating a greater financial guarantee on the part of HHAs in order to qualify for a surety bond. In written testimony the surety industry said:

> [i]t is our understanding that many HHAs are uncomfortable with signing the personal indemnity agreement often required to obtain an overpayment bond. That 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 surety, personal indemnity is a very common underwriting tool.[45]

In addition, when HCFA made the decision to issue a surety bond requirement that was more than an anti-fraud bond, but an overpayment and financial security bond as well, the criteria to secure such a bond were expanded. The surety industry stated in written testimony that the broader financial guarantee "affected the availability of these bonds for small HHAs."[46]

A home health witness stated before the subcommittee:

> [b]ut 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.

[45] Statement of Lynn M. Schubert, president, Surety Association of America, Human Resources Subcommittee hearing, July 22, 1998, p. 4 (in subcommittee files).
[46] Ibid., p. 3.

> They will happen. They are happening and will continue to happen as long as that system is in place.[47]

Speaking to HCFA at the subcommittee's July 22 hearing, one Member stated:

> [l]ast 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. . . . [w]hat 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?[48]

Because the IPS payment rate was based on 1994 data, HHAs argue the rates penalize providers who were efficient in 1994, and rewards those who were inefficient. The rates are composed of a combined agency specific and regional rate. Specifically, home health agencies will be paid the lessor of (1) their actual costs, (2) specific per-visit cost limits (105 percent of the median costs of home health agencies), or (3) agency-specific per-beneficiary limits (based on 75 percent on the agency's cost per beneficiary and 25 percent on average per-beneficiary costs for agencies in the same region). The interim payments were intended to remain in effect until October 1, 1999, when Congress mandated implementation of the new prospective payment system for home health, beginning on or after that date.[49]

However, on June 25, 1998, HCFA notified Congress that the need to focus far more resources on their year 2000 computer problems meant several of the BBA mandated changes, including a prospective payment system for home health, were being postponed until after January 1, 2000. That decision is of particular concern to the home health industry because extending IPS prolongs financial pressure on agencies that may result in closings.

SURETY BONDS CHARACTERISTICS

Part of the difficulty in implementing the home health surety bond requirement was due to a lack of experience and only limited understanding of surety bonds, and their unique features, by regulators and the affected industry. A surety bond is a written agreement for monetary compensation in case the principal fails to perform services as promised. Surety is a unique insurance product that is created whenever one party guarantees full performance of an obligation by another party. There are three parties to the agreement: (1) the principal is the party that undertakes the obligation (i.e. a home health agency); (2) the surety (i.e. an insurance company) guarantees the obligation will be performed; and (3) the obligee (i.e. HCFA) is the party who receives the benefit of the bond in the event of default by the principal.

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[47] Testimony of Steven Richard, CFO, Sun Home Health Service, (July 22, 1998) Human Resources Subcommittee hearing transcript, p. 100 (in subcommittee files).

[48] Testimony of Representative Michael Pappas, (July 22, 1998) Human Resources Subcommittee hearing transcript, pp. 51, 54 (in subcommittee files).

[49] Public Law 105–33, Sec. 4602 (Balanced Budget Act of 1997).

Surety bonds are different from other lines of insurance. In traditional insurance, the risk is transferred to the insurance company. In surety bonds, the risk remains with the principal. If a principal defaults on an agreement, the obligee receives the amount the principal owes or the amount needed to fulfill the contract, after which the principal must pay the surety back in full. In underwriting traditional insurance products, the goal is to spread the risk. Premiums are based on expected losses. In surety bonds, surety writers see their underwriting as a form of credit, premiums are service fees and the emphasis is on prequalification and selection.

That emphasis can be very useful in screening out unqualified or high-risk principals. Although each surety company has its own guidelines and criteria, there are basic features found in all surety products which include the applicant's capacity, skill and ability to perform the obligation, the capital of the applicant and whether the financial condition of the applicant justifies approval of the particular risk, and character—whether the applicant's record shows him or her to be reputable and likely to perform the assumed obligation.

