PROBLEMS ASSOCIATED WITH HOME HEALTH CARE AGENCIES AND MEDICARE PROGRAM IN THE STATE OF FLORIDA

REPORT
PREPARED BY THE SUBCOMMITTEE ON FEDERAL SPENDING PRACTICES, EFFICIENCY, AND OPEN GOVERNMENT OF THE COMMITTEE ON GOVERNMENT OPERATIONS UNITED STATES SENATE

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LETTER OF TRANSMITTAL

U.S. Senate,
Committee on Government Operations,
Subcommittee on Federal Spending Practices, Efficiency, and Open Government,
Washington, D.C.

HON. ABRAHAM RIBICOFF,
Chairman, Committee on Government Operations,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The Subcommittee on Federal Spending Practices, Efficiency, and Open Government of the Committee on Federal Operations, conducted investigations and inquiries into the inefficiencies of the medicare payments to Home Health Agencies, particularly in the State of Florida.

It was our desire to use the Florida situation as a case study to hopefully provide valuable insight on the problems that have arisen all over the country with regards to the private, nonprofit home health care agencies. These agencies are practically self-regulatory and completely independent of meaningful guidelines for operation.

The subcommittee found an urgent need for administrative and possibly legislative overhaul in three major operational areas—claims processing, utilization review, and provider audit and reimbursement.

In anticipation of further congressional action in this matter, I am hereby transmitting for publication as a committee print the report by the subcommittee on Home Health Agencies and Medicare payments.

Sincerely,

LAWTON CHILES, Chairman.
CONTENTS

Letter of transmittal .................................................. 1
Introduction .......................................................... 1
Historical perspective ................................................. 2
Private, nonprofit agencies ......................................... 3
Illegality and irregularities ......................................... 9
Kickbacks and referral fee payments ................................. 24
Overutilization ....................................................... 28
Administrative abuses that were listed by Home Health Agency personnel .......................... 42
Referrals ............................................................ 42
Discharges ............................................................ 44
Audit abuses .......................................................... 44
Reasonable cost ....................................................... 44
Abuses with durable medical equipment ............................ 52
Conflict of interest .................................................... 55
The proprietary agencies ............................................. 58
General findings and recommendations ............................ 62
Findings and conclusions ............................................. 65
Additional views of Senator Lawton Chiles ......................... 70
Supplemental views of Congressman Claude Pepper ............... 72

APPENDIX

Letter from Mrs. Dorothy Deagan, executive director, Visiting Nurses Association of Broward County, to Senator Lawton Chiles, with attachments, Mar. 26, 1976 ..................... 77
Letter to the Editor, Tampa Tribune, from Ms. Blowers, Apr. 21, 1976 ... 84
Letter from Anne Villi Ras, R.N., Associated Home Health Agency, Inc., to Senator Lawton Chiles, June 4, 1976 ... 85
Memorandum from Florida's Department of Health and Rehabilitative Service, Nov. 24, 1974, with attachments .................. 86
Letter from the Massachusetts Association of Community Health Agencies to Senator Lawton Chiles, June 8, 1976 .................................................. 93
Letter from J. C. Parme, president, Bay Home Health Care Agency, Inc. to the subcommittee, Apr. 21, 1976 ..................... 94
Letter from Gold Coast Home Health Services, Inc. to Senator Lawton Chiles, May 4, 1976 .................................................. 98
Memorandum from the Florida Department of Health and Rehabilitative Service, Feb. 4, 1975 ............................... 103
Letter from Douglas M. Richards, Bureau of Health Insurance, Regional Office, to Senator Lawton Chiles, with attachments, May 11, 1976 ........... 106
Memorandum from Bureau of Health Insurance, May 21, 1976 ... 106
Letter from Council of Home Health Agencies and Community Health Services, to Senator Lawton Chiles, with attachments, July 3, 1976 ... 113
Editorial: "Get Medicare's House In Order," from the Tampa Tribune, Apr. 14, 1976 .................................................. 114
Article: "Medicare Audit Finds Rental Cost Draining Funds," from the New York Times, February 9, 1976 ... 115
Letter from Hon. L. H. Fountain to Hon. F. David Mathews, Aug. 9, 1975 ... 115

(v)
INTRODUCTION

The intent and validity of home health care programs is, without a doubt, a vital and important part of the lives of millions of elderly persons all over this country. The payment for these services, as provided by the law, under Medicare is also of great importance to the persons most involved—the American taxpayer. The concern for quality home health care was and is uppermost in the minds of the sub-committee. There was considerable concern over the administration of the agencies. Concerns which were expressed by the chairman, Senator Lawton Chiles. We have disturbing reports about some health care in Florida involving private, nonprofit home health agencies and Medicare payments, which include:

- Reports that persons were tested for respiratory function tests when they were not physically able to do so.
- Reports that Medicare has had trouble collecting from an agency which has a vast amount of money owed to Medicare.
- Reports that somehow real costs are hidden in some agency reports and claims to Medicare.
- Reports that bribes and rebates are all too common in the referral of Medicare payments.
- The tremendous proliferation of home health agencies in the State.
- Overutilization of services allowed by Medicare simply because they are allowed.
- Reports that some medical supply companies advertise in the media about "cost-free" equipment for Medicare patients.
- Reports that oxygen abuses are continuing in spite of the fact that Medicare authorities have been notified about this abuse.
- Reports that in New Jersey, for instance, a wheelchair that cost $168 to purchase was rented for 72 months at a total cost of $1,080.
- A hospital bed that cost $983.50 was rented for 36 months at a cost of $3,050 — Medicare funds pay 80 percent of rental costs.

Although these are perhaps isolated items they underscore the potential abuse that can exist in the rental of equipment.

Perhaps one solution is to raise the amount that the law allows for immediate reimbursement for equipment from $50 or less to a higher figure. When we consider the fact that the amendment allowing $50 was passed in 1968, illustrates that Congress in this respect has not kept pace with rising costs.

At any rate we need to close the "end" on equipment rentals.

Finally, I think the Congress is committed to providing high-quality health care for the elderly and closing the loopholes that presently exist in the Medicare/home health field.1

1 From Senator Chiles' opening statement at Tampa, Fla., hearing, dated Apr. 12, 1976.
In hearings held in Tampa and Miami, Fla., the subcommittee heard from a total of 28 witnesses. The theme remained the same: abuses and illegalities are certainly present in the program and proper safeguards are not.

The subcommittee felt that several key and important aspects of the investigation should be developed in the hearings. Those special areas were:

1. The great discrepancy between the "cost of operation" of public and private nonprofit home health agencies. The particular costs which were most obvious were skilled nursing care, nursing aide care, administrative salaries, pension plans, et cetera.

2. The illegal payments of rebates, referral fees, bribes and kickbacks with involving false medical reports and highly questionable medical practices.

3. The overutilization of home visits by private, nonprofit home health agencies often to the detriment of the patients involved. The investigation by subcommittee staffers turned up instances where many patients were forced to turn to public agencies after being dropped by the private agencies after their allotted medicare visits had been exhausted.

4. The overutilization of durable medical equipment to the extent that many times the original cost of the item has been greatly exceeded in the payment of rental fees.

5. The steady proliferation of private, nonprofit home health agencies in Florida because of the ease involved in the establishment of such an agency.

6. The possible conflict of interest that exists when a doctor owns or has substantial vested interest in a home health agency where he refers patients/clients.

7. The deliberate evasion of certain aspects of the law in order to gain an unfair competitive advantage by some durable medical equipment dealers. Prime example of this type of practice is the agreement that the DME dealers customarily forgive the 20 percent co-pay and instead turn it over to the private, nonprofit home health agency "for doing the necessary paperwork."

8. The addition of an "administrative markup" to the DME providers invoice by home health agencies and the submission of the larger figure to the Bureau of Health Insurance for payment. Such a "markup" is in violation of BHI regulations.


The subcommittee chairman, Senator Chiles, added one other concern: "That the patient will not become the 'forgotten person' during the entire controversy, that the importance of proper home health care for the elderly will ultimately gain from this investigation."

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**HISTORICAL PERSPECTIVE**

The growth of private, nonprofit home health agencies in Florida:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Agencies eligible for payment</th>
<th>Amount</th>
<th>Average Cost Per</th>
</tr>
</thead>
<tbody>
<tr>
<td>1969</td>
<td>82</td>
<td>$1,702,958.51</td>
<td>98</td>
</tr>
<tr>
<td>1970</td>
<td>220</td>
<td>$1,120,100.72</td>
<td>54</td>
</tr>
<tr>
<td>1971</td>
<td>220</td>
<td>$1,068,902.54</td>
<td>57</td>
</tr>
<tr>
<td>1972</td>
<td>220</td>
<td>$1,442,167.28</td>
<td>67</td>
</tr>
<tr>
<td>1973</td>
<td>220</td>
<td>$3,000,690.82</td>
<td>158</td>
</tr>
<tr>
<td>1974</td>
<td>220</td>
<td>$9,847,823.57</td>
<td>179</td>
</tr>
<tr>
<td>1975</td>
<td>220</td>
<td>$22,900,369.61</td>
<td>226</td>
</tr>
</tbody>
</table>

Committee's projection based on mid 1975 growth patterns and the implementation Florida licensure procedures.
Most of the present home health care agencies were county based and Visiting Nurse Associations. These associations operated under an organization similar to the example below:

TABLE OF ORGANIZATION

VISITING NURSE ASSOCIATION OF HILLSBOROUGH COUNTY, INC.

<table>
<thead>
<tr>
<th>Visiting Nurse Association Board of Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Advisory Committee</td>
</tr>
<tr>
<td>Professional Staff</td>
</tr>
<tr>
<td>A.N. Director</td>
</tr>
<tr>
<td>Medical Advisory</td>
</tr>
<tr>
<td>Executive Director</td>
</tr>
<tr>
<td>Clinical Head</td>
</tr>
</tbody>
</table>

Basically, these public non-profit organizations were instituted out of a community need to provide nursing care for the low-income elderly that were unable to do so for themselves.

Most Visiting Nurses Associations collect fees from those patients who can afford to pay for services rendered from Medicare and Medicaid and the United Way or other community oriented contributors. The central point is that the public non-profit home health agencies do not get 100% funding from Medicare and Medicaid; in fact, the average for federal funds received by VNA's range from 99% to 84%.

The hearings in Tampa and Miami explored the health care problems and solutions of VNA's in testimony from several directors from the State of Florida. Their testimony will be dealt with later in this report.

Many of the private non-profit Home Health Agencies have a structure such as the one listed below:
The growth of these types of agencies is illustrated by the testimony of Mr. Robert Wilson, associate director of the Health Planning Council, Inc. of West Palm Beach, discussed the proliferation of private nonprofit home health agencies thusly:

**Proliferation of home health agencies**

The second problem concerns the proliferation of home health agencies in Florida. Reports indicate that at the end of 1972 there were only 29 medicare-certified home health agencies, while there were 83 as of April 2, 1976. The majority are "private, nonprofit" agencies established only to serve medicare beneficiaries. It can be argued that these agencies were established to serve a need for noninstitutional health care. I question, however, how many would have been started if tax dollars were not available to pay for services. As with other programs funded with an infusion of federal tax dollars, it produced an environment which allowed many persons to feel they had found their pot of gold. People from all walks of life suddenly became experts in home health care. Congress, in its attempt to provide for a needed, less expensive, level of health care opened a Pandora's box by not establishing a mechanism which would balance resources with real unmet needs. This same problem occurred with the Hill-Burton hospital program and the medicare nursing home program.

Congress has attempted to rectify the proliferation of hospitals and nursing homes by establishing a mechanism requiring what is called a "Certificate of Need." The certificate of need operates through a designated planning agency at the State level with appropriate input from the local health systems agency. Public Law 92-608, and in particular, section 1122 of the Social Security Act, established this mechanism. Although home health agencies were included in section 1122, Florida's designated planning agency has not required new home health agencies to obtain a certificate of need even though the establishment of a new service was one of the criteria which necessitated a certificate of need.

Florida last year passed a law which requires home health agencies to be licensed. Prior to the issuance of the license, the Department of Health and Rehabilitative Services shall obtain a statement from the local health systems agency attesting to the need for the agency. It is ironic that proprietary home health agencies were the most vocal in support of the licensure law so that they could participate in the medicare program. While a statement attesting to the need for a home health agency as required by the State licensure law is good, it does not have the same effect as the certificate of need required under Federal law.

Under current regulations, home health agencies must be certified annually to participate in the medicare program. It would appear logical to dovetail the State licensure procedure with the medicare certification procedure and that a
statement attesting to the need from the local health systems agency be used for both programs. There is a precedent for this in the public health service programs. For some years now the local health systems agency has reviewed the appropriateness and need for local health service programs funded by the Public Health Service Act. We have had experience in determining the need for these programs, the appropriateness of the budget, and the capability of the agency to provide the service. Extending this function to include home health agencies funded by tax dollars, would prevent the problems that proliferation has created.

The recommendation in regards to the problem is as follows:

"That the local health systems agency review and comment on each home health agency's application for their health service area in regards to determining need for the home health agency prior to annual certification by the State agency."

PRIVATE, NONPROFIT AGENCIES—A CLOUDY DEFINITION

The subcommittee heard testimony that the term generally used to describe agencies that are considered nonprofit are usually supported by public monies to assist the established institutions in dealing with indigent clients. A most important consideration is that the nonprofit corporation does not accumulate capital, does not make investments, does not provide services for the expressed intent of making money.

Private, nonprofit home health agencies have generally engaged in the kind of practices that have caused some doubts about whether they should be classified as "nonprofit".

In the hearing in Tampa on April 12, 1976 Mr. Douglas Richards stated:

IRS tax exempt status

Proprietary organizations may participate as HHA's in medicare only if State law licenses proprietary HHA's. There is some concern that IRS may be granting nonprofit status under section 50 of the Internal Revenue Code of 1954 that are really proprietary. Central office staff has discussed tax exempt status of franchised agencies and chains with IRS. IRS has indicated that they do not believe their current policies require revision; however, IRS advised us they would accept for review any questionable cases of tax exempt status where there are high salaries or other high administrative costs that are out of line with the services rendered indicating possible abuse of tax exempt status.

Personnel of the RO have met with IRS officials in Atlanta to discuss the tax exempt status of nonprofit HHA's which claim high administrative salaries and pension compensation. The RO is in the process of gathering cost reports on such situations for IRS to examine. They have also recently uncovered situations where HHA's may be incorporated as "profit-making" entities in Florida and have illegally obtained tax exempt status. If these situations are verified by investigation, they will be referred to IRS for action.

In a widely circulated report, issued in January of 1976, Amitai Etzioni and Pamela Doty made these assertions about profit in not-for-profit institutions:

The essence of the not-for-profit organizational structure is that the pecuniary interests of the trustees and staff be decoupled from the rises and falls in the output and income of the corporation. This, in turn, allows them to concentrate on the public or client needs, without concern that this will affect their income. A conflict of interest between trustees and staff
on the one hand and the public and clients on the other is basically avoided by paying the trustees and staff salaries, wages, or fees not dependent on the client's payments, and by disallowing compensation for ownership and capital investment. This is the reason these corporations have no stockholders and pay no dividends, and their trustees receive no or only nominal compensation.

Our central thesis is that existing laws and regulations governing not-for-profit corporations are insufficient to safeguard the underlying legitimate purpose of these corporations. For instance, the HEW guidelines for not-for-profit corporations; elaborated over 60 pages, define a not-for-profit corporation as one "*** which is not organized primarily for profit and which uses all income exceeding costs to maintain, improve, and/or expand its operations. The term "primarily" leaves open the door to profitmaking (if it is not "primary") and the question, how much is "not-primarily"—10 percent, 20 percent, 40 percent?

That this ambiguity is not a hypothetical one is illustrated by the following case: in Anaesthesia, a 1968 case, U.S. 366 F. Supp. 118 (W.D. Ark. 1973), a Federal district court ruled that a commercial pathology laboratory was a not-for-profit corporation for Federal tax purposes, because aside from its highly lucrative pathology services to various hospitals, it provided training to high school and medical students.

The Georgia code states "nonprofit corporation" means a corporation no part of the income or profit of which is distributable to its members, directors, or officers. (Georgia Code, Ann. No. 59-2106(a) (1970).) As we see it, the intentions of those who formed the corporation is not a sufficient criterion, as even if their purposes were pure of any profit considerations, later they—or those who succeed them—may change their minds. However, the main difficulty is with the phrase "no distribution of income." As the staff is being paid and not working as volunteers, it is necessary to determine where their income is a reasonable compensation for work or services rendered, and where it exceeds this level and becomes but a veiled form of profitmaking. The cited codes do not cover this issue. Nor does the often cited section 501(c)(3) of the 1954 IRS code: *** no part of the net earnings of which exceeds to the benefit of any private shareholder or individual.*** The notion of a net as definition of profit, as derived from the difference of expenditures and revenue, is borrowed from profitmaking corporations. In a not-for-profit corporation, illicit gains are made by the staff and trustees, we shall see, when expenditures are smaller, equal to, or larger than revenues—even when there is no "net" at all. Our definition attempts to get at this matter by defining explicitly what distributions are allowed: a not-for-profit corporation will provide to persons associated with it (such as trustees, managers, staff and employees) no benefits apart from reas-sonable and customary fees, salaries and fringe benefits. To put it differently: while the existing definitions cited above are "exclusive" or "negative" in the sense that they characterize what may not be done, ours is "inclusive" or "positive" in the sense that it defines which allotments are proper. Of course the two definitions may be combined.