Surety bonds commonly require a pledge of personal assets of the owners of closely held corporations, including assets held jointly with spouses and family members. This requirement often presents an insurmountable obstacle to small, community-based, not-for-profit enterprises whose directors and board members face the loss of homes and savings accounts to meet bond liability. Anecdotal information indicates many home health providers were both surprised and unwilling to pledge the needed personal indemnification and collateral required to secure the bonds.

SUSPENSION OF THE SURETY BOND COMPLIANCE DATE

Facing the prospect of Senate disapproval of the surety regulation, HCFA suspended the implementation date of the June 1 rule.[50] HCFA agreed to take no further action on surety bonds until GAO completed a study and report on the surety bond issue. GAO was asked to look at three aspects of the surety requirement: 1) considering the intent of Congress, and HCFA, what is the most appropriate type of surety bond for home health now and in the future; 2) how do bonds affect costs for home health; 3) to what extent and under what conditions are home health agencies able to obtain surety bonds?

HCFA also agreed to:

1) publish a notice in the Federal Register announcing the indefinite suspension of the compliance date of July 31, 1998, contained in the June 1, 1998, final rule;

2) to incorporate the results of the GAO study in subsequent surety bond regulations; and,

3) to postpone the effective date of any surety bond requirement until February 15, 1999, or a later date subsequent to a 60-day notice and comment period.

On July 31, 1998, HCFA published a notice in the Federal Register announcing suspension of the surety bond compliance date of

[50] Letter from Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services to Senator Christopher S. Bond, July 14, 1998 (in subcommittee files).

July 31, 1998, and prohibiting further agency action until HCFA had the opportunity to evaluate the requested GAO report. HCFA's July 31, 1998, final rule states: "[a]lthough the surety bond requirements remain in effect, the practical effect of this document is to absolve participating HHAs from having to show compliance with the requirements until 60 days following publication of a new final rule but no earlier than February 15, 1999." [51]

At the time the surety bond compliance date was retracted by HCFA due to congressional pressure, HCFA reported 40 percent of the home health agencies had been able to secure bonds. HCFA data indicated those with bonds were equally distributed among small, medium and large HHAs, indicating small agencies were as successful in acquiring bonds, contrary to industry concerns the requirement was disproportionately harming small agencies.[52]

For those home health agencies who secured bonds and the surety dealers who wrote them, it remains unclear what liability the surety might have on the bonds. Only if the obligee on the bond, HCFA or the State Medicaid agency provides full release on the bond, can the surety be absolved of liability under those bonds. If the bonds were released, then any question of a possible prorated return of the premium or release of collateral would be governed by applicable State law.

During the July 22, 1998, subcommittee hearing, witnesses representing HHAs covered by surety bonds raised the question about status of the bonds in view of HCFA's postponement of the effective date. Mr. Schneider, representing a large visiting nursing association [VNA] home health agency, noted that while they had been successful finding a surety bond, they nevertheless had spent money that would normally have been directed to charity care or payroll expenses. He said: "The success of the Visiting Nurse Association of Central Jersey in securing the surety bond has now created the other problem of what to do with it now that we have it." [53]

In response to a subcommittee request regarding the status of bonds obtained, HCFA stated in written testimony,

> 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 agencies.[54]

On July 31, 1998, Human Resources Subcommittee Chairman Christopher Shays and Ranking Member Representative Edolphus Towns wrote a letter to HCFA which was designed to determine the genesis, impact and current status of the agency's rule on those HHAs with surety bonds. At the same time, Mr. Shays and Mr. Towns wrote a letter to GAO which requested detailed information

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[51] 63 FR 41170.

[52] See *supra* note 37, pp. 27–28.

[53] Testimony of Steve Schneider, president and CEO, Visiting Nurse Association of Central Jersey, (July 22, 1998) Human Resources Subcommittee hearing transcript, p. 81 (in subcommittee files).

[54] See *supra* note 2, pp. 6–7.

about the surety bond experience in Florida and an assessment of possible disproportionate effects of surety bonds on small and minority-owned businesses. At this date, the subcommittee has not received a written response to either letter.