A 1969 survey of 3,434 American hospitals found that approximately 70 percent of radiologists, 45 percent of pathologists, 40 percent of physicians specializing in EKG, BMR and related readings, 52 percent of specialists in physical medicine, 19 percent of internists, and 14 percent of anesthesiologists earned their income exclusively from such a "percentage of the take." A 1969 study found that 44 percent of pathologists and 60 percent of radiologists practicing at the hospitals surveyed were paid a percentage of their department's income. A 1972 survey, based on a comparable universe of hospitals (N=1,798) found 52 percent of pathologists and 62 percent of radiologists receiving their remuneration in the form of a percentage of departmental income.

The percentage of gross or net income was found in general to be more lucrative for the specialists than straight salary or, in some cases, fee-for-service. The following table indicates the median salary ranges found by the 1972 survey for pathologists and radiologists according to the four methods of compensation:

<table>
<thead>
<tr>
<th>MEDIAN EARNINGS</th>
<th>Chief pathologist</th>
<th>Chief radiologist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Arrangement</strong></td>
<td><strong>Chief pathologist</strong></td>
<td><strong>Chief radiologist</strong></td>
</tr>
<tr>
<td>Percentage of net</td>
<td>$47,000-$50,000</td>
<td>$41,000-$45,000</td>
</tr>
<tr>
<td>Straight salary</td>
<td>$47,000-$50,000</td>
<td>$41,000-$45,000</td>
</tr>
<tr>
<td>Percentage of income</td>
<td>$47,000-$50,000</td>
<td>$41,000-$45,000</td>
</tr>
<tr>
<td>Percentage of expenditure</td>
<td>$47,000-$50,000</td>
<td>$41,000-$45,000</td>
</tr>
</tbody>
</table>

In addition, it is uncommon for specialists to draw a salary from one not-for-profit corporation while providing services on a "concession" basis to several others.

A recent General Accounting Office study of compensation arrangements for pathology and radiology specialists at 17 hospitals in Washington, D.C. and Missouri found that nine pathologists with percentage of gross arrangements earned an average of $85,000 over annual periods ending between December and April 1972. In contrast, the four radiologists earning salaries averaged $26,000.

Why do we hold that these arrangements, known in the for-profit corporations as "profit sharing," are incompatible with the basic concept of not-for-profit corporations? Because as long as the income of the staff rises as more services are rendered, the motivation to provide the services may not be the clients' or public's needs but the desire of the provider to increase his or her income. Overutilization tends to result, causing both unnecessary financial burdens on the client and
taxpayer, and unnecessary health risks which medical interventions entail.

When the income of the staff is tied to provision of fewer services, the opposite effect—underutilization—may result; that is, clients will receive less than their needs call for, which again calls for separating the income of the provider from the needs of the client. Thus, in some not-for-profit health maintenance organizations physicians receive a bonus, above their salary, calculated as a percentage of the organizations' net surplus. The fewer services rendered, the higher the surplus, all other factors remaining equal.

Self-dealing refers to business transactions in which the same persons (or their kin) appear on both sides of the transaction, once as the staff or trustees of a not-for-profit corporation, once as a profitmaking provider of goods or service to the other side (the not-for-profit corporation). In 1970 a number of practices of this sort were reported in Washington, D.C.'s largest not-for-profit hospital, the Washington Medical Center. A member of the administrative staff in charge of data processing had decided that the existing facilities at the hospital for billing, keeping track of patient records and accounting through the hospital's computer were inadequate. His solution was to hire an outside for-profit firm to furnish these services, and selected one he had started himself—with the help of a $50,000 deposit from the hospital. The hospital administrator received stock in the new company free of charge; five other top administrators of the hospital bought stock at $1 a share. Following public disclosure of these relationships, most of the administrators disposed of their stock. In 1974, however, when the General Accounting Office included the Washington Medical Center in a review of self-dealing transactions in 19 hospitals, it found that 4 hospital officials and several relatives of another official owned stock in the same computer firm; a physician employed by the hospital provided consultant services to the firm; and the firm's president was a hospital consultant and a member of the hospital's action committee. The GAO also found that it was not until mid-1973 that the Washington Medical Center requested competitive bids for computer services. According to the hospital administrator the other bids were not comparable with the present firm's services for a number of reasons, thus the hospital decided to continue retaining the firm's services for 12 to 18 months during which time a "more specific request for bids would be developed." The GAO report concluded that the overlapping interests of the hospital officers with the firm were likely to continue to give the firm an advantage over potential competitors.

In addition, at this same hospital, the official in charge of managing the institution's finances placed hospital funds in an interest-free account at a bank where he was vice president. The hospital's account balance is reported to have generally hovered around $1 million, sometimes going as high as $1.8 million; a conservative estimate placed the hospital's annual loss of interest because of this account at $60,000. That hospital staff gained something from these transactions is suggested by the fact that the hospital's administrator admitted this bank had lent him money at a low interest rate. More recently, Medicare officials disclosed that millions of dollars in Federal and private funds entrusted to Blue Cross and Blue Shield are being channeled through banks with officers who serve on the boards of trustees of these not-for-profit health organizations.

The easiest way to violate the essence of a corporation's not-for-profit status is to provide its staff or officers with unreasonable and uncustomarily high fees, salaries, or fringe benefits. In principle, income is not a violation of the not-for-profit concept, and as it is rather difficult to establish what is proper and what is exaggerated compensation, this area is rather difficult to regulate. Attention must hence focus on those situations in which the income provided is manifest. One such example is a hospital paying for the poetry and drama lessons of the physicians' children. No reasonable person would define such fringe benefits as typical, common or legitimate. That a not-for-profit hospital can provide such benefits is ironic: this case involves New York City voluntary hospitals that have contracted with the city's municipal hospitals to be paid for providing the municipalities with such services as physician and nursing assistance and laboratory work. These affiliation contracts were entered into by the city because it could not attract the needed qualified personnel for its own hospitals. By paying the voluntary hospitals, however, they are aggravating the problem, since the voluntary hospitals pass the contract money to pay for the education of doctors' children and for poetry and drama lessons, turning these fringe benefits into actual attrac good personnel, and the voluntary hospitals use this money to attract the personnel via benefits the city cannot match.

The ambiguities of the law and regulations concerning not-for-profit status of a corporation are illustrated by the trial and appellate decisions in American Automobile Association vs. Bureau of Revenue, 292 P. 2d 928, 96 N.M. 466 (1954). The AAA claimed tax exempt status as a not-for-profit corporation despite many discounts and other benefits it distributed to its members. The court held—292 P. 2d 928—that "Profit does not necessarily mean a direct return by way of dividend, interest, capital allocation or salaries. A saving of expenses which would otherwise necessarily be incurred is also a profit to the person benefited." However, the New Mexico Court of Appeals rejected this analysis because there was no income or dividends, the corporation was chartered without capital stock, and the corporation's purpose was not profit so that any benefit conferred upon its members was "wholly irrelevant." As we see it, a third position seems worthy of consideration: some benefits to members are not, prima facie,
evidence of profit, as of course salary is not. However, unreasonable and uncustomary benefits are, because they are but a different form of what in effect amounts to sharing of profit.

An example of out-of-line salary seems to be provided by a prepaid health plan contractor who employed a physician as plan administrator at an annual salary of $120,000 plus expenses. The contract with the physician read:

"Employer recognizes employee is involved in other medically related ventures such as inhalation therapy contracts and other nonmedically related business ventures. These ventures shall at all times remain under the strict control and ownership of the employee."

That one can establish what reasonable and customary salaries are is illustrated by court cases which have on a number of occasions disallowed salaries and fringe benefits in part because they failed to satisfy criteria of reasonableness. While the only cases we have come across deal with profitmaking corporations, we see no reason the same procedures may not be applied to not-for-profits.

The impact of total Medicare participation is of great importance to the committee because providers/suppliers operate on behalf of different type health facilities.
HIGHLIGHTS

1. The table below shows the changes in the number of providers/suppliers of services participating in the Medicare program between June 1974 and June 1975. Figures are shown separately for each type of provider. The number of beds located in facilities are also shown, where applicable.

<table>
<thead>
<tr>
<th>Type of provider</th>
<th>Facilities</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals 1/</td>
<td>6,733</td>
<td>6,721</td>
<td>6,707</td>
<td>6,727</td>
<td>6,773</td>
</tr>
<tr>
<td>Short-stay</td>
<td>6,102</td>
<td>6,095</td>
<td>6,084</td>
<td>6,075</td>
<td>6,107</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>54</td>
<td>52</td>
<td>45</td>
<td>44</td>
<td>43</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>357</td>
<td>356</td>
<td>358</td>
<td>375</td>
<td>385</td>
</tr>
<tr>
<td>Other long-stay</td>
<td>218</td>
<td>218</td>
<td>220</td>
<td>233</td>
<td>238</td>
</tr>
<tr>
<td>Skilled nursing facilities 1/</td>
<td>3,952</td>
<td>3,813</td>
<td>3,892</td>
<td>3,890</td>
<td>3,932</td>
</tr>
<tr>
<td>Home health agencies</td>
<td>2,248</td>
<td>2,237</td>
<td>2,254</td>
<td>2,262</td>
<td>2,262</td>
</tr>
<tr>
<td>Independent laboratories</td>
<td>3,029</td>
<td>2,952</td>
<td>2,994</td>
<td>3,024</td>
<td>3,048</td>
</tr>
<tr>
<td>Outpatient physical therapy</td>
<td>116</td>
<td>108</td>
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<td>886,187</td>
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1/ Excludes Christian Science sanatoriums.

2. Between June 1974 and June 1975, the number of participating hospitals registered a net increase of 40, while the number of beds decreased by 3,300. Beds in psychiatric hospitals continued to decrease substantially--a net loss of 16,700. Short-stay hospitals increased by 3 but showed a substantial gain (19,300) in the number of certified beds. Net losses of 20 skilled nursing facilities and 6,500 beds were recorded between June 1974 and June 1975. Participating home health agencies showed a net decrease of 6, while the net number of participating independent laboratories rose by 19.

3. In June 1975, 176 hospitals were certified on an interim basis to provide kidney transplants. In addition, 607 hospitals and 136 free-standing facilities were authorized to furnish renal dialysis services. The number of facilities approved for kidney transplant and/or renal dialysis services by administrative region are shown below.

<table>
<thead>
<tr>
<th>Region</th>
<th>Hospital based Transplant facilities</th>
<th>Dialysis facilities</th>
<th>Free-standing dialysis facilities</th>
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<tr>
<td>Philadelphia</td>
<td>28</td>
<td>87</td>
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<tr>
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4. Detailed State data on the number of providers/suppliers of services are shown in general tables 1 and 2.
Table 1.--Number of participating hospitals and beds, by type of hospital, region, and State, June 1975--continued

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<th>Region and State</th>
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<th>Other long-stay</th>
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Table 2.--Number of participating skilled nursing facilities and beds, home health agencies, independent laboratories, outpatient physical therapy, and portable X-ray services, by region and State, June 1975

<table>
<thead>
<tr>
<th>Region and State</th>
<th>Skilled nursing facilities</th>
<th>Home health agencies</th>
<th>Independent laboratories</th>
<th>Outpatient physical therapy</th>
<th>Portable X-ray</th>
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</table>
Table 2.—Number of participating skilled nursing facilities and beds, home health agencies, independent laboratories, outpatient physical therapy, and portable X-ray services, by region and State, June 1975—Continued

<table>
<thead>
<tr>
<th>Region and State</th>
<th>Skilled nursing facilities</th>
<th>Home health agencies</th>
<th>Independent laboratories</th>
<th>Outpatient physical therapy</th>
<th>Portable X-ray</th>
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</table>
Table 2.--Number of participating skilled nursing facilities and beds, home health agencies, independent laboratories, outpatient physical therapy, and portable X-ray services, by region and State, June 1975--continued

<table>
<thead>
<tr>
<th>Region and State</th>
<th>Skilled nursing facilities</th>
<th>Home health agencies</th>
<th>Independent laboratories</th>
<th>Outpatient physical therapy</th>
<th>Portable X-ray</th>
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</thead>
<tbody>
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<td>Number</td>
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Table 2.—Number of participating skilled nursing facilities and beds, home health agencies, independent laboratories, outpatient physical therapy, and portable X-ray services, by region and State, June 1975—Continued

<table>
<thead>
<tr>
<th>Region and State</th>
<th>Skilled nursing facilities</th>
<th>Home health agencies</th>
<th>Independent laboratories</th>
<th>Outpatient physical therapy</th>
<th>Portable X-ray</th>
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<td>Number</td>
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<td>3,100</td>
<td>22</td>
<td>60</td>
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</table>

(“—” indicates zero or less participation.)
Some administrators claimed that fees are a reflection of their business success or lack of it and for that reason the fees are unstable.

Raymond Bishop of Alaris Home Health explained his "business venture" in the following terms: The home-health care business is unique and distinctive. It was sort of a mastonian call. We have been giving quality service, and it had certainly perpetuated itself in referrals. I would like to say something about—something was said about the expenditure of visits. To my knowledge we have not had any patients who have run out of visits. We have on the other hand assisted the health department in Pinellas County especially in the teaching of new diabetics because their budget would not permit them to send nurses out. We have used their personnel to assist as in teaching of our home-health aides in the care of patients. We have worked cooperatively with the Pinellas County Health Department.

Our rates are as follows presently: Skilled nursing $35 per visit; home-health aide $15 per hour; speech therapy, $20; all therapeutic services you will notice is $20 per visit.

At the early stages of the agency's existence we charged $18.50 for skilled nursing, and with the mileage involved many times and the cost, we could not make it. So we had to go up to the $35.

Mr. Bishop's outlook on his future business expansion was characterized as "bright." Alaris agencies already exist in three different counties in Florida.

Senator Chiles drew the careful line of distinction that made this "business" unique in this exchange with Dr. Samuel Leone during the subcommittee hearings in Miami on May 5, 1975:

Dr. Leone. Yes, I refer them (patients) to my agency, as I would eat in the same restaurant that I own if I know what I am doing is good.

Senator Chiles. Well, when you eat in a restaurant that you own, you are not using taxpayer dollars.

Mr. Paul Meyers expanded on that particular aspect of the "business" when he stated:

There is one further aspect of the operations of the private not-for-profit home-health agencies that should be clearly recognized because of its impact on the medicaid program. These agencies accept only medicaid patients and have no other source of revenue than the medicaid program. Additionally, there is literally no equity capital involved and only minimal physical assets owned by the provider. When these three facts are considered together it becomes evident that at all times the allowable reimbursement from the medicaid program and all of the costs being incurred by the home-health agency must be in exact balance. An underpayment by the program is intolerable to the provider since he will not receive sufficient revenue to cover costs. An overpayment is intolerable to the medicaid program since the only source of money to repay the overpayment is the medicaid program itself. In other words, future payments for covered services are used to recoup past payments for noncovered services or costs. Regulations or possibly legislation are needed.
ILLEGALITIES AND IRREGULARITIES

The most revealing testimony concerning outright fraud and illegality was dealt with in the first of the State hearings in Tampa, Florida on April 12, 1976.

Two excellent investigative reporters from the Tampa Tribune submitted testimony in the form of news articles as well as orally. The news items carried prime examples of the type and kind of fraudulent action that Mr. Etzioni and Ms. Dety wrote about in their report.

Specifically, Dan Ruth and Charles Hendrick were concerned about (1) kickbacks and referral fees being paid to doctors out of medicare funds and (2) obvious lack of controls on medicare funds to home-health agencies.

Ruth and Hendrick clearly outlined the problems in news articles published August 24 and 25, 1976.

KICKBACKS AND REFERRAL FEE PAYMENTS

The subcommittee explored the evidence accumulated by Tampa Tribune reporters Dan Ruth and Charles Hendrick. The newsmen testified before the subcommittee in Tampa on April 12, 1976.

After a month-long investigation, the reporters issued their first story on August 24, 1976. The first story contained the following allegations:

(1) That thousands of dollars in medicare funds had been paid as "referral fees" to osteopaths and chiropractors through three Tampa-based medical-laboratory firms in violation of medicare regulations.

(2) That some osteopaths and chiropractors interviewed by the reporters candidly called the payments "kickbacks" or "fee-splitting," a practice banned by medicare law under certain conditions.