III. FINDINGS

1. Progress in combating waste, fraud, and abuse in home health during the past year has been minimal

The administration's home health moratorium on new applicants did nothing to detect or remove fraudulent home health providers already enrolled in Medicare. The demise of the surety bond program denies HCFA a potentially effective tool to screen out unqualified agencies. Meanwhile, reports of home health fraud continue to reflect the program's structural and operational vulnerabilities.[55]

Months after the January 5, 1998 lifting of the moratorium, HCFA could provide no definitive data as to whether that extraordinary step actually helped combat waste, fraud, and abuse.[56] At the written invitation of the subcommittee, several hearing witnesses were specifically asked to address the moratorium in their written and oral testimony. The agency took the position the hiatus protected Medicare from new, bad providers while HCFA imposed new eligibility requirements for home health agencies. The OIG remained supportive of the moratorium as an administrative remedy "to stop the admission of untrustworthy providers while HCFA strengthened its requirements for entering the program."[57]

However, the moratorium blocked qualified providers from enrolling as well, while HCFA could have imposed new enrollment requirements at any time, with or without a highly publicized moratorium. Home health providers appearing before the subcommittee on July 22, 1998, spoke about the impact of the moratorium. A new home health agency, part of a community hospital, began the process of licensing and certification in early 1997. Their efforts were halted by the moratorium. Describing the process and impact the witness stated: "[a]t that point in time, we had invested a lot of money and resources and then, when the moratorium was enacted, we were stopped dead in our tracks. . . . [s]o the moratorium prevented us from doing that, and it prevented our patients from getting access to that continuum of care for at least a six-month period."[58]

The opportunity to move ahead forcefully in the effort to reign in waste, fraud, and abuse has been hindered by the current stalemate over surety bonds. HCFA's failure to write a surety bond rule that met congressional approval resulted in lost time, and lost bond premiums by HHAs who complied with the flawed rule. The inadequacy of both iterations of the surety regulation provided time, opportunity and ammunition for the home health industry to launch

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[55] Home Health Care "All the Components for Disaster," USA Today Web Site (http://www.usatoday.com/life/health/hcare/home/lhhhh014.htm).

[56] See *supra* note 2, p. 2.

[57] See *supra* note 15, p. 7.

[58] Testimony of Jayne F. Quinn, home care coordinator, York Hospital Home Care, (July 22, 1998) Human Resources Subcommittee hearing transcript, pp. 90, 92 (in subcommittee files).

a vigorous, at times shrill, and ultimately successful campaign against the surety bond requirement.[59]

2. HCFA failed to follow the regular administrative rulemaking procedures in crafting the surety bond requirement

The surety bond rule promulgated by HCFA was inadequate and technically flawed in spite of meetings with and correspondence from the home health and surety bond industries.

Early in the process, the surety industry indicated a willingness to collaborate and work with HCFA in developing a viable product. They provided technical assistant to congressional sponsors during consideration of BBA, met with and corresponded with HCFA as the regulation was being drafted.[60]

The home health industry, always wary but not overtly opposed to surety bond provisions during the BBA debate, also provided HCFA with technical assistance during drafting of the regulation. But as the specifics of surety requirement were finalized by HCFA in the proposed interim final rule, the home health industry began to take an active position against the regulation.

Both industries objected that the January 5, 1998 proposed interim final regulation prohibited them from providing formal comments to support the rulemaking. Both industries stated it was their view many home health agencies would be unable to secure a bond due to costs associated with the "$50,000 or 15 percent, whichever is higher" requirement. The surety industry stated they would not be able to offer a surety product given the potential for extended liability.[61]

The rule proved so problematic HCFA announced that technical corrections would be made to in attempt to address some concerns of the industries who would have to offer or purchase the surety products HCFA envisioned. But even the revised rule issued June 1, 1998, did not resolve several of outstanding issues believed to affect viability and widespread acceptance of the HCFA home health surety bond.