(3) That the three firms involved—Feegal and Howard Doctors Laboratories, Inc., F. & W. Corp. and Medicine In Motion—all had an interlocking link—Ernest A. Winkle. It was alleged that Winkle was president of Medicine In Motion, Secretary-Treasurer of F. & W. and a top level employee of Feegal and Howard labs.

(4) That Mr. Winkle's background in other States, should have disqualified him from participating in the medicare program. Medicare investigators had investigated Mr. Winkle's previous involvement in New York and New Jersey where "gross abuse" had occurred in firms operated by Mr. Winkle during the period 1972-1974.

The reporters were concerned that medicare officials had no continuing link with persons who left one geographical area, under a cloud of suspicion, only to turn up in another area to revive the same scheme.

It was reported that the medicare officials in the New York area were proud that Winkle had been forced to leave, even without prosecution.

The Tribune investigation also learned, at that time, that:

(1) The U.S. Department of Justice and the General Accounting Office have been brought into the investigation of the three firms by medicare, and a Federal grand jury may be asked to review evidence in the case.

(2) Contrary to medicare regulations, medical lab work for chiropractors has been billed to medicare.

(3) In at least one instance, respiratory function tests were performed by F. & W. Corp. employees on about 60 nursing home patients without consent of their doctor.

(4) X-ray machines rejected by a State examiner, as not fit for use in the State of Florida, were used by Medicine In Motion employees examining patients and employees of nursing homes.

(5) Medicare officials have made demand on Winkle, as president of Medicine In Motion and Integrated Health Services, Ltd., for repay-
ment of medicare of $84,101 paid the firms in New York and New Jersey in the period 1973-74.

(6) Medicare officials stopped payment on $120,000 in claims by the two firms operated by Winkle in New York and New Jersey after medicare agents said they found "gross abuse" in operations of the firms.

The Tribune story further stated: "Osteopaths and chiropractors who said they promised payments or who had received them called the referral plan 'an attractive provision.'"

Basically, the plan worked thusly: The agency of the firm involved contacts the doctor, the doctor upon assuring the patient that no cost is involved, obtains the patient's signature on a medicare claim form. The doctors would then be free to order as many clinical tests as desired without concern for cost. All the billing would be handled by the firm. The firm then bills medicare for cost plus profits and submits payments to the doctors to cover their services to the patients.

The plan was called a referral fee program and was called legal by representatives of the firm. The subcommittee investigators presented the plan to several doctors who said that they were very sure that it was a kickback and as such was disallowed under section 1877(c) of the Social Security Act.

Section 1877(c) is as follows:

Whoever furnishes items or services to an individual for which payment is or may be made under this title and who solicits, offers or receives any: (1) Kickbacks or bribes in connection with the furnishing of such items or services or; (2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services—shall be guilty of a misdemeanor.

The penalty for this offense is a fine of up to $10,000 or 1 year in jail upon conviction of the misdemeanor.

The medical doctors, osteopaths, and chiropractors were led to believe that they would receive rebates from the labs amounting to twice the standard fee because of the high rates the labs would charge medicare.

From early 1974 until mid-1975 the three firms submitted medicare claims totaling approximately $287,000.

On August 22, 1976 the followup story by Tribune reporters stated that at least 21 Tampa area medical men were involved in the referral fee scheme. Although some of the chiropractors, osteopaths, and medical doctors had questions about the ethics involved in the scheme, they regarded it—the referral fee program—as a way to bum to patients and the elimination of dreaded paperwork by the doctors.

In the continuing investigation the reporters discovered that the firms who3ached the scheme for referral fees had also participated in an unauthorized testing of patients at a Tampa nursing home. The patient's doctors were not informed of the test, did not desire the test for their patients and did not authorize the test.

The unauthorized testing scheme produced gross billings to medicare for approximately $46,270.

The intermediary could offer little explanation as to why the inhalation plan was adopted.

The scope of the investigation by the reporters expanded to include home health care agencies. The focus on home health care agencies involved the great degree of variance on charges per visit between the public and private agencies.

The problem concerning overutilization in the State was vividly demonstrated by figures submitted in the November 30, 1976 article in the Tampa Tribune.

Figures show for 7 months of this year that 37 nonprofit firms made 356,938 visits to 29,120 patients at a cost of $8.1 million.

The 28 visiting nurses associations made 94,653 to 15,220 patients at a cost of $13.5 million.

The subcommittee's random survey showed that VNA's and county nurses averaged about 5.9 visits per patient while the private nonprofit home health agencies averaged 13.1 visits per patient. This problem will be explored later in the report.

The Tampa Tribune investigation added fuel to the investigation started by the subcommittee, probably prompted action by the medicare investigators and led to grand jury action by the local U.S. attorney and other officials.

Because similar allegations concerning referral fees, rebates and kickbacks were raised in other sections of Florida as well as other sections of the country, the subcommittee felt the report from articles appearing in the Tampa Tribune would be of immeasurable illustrative value.

Allegations surfaced in Miami, Cocoa Beach, Fort Lauderdale, West Palm Beach, and Hollywood. Nationwide, the allegations have surfaced in Los Angeles and Chicago, as well as other areas.

Subcommittee investigators were able to answer inquiries from news reporters and law enforcement personnel which could be held in their successfully apprehending persons engaged in this practice.

In testimony submitted in Tampa, Mr. Richard gave a breakout of the cases under investigation by the Bureau of Health Insurance regional office:

Information on investigative activities in program evaluation

I. Total fraud cases, all categories: regionwide, 463; Florida, 273; percent of region, 58; Miami, 118; percentage of Florida, 62.

II. Cases identified as having investigative potential: regionwide, 417; Florida, 85; percent of region, 58; Miami, 56; percentage of Florida, 86.

III. Cases actively being investigated: regionwide, 18; Florida, 11; percent of region, 71; Miami, 10; percentage of Florida, 77.

IV. Cases pending with U.S. attorney for criminal prosecution: regionwide, 29; Florida, 11; percent of region, 58; Miami, 6; percentage of Florida, 55.

V. Total fraud receipts in calendar year 1975: Region wide, 739; Florida, 413; percent of region, 57; Miami, 1; percentage of Florida.1

1 Figures not available.
VI. Number of investigators in region IV and State assignment:

- Miami: 2
- Remainder of Florida and North Carolina: 1
- Georgia and Mississippi: 1
- Alabama and South Carolina: 1
- Tennessee and Kentucky: 1

Total: 6

Note: In commenting on the volume of work these six investigators do, you should note that the cases pending with U.S. attorneys are acting litigation cases and consume a professional portfolio of each investigator's time. It is not unusual for a program integrity specialist to work full time on one of these cases for several weeks—be the exclusion of everything else.

Overutilization—Abusive practices in home health care agencies (private, nonprofit)

The problem of overutilization was perhaps the most common abuse cited by home health care personnel in investigative interviews as well as the practice perhaps most difficult to substantiate according to Mr. Paul Meyers, vice president of Blue Cross of Florida. (P. 7, 3d paragraph.)

“There is competition for patients and we have heard many allegations concerning how patients are gotten: We have heard of allegations about the solicitation of doctors and hospital personnel for patients.”

The most illustrative testimony concerning the problem of “overutilization” was submitted by Ms. Delores Wrenland, representative of the State Department of Health and Rehabilitative Services.

Senator Chiles, members of the committee, and others, I wish to express my appreciation for the opportunity to address you.

Prior to the enactment of the Title XVIII Medicare Act, home health services were delivered almost exclusively by voluntary or official nursing agencies and sometimes a combination of both. Services were provided to those who needed them, were known or referred to the agency, and who had medical supervision. The need for care was determined mutually by the family or patient, the nurse, guided by agency policy in keeping with nursing privileges and standards, and the attending physician. Costs were met in voluntary agencies by fees, graded according to the ability to pay, contracts with third party payers, e.g., Veteran's Administration, and contributions and endowments. Tax money supported these services in official agencies.

The philosophy of these agencies focused on self-help whenever safe and feasible. There were goals and services related to restorative and educational measures for patients with a potential for improvement and maintenance of a high level of self-help as long as possible for those patients with progressive pathology. Families were expected and taught to provide care between nursing visits and take over full care when competent to do so. This philosophy persists today and is incorporated in the standards for nursing practice.

The Medicare regulations precipitated some difficulties for these agencies in their failure to reimburse agencies for long-term subacute care which constitutes a fair portion of the caseload. However, the popular notion that all health services for the elderly would be covered resulted in drastic cutbacks in community contributions. Smaller agencies could not continue to provide services to those unable to pay full fees and were not eligible for Medicare. Several went out of business or combined with Health Departments.

During the past five years we have witnessed the decline in the numbers of certified voluntary and official home health agencies and the growth of private non-profit agencies. In 1970 there were 41 County Health Departments certified for Medicare
reimbursement. 12 Visiting Nurse Associations, and 6 private non-profit home health agencies who limited their caseloads to Medicare eligible patients. In 1974, there were 22 county health departments, 6 Visiting Nurse Associations, and 56 private agencies. When I last checked a few weeks ago, there were 70 or more private agencies (Attachment 1).

Complaints began to come in to the Division of Health (previously known as the Health Program Office) and Public Health Nursing Section regarding the business practices of the private agencies. Complaints generally related to solicitation of patients and physicians, abandonment of patients after benefits were exhausted or referral of these patients to a voluntary or public agency for free care, and that patients and families were not taught nor encouraged to assume responsibility for their own care.

Comparative studies showed that voluntary and official agencies made an average close to half the number of visits made by private agencies. Despite the fact that professional nursing visits outnumbered non-professional visits by 5 or 6 to 1, while the private agencies were closer to 1 to 1, the costs per visit by the private agencies were higher (Attachments 1, 2 and 4).

Legislation to develop, establish, and enforce minimum standards for safe and adequate care of persons receiving health services in their homes under plans of treatment established by the attending physician, was enacted by the 1975 legislature. Rules to implement this law were developed by the Public Health Nursing Section with the advisement and assistance of representatives of each type of provider agency as well as other involved or related state agencies. The rules are in the final phase of promulgation.

I will highlight those sections of the rules that received the most attention or needed explanation. First, we had to differentiate the services and training of the home health aide from the homemaker. Misconceptions were prevalent and there was some resistance to limitations of the functions of these two non-professional workers.

Secondly, the part-time intermittent characteristic of home health services in the definition was challenged by agencies that provide continuous care in the home. The legislation does not address services provided by private duty nurses wherever they are performed. Agencies that provide continuous aide or homemaker services can contract with licensed home health services agencies for professional care and supervision if desired, if they wish to participate as a licensed home health agency then they are required to comply with the regulations.

Qualifications of staff and ratios between supervisory, staff nurses and non-professional personnel were established as minimum reflections of existing patterns in Florida and nationwide. We require that the executive director have at least 3 years executive or supervisory experience in a health agency. A nursing supervisor shall be responsible for no more than 11 full time or 18 part time personnel. There is a maximum ratio of five non-professional to one professional worker.

Other efforts to assure the safety, quality, and continuity of care are demonstrated in those rules defining policies for the acceptance of patients, plan of treatment, plans for termination of care, and utilization review.

Licensure procedures include an on-site survey to ascertain compliance with the rules, evidence of fiscal responsibility, and a certificate of need from the statewide health planning council. Separate licenses are required for each county in which an agency operates and for autonomous subdivisions. We are anticipating enabling legislation to allow statewide health planning councils to issue certificates of need.

Enforcement procedures include consultative services, surveys, inspections of records and patients, annual reports, renewal of applications, and denial, suspension and revocation procedures.

Throughout the rules, we have attempted to avoid conflict or contradictions with the Medicare regulations while remaining responsive to the needs of patients in relatively stable dependent conditions. The amount and frequency of professional services is often diminished in these circumstances. However, restorative, educative and protective measures must be incorporated in maintenance care during these stabilized periods. Chronically ill and aging persons receiving health services in their homes are the most vulnerable of all health care consumers. We hope that the Home Health Service Rules will protect these persons from abuse and exploitation and assure them of safe, competent, necessary care.

However, these rules will not do much to assist those agencies who offer care to all those who are referred despite ability to pay. Factually their status now will be worsened since we now have close to 60 proprietary agencies awaiting licensure in addition to the non-profit agencies. Licensure opens the door to Medicare certification. Given the present numbers we will have about 150 agencies taking only patients with a full payment. The non-profit agencies follow the pattern set by the non-profit proprietary agencies taking part rate and free patients. If agencies they will cluster in the southeast and Tampa Bay area of the state, creating geographic maldistribution as well (Attachment 5).
If home health services are to be a reasonable alternative to institutional care then a system that reimburses for long term care for the chronically ill needs to be worked out. Standards of care to meet the nursing needs of such persons are already established by the American Nurses Association. Reimbursement for the services of certified nurse practitioners and clinical nursing specialists as co-managers of patient care with medical endorsement should be instituted.

Thank you for permitting me to address this committee today. I join you in seeking the improvement in the delivery of health care.

Attachment 1

Comparative Growth Rates of Certified Home Health Services Agencies from 1970 - 1975

<table>
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<tr>
<th>Year</th>
<th>Proprietary</th>
<th>Voluntary</th>
<th>County Health</th>
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<tr>
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<td>41</td>
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<td>6</td>
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<td>10</td>
</tr>
<tr>
<td>1975</td>
<td>22</td>
<td>9</td>
<td>56</td>
</tr>
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57 Proprietary Agencies including branches requesting licensure in 1975.

- Proprietary Agencies
- Private Non-Profit Agencies
- Voluntary Nursing Agencies
- County Health Departments
COMPARISON OF AVERAGE NUMBER OF VISITS TO MEDICARE PATIENTS BY SELECTED HOME HEALTH AGENCIES

COMPARISON OF RATIO OF RN VISITS TO HOME HEALTH AIDE VISITS BY TYPE OF AGENCY
Attachment 4

Comparison of Average Cost per Visit by Registered Nurses and Home Health Aides in Selected Home Health Agencies

- Home Health Aides are used for lengthy visits (upto 3-4 hours) in this county.

Map of Florida showing the location of Home Health Agencies.
Douglas Richard of the Bureau of Health Insurance, Atlanta regional office, explained how the program operates and what conditions should exist in order for service to be rendered. The pertinent part of Mr. Richard's testimony follows:

The Medicare Act specifies that these services can be furnished to homebound individuals under the care of a physician, by a home health agency under a plan established and periodically reviewed by a physician. These services are to be provided generally on a visiting basis in a place of residence used as such individual's home.

Home health services covered under medicare are furnished by home health agencies which must meet specific requirements of the act to participate in the program. The act defines a home health agency as a public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services.

To be eligible for coverage for home health care under medicare a person must be essentially confined to his residence, be under the care of a physician, and need part-time or intermittent skilled nursing service and/or physical or speech therapy. The need for such care must be prescribed by a physician. If these requirements are met, a person is also eligible to receive other covered home health services. To qualify for home health care benefits under hospital insurance (part A of medicare), a person must have been in a hospital for at least 3 consecutive days prior to entry into home care.

The care to be provided must be for a condition for which the person received services as a bed patient in the hospital and must be provided within the year following hospitalization or after a covered stay in a skilled nursing home following such hospitalization. Under part A, a person's coverage is limited to 100 home health visits in that 1-year period after the start of one spell of illness and before the beginning of another. A person may qualify for home health care benefits under medical insurance (part B of medicare), without prior institutionalization provided certain conditions are met. In such cases a person is limited to 100 home health visits in any one calendar year.

The Bureau of Health Insurance (BHI) of SSA is responsible for establishing policy, and developing operating guidelines, and in collaboration with the Public Health Service, for prescribing standards for the participation of home health agencies under medicare. SSA has entered into agreements with public and private organizations and agencies to act as fiscal intermediaries in the administration of home health care benefits under part A and part B. Among other things, these fiscal intermediaries are responsible for (1) making determinations as to the coverage of services and making payments for services provided, (2) communicating to home health agencies information or instructions furnished by BHI and serving as a channel of communication between home health agencies and BHI, and (3) assisting

home health agencies in establishing and applying safeguards against unnecessary use of services under the program. A hospital coordinator and a speech therapist who have had extensive experience in various home health agencies, related the most common abusive tactics to the subcommittee staff.

Speaking during an interview session immediately after the Miami hearings, the two home health agency personnel agreed that the following abuses were fairly common in many agencies and have generally gone undetected and uncorrected:

One: Home health agency patients are often kept longer than needed—patients given 6-day-a-week care and almost never decreased, causing the patient to become dependent on the agency. It becomes difficult for the home health agency to pull out even when skilled care is no longer needed.

Two: There have been instances where registered nurses in diabetic cases will visit for several weeks even if there are no complications—never utilizing teaching and fast rehabilitative practices. Again, the "maximum visits code" is practiced.

Three: Doctors on the agency board have been known to change diagnoses and often order prolonged care for patients. One patient (Broward County) was admitted in May for hypertension, was seen two times a week and never had any specialized care. The same patient was still being seen in July for osteoarthritis and internal bleeding.