Hearing testimony supported the view that HCFA's surety bond rule misjudged the diversity in size, structure and financial wherewithal of home health agencies. HHAs affiliated with other providers with a capital base (i.e. hospitals) were generally able to get surety bonds without providing collateral or personal indemnification. One home health agency director stated ". . . 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 a broker, to one surety company . . ."[62]

Another free-standing agency was unable to secure a surety bond because it lacked capital and assets to use as collateral.

> We tried everything to get a bond. We sent personal resumes, personal financial statements to some companies. We sent appraisals of any property we owned. We went out and tried to talk to legislators who knew us, tried references. Having done all of these things, including we have

[59] See *supra* note 39.
[60] See *supra* note 45, p. 2.
[61] Ibid., p. 3.
[62] See *supra* note 58, p. 91.

> a life insurance policy that a donor has named us as a beneficiary. It's a million dollar 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.[63]

This same witness, unable to secure a surety bond because of inadequate assets and capital, observed: "[t]he home health industry is not a capital-asset-intensive organization. We are a very staff-intensive organization."[64]

It is the position of the affected industries that many of these difficulties would have diminished had HCFA followed the requirements of the Administrative Procedures Act [APA] and sought comments once the regulations were published. In written testimony before the subcommittee on July 22, 1998, the home industry said:

> [w]here 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.[65]

In an April 15, 1998 letter to HCFA petitioning an amendment to the final rule on surety bond and capitalization requirements, the Office of Advocacy of the Small Business Administration faulted HCFA for not complying with the notice and comment requirements of the Administrative Procedures Act as required by statute.[66] Although HCFA took the position that it had good cause for not complying with the APA and waived notice and comment, the Office of Advocacy viewed HCFA's rational for such action as improper, writing: "the agency must comply with the Regulatory Flexibility Act."[67] The Regulatory Flexibility Act requires agencies to adhere to certain requirements prior to issuing the implementing regulation such as: "the impact of proposed regulations on small entities and consideration of flexible regulatory alternatives that reduce the burden on small entities—without abandoning the agency's regulatory objectives."[68]

Members of Congress wrote HCFA conveying concerns about the surety bond regulation, specifically taking issue with the 15 percent requirement and the lack of the waiver options. In addition, Members of the Senate introduced a joint resolution under the Congressional Review Act [CRA],[69] S.J. Res. 50, to disapprove the rule

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[63] Testimony of Steven Richard, CFO, Sun Home Health Service, Human Resources Subcommittee hearing, July 22, 1998, p. 86 (in subcommittee files).
[64] Ibid., p. 104.
[65] See *supra* note 17, p. 11.
[66] 5 U.S.C. Sec. 553.
[67] Letter from Jere W. Glover, Chief Counsel for Advocacy and Shawne Carter McGibbon, Assistant Chief Counsel for Advocacy, to Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services, Apr. 15, 1998, p. 2 (in subcommittee files). Note: The Office of Advocacy is a quasi-independent agency within the U.S. Small Business Administration.
[68] Ibid., p. 6.
[69] 5 U.S.C. Sec. 801–808.

proposed by HCFA on June 1, 1998, relating to surety bonds for home health.

Under the CRA, two types of rules, major and non-major, must be submitted to both houses of Congress and the GAO before either can take effect:

> CRA defines major as a rule that is likely to or has resulted in (1) an annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individual industries, government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of U.S.-based enterprises to compete with foreign-based enterprises in domestic and export markets. Major rules cannot be effective until 60 days after publication in the Federal Register or submission to Congress and GAO, whichever is later. Non-major rules become effective when specified by the agency, but not before they are filed with the Congress and GAO.[70]

Formal rulemaking, with notice and comment, would also have allowed HCFA to learn more about the specifics, and limitations, of other surety programs. In particular, affected industries and some Members of Congress pointed to HCFA's failure to follow the Florida surety bond model. In written testimony, the surety industry noted the specifics of the Florida program and suggested a: "similar requirement could be crafted for the federal bond mandate." [71]

The Florida Medicaid program undertook the task of revising the Medicaid provider agreement for non-institutional providers to protect the Medicaid program should fraudulent and abusive providers become enrolled. One provision required:

> . . . a bond or letter of credit for certain provider groups. Such bond or letter of credit would only be required for non-institution, non-licensed entities, and certain other providers unless such providers can show that they have enrolled in the Medicaid program for a specified period of time without a sanction being imposed by the Agency for Health Care Administration. A provider subject to a bond may also request a hardship waiver if it is unable to comply with the above-stated bond requirements. This bond requirement would enable the Medicaid program to recoup overpayments from corporate entities who fraudulently bill the program and then go out of business, leaving a corporation without any funds to pay a fine or overpayment back to the state.[72]

The purpose of the Florida bond was to act as a proxy for background checks of finances, history of problems and references. It

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[70] *Congressional Review Act: Update on Implementation and Coordination,* 105th Cong., 2d sess., (June 17, 1998) (National Economic Growth, Natural Resources, and Regulatory Affairs Subcommittee hearing) (statement of Robert P. Murphy, General Counsel, U.S. General Accounting Office), p. 1 (in subcommittee files).

[71] See *supra* note 45, p. 6.

[72] *Keeping Fraudulent Providers Out of Medicare and Medicaid,* 104th Cong., 1st sess., p. 98 (June 15, 1995) ("Human Resources and Intergovernmental Relations Subcommittee" hearing) (statement of Rufus Noble).

was a uniform $50,000 bond for all new home health agencies serving the Medicaid population and had to be obtained only once. The cost of the bond was not reimbursable.

The Florida surety bond requirement, combined with other anti-fraud measures, resulted in substantial savings to the Medicaid program. In addition, there was a significant reduction in the number of home health agencies in the State.[73] The State did not track ownership nor the size of the agencies who left the program as a result of the surety bond requirement. The State did not track whether the surety requirement disproportionately harmed women owned, minority owned or non-profit home health agencies more than others. While no studies were done on possible effects on access to care as a result of the several anti-fraud initiatives, the State of Florida did say there was no anecdotal information presented to them to suggest any access problems were created.[74]

HCFA's formulation of a home health surety bond went well beyond the more limited Florida approach, requiring continuous and cumulative bond coverage in variable amounts without regard to organizational structure or program experience. Subcommittee Chairman Shays and Ranking Member Towns asked the General Accounting Office to consider including an analysis of the Florida surety bond program in the study being conducted for the Senate Finance Committee.[75]

Given the other home health initiatives contained in the BBA, it seems unlikely Congress expected the surety bond requirement to act as the comprehensive program safeguard and repayment source envisioned in the HCFA regulation. Nor is it likely Congress would enact self-contradictory provisions, requiring bonds on the one hand, while imposing a payment system making it impossible to qualify for the required bond on the other. Congress had reason to know the IPS would change the financial profile of most agencies, affecting in turn the very factors underwriters consider in determining bond qualifications: cash flow and contingent liability for overpayments.[76]

In view of the legislative context, a more reasonable statutory interpretation of the BBA surety bond provision would dictate a far more limited application.

3. As the result of limited enrollment standards, HCFA was not able to ensure the financial responsibility of Medicare home health providers

Medicare statute requires that home health agencies be certified to served Medicare beneficiaries. HHAs must meet specific requirements which are referred to as conditions of participation. These

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[73] *Florida Medicaid's Fraud and Abuse Initiative,* State of Florida, Agency for Health Care Administration, March 1997, p. 6 (in subcommittee files).

[74] Rufus Noble, Rebecca Knapp, and Douglas Cook, Florida Medicaid and Agency for Health Care Administration, interviewed by subcommittee staff Sept. 11, 1998 (notes in subcommittee files).

[75] Letter from Representatives Christopher Shays and Edolphus Towns to James Hinchman, Acting Comptroller General of the United States, General Accounting Office, July 31, 1998 (in subcommittee files).

[76] *Interim Payment System for Home Health Agencies,* 105th Cong., 2d sess., p. 1 (Aug. 6, 1998) ("Health Subcommittee" hearing) (Statement of William J. Scanlon, Director, Health Financing and Systems Issues, Health, Education, and Human Services Division, U.S. General Accounting Office) (in Health subcommittee files).

requirements consider the HHAs' qualifications and their capacity to perform such business and patient care activities as appropriate recordkeeping and records privacy, as well as providing the necessary and appropriate skilled nursing services. This function is conducted by State public health agencies for HCFA.