The physical therapist refused to give free hotpack to a patient bleeding internally so the doctor changed the diagnosis and order so the registered nurse would see the patient 3 times a week and initially for 4 days. This doctor also referred patients for chronic problems: One patient was receiving physical therapy, his wife wanted it so this doctor ordered physical therapy for the wife who had leg deformities for over 20 years.

Four: The executive director often overrides professional personnel in their judgments of what is indicated. The director-agency in Broward County—would tell the staff to add vital signs, monitoring, and other services and could not decrease patient care without his approval. The executive director of this same agency has no medical background.

Five: The executive director has told registered nurses to change notes and add orders; that is, monitor diet, to the plan of treatment which is mailed to the doctor to sign. The director then uses the excuse that the doctor signed it so we are covered.

Patient charts were changed with liquid paper as needed. Xeroxed copies sent to Jacksonville were undetected as liquid paper not visible on copy.

Constantly personnel are told to stretch the limit: One owning doctor told a staff conference "have to judge a little." Staff are told in agency meetings: "Everyone rips off medicare" and felt there was nothing wrong with that. Staff is often told it's very important to use the "proper wording of medicare." Staff will pay.

Often when visits are nearing the 200 mark, the administrator will arrange to have patients readmitted for 5 days so that care can be resumed.

1 From testimony by Mr. Douglas Richard of the Bureau of Health Insurance.
In initial stages at Broward, a patient was admitted for physical therapy to receive hotpacks—there was no physical therapist at that time—the director of nursing instructed staff nurse to write a visit that she put hotpacks on the patient. No visit was ever made by a registered nurse or physical therapist and medicare was billed for the treatment. Aides instructed to spend more time than actually needed—if only one-half hour is needed told to say 1½ hours.

Told to "stretch the limit."* A patient discharged after 6 visits and no further problem told it doesn't look good.

On a patient basically constipated, the doctor ordered an enema. The director of nursing instructed the registered nurse to chart high colonic enema given because medicare will cover that.

The end product of overutilization was spelled out by the panel of executive directors of visiting nurses associations in testimony in Miami as they told of having to take on patients whose "visits" had been used up and had to depend on the public agencies for assistance. The subcommittee found no reason to believe that the total number of visits authorized by medicare—200—was inappropriate but rather that the patient was often "exploited" in the use of visits simply so that the agency could attain the maximum number of visits authorized by law.

The letter submitted in evidence at the hearings in Tampa on April 15, 1976, typifies the problem that overutilization often brings:

Mr. [Name],

Bureau of Health Insurance,
Atlanta, Ga.

Dear Mr. __________: I appreciate your call last Friday and enjoyed talking with you. Per request I am enclosing descriptions of some of the events that you transcribed which you may find of interest.

I am afraid that some of the impact will be lost without a personal interpretation. As a matter of course, these are copies as I collected them with only a few comments added to aid in clarification.

The patterns we have seen in dealing with another home health agency have been primarily (1) their aggressiveness, in securing patients by billing ever present in hospital clinics, on hospital wards, and in physicians' offices even to the extent of opening records on known VNA patients and (2) the amazing accuracy with which a patient's maximum rehab potential is forecast which almost without fail parallels the exhaustion of MCA benefits on a 2½ to 3 month period. An excellent example of course is (patient) whom we discussed, who received 39 visits in August having received 97 MCA visits through 31 August and miraculously improved so that her record could be closed on 9 September by telephone. You may wish to contact manager of the Medical Division of J. B. Hickey. His phone number is ______.

When I receive more information which I feel may be of interest to you, I'll send it along. In the meanwhile I hope you find the enclosed of at least some help.

Sincerely,

(Mrs.) JUDITH TRAVIS, R.N.

Senator Chiles inquired as to the frequency of that problem—overutilization—for the public agencies during hearings in Miami:

Senator Chiles. Have you all had any patients referred to you that had expended as charitable patients, their 200 visits expended under medicare?

*From interview with home health agency personnel in Broward County and Dade County by subcommittee investigators.
intake. The E.D. was not a registered nurse and frequently did this—actually taking verbal phone orders from doctors.

(9) In several instances, the doctor will tell the registered nurse—will sign anything sent to him after the nurse sees the patient. He relies on the registered nurse to do a fair evaluation—if care is not indicated, the orders are sent to the doctor—including monitor vital signs, medicine, and home-health agencies.

(10) The office registered nurse will often question the doctor if the patient has hypertension or diabetes or heart disease if one of them is present, the registered nurse will tell the doctor “we can see the patient for this” regardless if the problem is chronic. Long standing diabetes cases are picked up to monitor diet and medicine. Stabilized hypertension and heart disease are picked up to monitor vital signs and medicines.

(11) Patients that are not homebound are seen for therapy at home after it is suggested to them if they would like therapy at home rather than going out.

Examples:

(a) Patient with diabetes for several years and controlled hypertension controlled was admitted after hearing a speech by the agency. Patient's son wanted someone to stay with the patient for an hour every day for a while, while his wife was in the hospital. The registered nurse went to monitor medicine, the aide went five times a week after several days, the son's wife came home and he canceled care—patient no longer needed it.

(b) A patient with diagnosis of acute arthritis had a CVA 3 years ago was explained to the office that homebound was a requirement. This patient went out for speech and physical therapy. The admitting doctor—connected with the agency—ordered passive range of motion. It was explained that this was not covered under medicare—the doctor changed the orders and insisted on the admission. The patient was receiving speech therapy for the primary diagnosis of arthritis—was not homebound and preferred to get therapy at home rather than go out—also it was free this way.

(c) The order was received with diagnosis of arthritis. The executive director changed the diagnosis to acute arthritis so medicare would cover. This patient's doctor is also on the review committee of the agency—several days later his diagnosis to degenerative arthritis with acute exacerbation and needs physical therapy for ambulation purposes. This patient was not homebound—took the bus weekly to see the doctor—this patient seen five times weekly for physical therapy.

(d)chart backdated so they will be eligible for plan “A.” If patient can be admitted within several days of the 14 day period, chart can be backdated—explained to family they can have 900 visits.

(e) Patients seen without receiving orders from physician. The field nurse calls the doctor with a question and he wants to know what you are seeing the patient for—he never gave orders.

(f) The nurse is told by the executive director to always add vital signs to plan of care so there will be a skilled care.

(15) After a doctor is appointed to the board, his patient referrals start to come in rapidly and often with little thought given to eligibility.
One doctor ordered care on a patient who had a Foley catheter for years—he ordered special care—the office was told not to see the patient at certain times because the patient went out to eat and wouldn’t be home then.

This same doctor ordered registered nurses daily on another catheter patient and also physical therapy. Also ordered another patient to see the patient. Made sure patient at certain times because the patient went out to eat and won’t be home within 1 day of his board appointment.

On referrals, the registered nurse in the office or administrator are sure to speak to the doctor or his nurse and suggest some means to see the patient.

**Discharges**

The order is constantly given to home health personnel not to discharge the patient too soon as Medicare will get suspicious.

One agency will not allow the registered nurse to call the doctor regarding a discharge—the administrator will review the chart and decide when the patient should be discharged. This administrator (BHHA) felt there were too many discharges in 1 week—she told the registered nurse when a doctor orders a discharge she should not write discharge patient—she should write “doctor is suggesting discharge in future.” She, the administrator, would explain to the doctors that medicare requires the care to be taken away slowly.

If there is an end to the skilled care and the home health agency is still going in—the care must continue until the side can be gradually decreased.

Some patients are kept so long that doctors call and ask why the patient is still being seen or concerned patients dissemble the care themselves.

Often care is prolonged for discharge planning—started too late—care then extended so a patient turnover to a custodial agency can take place.

**Audit abuses**

Personnel at several home health agencies identified problems dealing with improper auditing procedures used by private home health agencies.

Those problems were: (1) A complete review and rewriting of doctors’ orders on patients to conform to actions already taken that the doctors did not authorize; (2) persons—usually registered nurses—who never saw the patients gave detailed instructions or filled out charts themselves to reflect skilled nursing care when unskilled care was, in fact, administered to the patient; (3) nurses were instructed to fill in items that were “medicare covered” on all visits made to patients when, in fact, some visits would not have been covered by medicare; and (4) some visits are upgraded to reflect different time spent on a visit or one visit of 1 hour is reflected on two different days although only 1 day was actually spent in the patient’s home.

**Reasonable cost**

The comparison between visiting nurses associations and private home health agencies in salaries, pension plans, and visit charges was

raised anew the allegation that the private agencies were abusive in their treatment of total cost.