At the subcommittee's July 22, 1998, hearing HCFA acknowledged the need for improving the survey and certification process. In written testimony HCFA stated: "Medicare has taken other steps to raise standards for home health agencies and protect program integrity."[77] These changes included new capitalization and a minimum demonstration of skilled nursing capabilities. In addition, HCFA stated they were instructing 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."[78] Other HCFA initiatives noted for the subcommittee included HCFA's ability to require HHAs disclose the identity of each person with an ownership or control interest, or subcontractor relationship in an agency: "directly or indirectly of more than 5% ownership interest."[79] This information would better enable HCFA and the OIG to track complex business arrangements which contribute to the inability to track inappropriate funds and overpayment of Medicare dollars. HCFA stated the agency was in the process of developing regulations requiring HHAs to be recertified every 3 years and to submit to an independent audit of records and practices as part of the re-enrollment process.[80]

HHAs appearing before the subcommittee July 22, 1998, agreed there is a need to strengthen anti-fraud efforts through existing administrative and regulatory tools at the disposal of HCFA. In discussing the surety bond requirement a new HHA stated:

> . . . 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 of state licensing and certification programs, which multiple and complex tools in place. . . . Instead of reacting, we need to work together to strengthen the systems we already have in place that are working.[81]

Appearing before the Senate Aging Committee, GAO testified in 1997 that HCFA's survey and certification process was inadequate, contributing to the concerns about the program's rapid growth, entrance of possible unscrupulous providers, and inappropriate payments. GAO stated:

> The certification, in effect, is Medicare's seal of approval on the services provided by a home health agency. How-

[77] See *supra* note 2, p. 7.
[78] Ibid.
[79] Ibid., p. 8.
[80] Ibid.
[81] Statement of Jayne F. Quinn, home care coordinator, York Hospital Home Care, Human Resources Subcommittee hearing, July 22, 1998, p. 9 (in subcommittee files).

ever, we believe that the survey and certification process currently fails to provide beneficiaries with reasonable assurance that their HHA meets Medicare's conditions of participation and provides quality care.[82]

IV. Recommendations

1. HCFA should better use existing authority and resources to augment efforts to address waste, fraud, and abuse in the Medicare home health benefit program

HHAs and Members who questioned the value of surety bonds, particularly HCFA's version, believe effective tools already exist which, if implemented by HCFA, could effectively deter waste, fraud, and abuse in the Medicare home health program. Some believe surety bonds are too blunt an anti-fraud tool, and a uniform requirement may jeopardize the existence of smaller HHAs.

Other approaches suggested to the subcommittee:

1) enhance State licensing requirements;

2) require certification programs and accreditation;

3) strengthen conditions of participation;

4) improve beneficiary education regarding the home health program, coverage, and eligibility;

5) require education and training to ensure competency of program administrators;

6) require Medicare compliance plans;

7) require background checks by the HHA of all employees;

8) develop outcome measures for evaluation of HHAs;

9) correct the IPS and move quickly to PPS which allows efficient agencies to be rewarded and places appropriate financial constraints on high cost providers; and,

10) develop a more collaborative, less adversarial, relationship between HHAs and HCFA.[83]

Despite persistent reports of serious problems in the home health benefit program, HCFA only recently began to use existing authority to strengthen participation requirements and other program safeguards. Effective January 1998:

1) HCFA established initial capitalization requirements for home health agencies to demonstrate sufficient available cash to meet operating expenses for 3 to 5 months of operation;

2) all agencies are required to re-enroll every 3 years, and must submit an independent audit of their records and practices for re-enrollment;

3) agencies must demonstrate their experience/ability in home health care by serving a minimum number of patients prior to Medicare beneficiary enrollment;

4) agencies must submit detailed information about related businesses to ensure that agencies will not use cross-ownerships and other financial schemes to exploit Medicare; and,

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[82] Testimony of Leslie Aronovitz, Associate Director, Health Financing and Systems Issues, Health, Education and Human Services Division, U.S. General Accounting Office, Select Committee on Aging hearing, No. 8, July 28, 1977, p. 132.

[83] *Medicare Home Health Agencies: Still No Surety Against Fraud and Abuse,* 105th Cong., 2d sess., (July 22, 1998) (Human Resources Subcommittee hearing) (in subcommittee files).

5) HCFA will double the number of home health agency audits and increase claims reviews by more than 25 percent each year.[84]

2. HCFA should follow the Administrative Procedures Act, permitting thorough and formal comments and collaboration with experts and congressional committees, in drafting regulations implementing novel and complex program requirements

Fueling congressional concern about the surety bond regulation was an opinion released by the Small Business Administration [SBA] on April 15, 1998.[85] SBA's Office of the Chief Counsel for Advocacy stated HCFA had not adequately analyzed the impact of the final rules on small home health agencies. SBA's Office of Advocacy noted their conclusions did not mean control of fraud and abuse was an unimportant policy objective, or that the interests of small businesses should supersede legitimate policy goals. Rather, SBA's Office of Advocacy sought to ensure "promulgation of common sense regulations that do not unduly discourage or destroy competition in the marketplace."[86]

The SBA's Office of Advocacy found the HCFA surety bond final rules "troubling" for several reasons:

1) the proposal, although probably within HCFA's regulatory and statutory authority, goes far beyond the requirements contemplated by Congress;

2) HCFA's good cause exception and waiver of notice and comment for the proposed rulemaking may be arbitrary and capricious under the Administrative Procedures Act; and,

3) nearly all the significant procedural and analytical requirements of the Regulatory Flexibility Act[87] were overlooked.

The Chief Counsel for Advocacy's letter requested HCFA 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."[88]

3. HCFA should pursue the use of existing statutory and regulatory authority to better assure the financial responsibility of home health agencies

Hearing testimony presented a wide range of opinion on the purposes, goals, structure, and applicability of surety bonds as an anti-fraud tool. As the chart below demonstrates, there is little consensus on the scope, effectiveness or practicality of a home health surety bond.

[The chart referred to follows:]

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[84] See *supra* note 2, pp. 2, 7.
[85] See *supra* note 67.
[86] Ibid, p. 2.
[87] 5 U.S.C. Sec. 601 [Enacted in 1980 and amended in 1996. Gives small businesses the opportunity to ensure agencies are considering the impact of agency actions on small businesses. The law recognizes that the size of a business, unit of government, or non-profit organization frequently has a bearing on its ability to comply with Federal regulations.]
[88] See *supra* note 67, p. 2.

Summary of Views Received at Surety Bond Hearing, July 22, 1998

Recommendation	Health Care Financing Administration	Office of Inspector General, HHS	Surety Association of America	National Association of Medical Equipment Suppliers	National Association for Home Care	Steve Richard, Home Health Provider	Jane F. Quinn, Home Health Provider	Steve Schneider, Home Health Provider
No surety Bonds							X	
Bonds for new entrants only					X	X	X	X
Bond for all providers, waiver option				X	X	X	X	X
Bonds for all providers	X	X	X	X				
One bond Medicare/Medicaid				X	X	X	X	X
Separate bond, state equivalent ok				X				
Separate bond, Medicare/Medicaid	X	X		X				
Bond for fraud only			X	X	X	X	X	X
Bond for fraud and overpayments	X	X						
Bond - $50,000 only			X	X	X	X	X	X
Bond - $50,000 plus 15% billings	X							
Bond - $50,000 plus 100% billings		X						

Through more rigorous certification and strengthened conditions of participation, HCFA could do more to ensure the financial responsibility of Medicare home health agencies using existing authority.[89] Based on the range of surety bond options offered in hearing testimony, it appears such an instrument would be most effective, and most accepted, as a discretionary requirement imposed on providers who pose some demonstrable risk to the Medicare program, not a uniform requirement on all HHAs.

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[89] 42 U.S.C. 1395.