Mr. Richard’s testimony dealt with the special problems encountered by the Bureau of Health Insurance when home health agencies are established:

**Interim rates and periodic interim payments**

When a new HHA is established it submits a project budget to the intermediary. Based on this and estimated visits to be made, a cost per visit rate is established. Of course, if the budget contains unreasonable costs which are not reduced, an excessive interim cost per visit rate may be set and, as claims for visits are paid, overpayments can occur. Therefore, it is important to examine the projected budgets closely, rather than waiting until cost reports are filed and audited at the end of the year.

In recognition of problems in this area, BHCO issued an alert dated February 12, 1976, to all intermediaries (attachment 2) to carefully review the reasonableness of projected overhead costs. The teletype message requested “that intermediaries bring to bear an immediate careful scrutiny of such reimbursement” with regard to newly established HHAs.

The alert also directed close intermediary examination of requests by new HHAs for periodic interim payment (PIP). PIP (periodic checks mailed to an HHA based on the interim rate established and on the projected medicare utilization) has the potential of causing overpayment to new HHAs where it turns out that the estimated costs are unreasonable and/or their projected volume does not materialize. In other words interim rates and PIP require close monitoring, rather than expecting the cost report and actual medicare utilization to coincide with what was estimated.

The reasonableness of administrative expenses claimed by “100 percent medicare” HHA’s is one of the more serious issues uncovered. For example, the RO found three members of a family-operating two HHA’s and claiming salaries from both facilities (including deferred compensation of 25 percent) totaling over $118,000 per year. We have instructed the intermediary not to settle the cost report for this provider without clearance from us.

When the RO became aware of the high amount of some of the administrative salaries, all intermediaries were requested to send a copy of the most recently audited cost report for each HHA they serve. Because of the four different methods under which cost reports of HHA’s may be filed, and the fact that all cost items are not reported identically within the particular line items of a cost report, meaningful comparisons were not possible. Therefore, in late October the RO designed a survey form and requested intermediaries to survey all Florida HHA’s with respect to salaries and deferred compensation.

Preliminary analyses of the survey data disclose a wide salary range in “nonprofit” HHA’s in Florida. Administr-
tions' salaries (adjusted to a 40-hour week) vary from $15,500 a year to $40,000, with an average of $25,790. Executive direc-
tors vary from $15,000 to $40,000 (average $24,790). Nurse-
directors vary from $10,000 to $20,000 (average $13,114). Administra-
tive assistants vary from $8,400 to $17,114. Not only do specific salaries vary, but also the number of major administrative positions (and costs); for example, one HHA has five key positions paid a

total of $136,533; another has three receiving $57,200. Deferred compensa-
tion plans also varied from 0 to 25 percent of yearly salary. This compensation and "headed" does not always seem to be related to relative administrative responsibilities.

The RO survey results are being used to develop guidelines regarding salaries and deferred compensation similar to what is done with respect to owner's compensation guidelines for proprietary hospitals and SNF's. When completed, they will be forwarded to the BHI central office for review prior to implementation.

However, even with the compensation guidelines, the RO has no illusions that the problems end there. For example, when unreasonably high salaries paid by one HHA were uncovered, at RO direction the intermediary made large cost reductions. In October 1975, the RO notified the intermediary to use the same cost reduction rationale when determining reasonableness of cost claimed by other HHA's. One HHA attorney has requested and received copies of the RO salary surveys. In other words, indications are that cost reductions will be rigorously appealed. This appeal will be heard in April.

The RO has also been concerned about the cost of management services furnished by some organizations. Central office is working on cost reimbursement policies applicable to management services. In the meantime, the RO is following up on indications that one organization may not be furnishing all the information is also being obtained on the fees and services of an attorney who is setting up and selling HHA's in Florida.

The most recent action on administrative salaries and pension costs occurred on March 25, 1976, when the Atlanta RO from intermediaries servicing Florida and from their home offices. Representatives from Aetna Life and Casualty, Blue Cross of Florida, Travelers Insurance Company of America, Blue Cross of America, the Division of Direct Reimburse-
ment of BHI, and the regional office met in Atlanta. The results of the recent RO salary survey of Florida HHA's, to exchange experiences, and to establish some degree of uni-
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*Cost per visit*
The subcommittee tried to determine why the cost per visit was so much higher among private, nonprofit agencies than among the public agencies. During the interviews that were held by subcommittee investigators, the one theme seemed to be that overhead cost by the private agencies justified higher charges per visit. Medicare officials were somewhat reluctant to deny these charges as the private nonprofits were in accord with prices established by other private, nonprofit agencies.
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Salary ranges for administrators of private nonprofit home health agencies were from $13,500 yearly to $69,400. The only guideline administrators had to follow was to be sure that they took in enough clients to cover their salaries.

Salary ranges for executive directors of private, nonprofit home health agencies are based from $13,500 to a high of $40,000 yearly. The projected salary for medical directors—if rates are used for a 40-hour week—would range from a low of $14,000 to a high of $60,000. Nursing directors are salaried from $13,500 to $20,000 yearly. The range for comptrollers is from $15,000 to $25,000. The range for hospital coordinators is from $12,212 to $14,080. The range for administrative assistant was from $11,500 to $20,000. For associate nursing directors the range was from $12,500 to $22,500.

One agency with approximately 100 personnel, a 25-percent pension plan paid its comptroller $20,000; administrative assistant $26,500; its office manager $26,500; its associate nursing director $14,040; its medical director $35,265; its executive director $40,000; and its nursing director $30,000. A total of $281,522 all with medicare funds.

ASSUMES WITH DURABLE MEDICAL EQUIPMENT

The abuses involving medical equipment were first brought to the subcommittee's attention by Mr. Paul Kreiner, president of Medical Home Products and Medicare Systems Consultants, of Hollywood, Fla. Mr. Kreiner illustrated the situation that has been standard operation for many durable medical equipment dealers concerning the false billing to medicare for oxygen which was not continuously supplied but continuously billed. He showed the situation that has been standard operating procedure for many durable medical equipment dealers concerning the false billing to medicare for oxygen which was not continuously supplied but continuously billed. He illustrated the situation that has been standard operating procedure for many durable medical equipment dealers concerning the false billing to medicare for oxygen which was not continuously supplied but continuously billed.

The problem of the 20 percent and the $60 deductible goes much further. Of late, through our own personal experience and the experience of others as well, more dramatic control of DME dealers by some HHA's has come to light. These HHA's have realized that there is supposedly no profit to be made in the including of DME in their plans and billing, therefore, they don't want to be bothered with the paperwork. On the other hand, many patients have become sophisticated enough to know that there should be no cost to them while nursing services are being received, so, to remain in the highly competitive market that now exists, the HHA forgives the 20 percent and frequently the $60 deductible. If the dealer refuses to go along, he gets no business from the agency. In such a case the HHA really asks the dealer to ignore the intent of the act and not to comply with regulations to bill under part B. It also, in effect, asks the dealer in profitmaking concern, to do away with 20 percent of reimbursement of allowable charges to which medicare says he is entitled. You remember, gentlemen, that DME dealers do not work on a cost-plus basis as an HHA does, but rather with charges as decided by medicare when he accepts medicare payment.

Therefore, a multistate DME company that has taken the approach of soliciting HHA business by blankly forgiving the deductible and 90 percent to all agency patients. BHI has been notified of this and has done nothing about it. The same company does other questionable practices such as oxygen cycle billing, a practice which Bob Harris well understands, and billing to intermediaries outside the patient service area—collecting incorrect rates. BHI has known of these practices for several months and has done nothing. Frustration!

We are now of Medicare's taking providers' bills which are attributable directly to a single patient, adding a markup to the providers' invoices, and submitting the marked-up figure for reimbursement to medicare. BHI in Baltimore agrees that this is wrong. Just last week I received a report that when this was turned in to the Philadelphia regional BHI office, they agreed that it was wrong, but weren't con-
concerned because the reimbursement is on cost, not submitted bills. A week before that, a BHI employee from the Atlanta region told me that he doubted that such things would ever be found on audit if the auditors were not told to look for the markups. He stated that until now they have not been instructed to look for such things. A portion of the Moreland Act Commission on Nursing Homes report, released last week, talked of “cursory” audits of medicaid nursing homes in New York. Should we assume that the quality of medicare audits of HHA’s is better considering the differences between the Philadelphia and Atlanta region statements?

CONFLICT OF INTEREST

The subcommittee explored the opportunity for abuse and over-utilization because of a doctor’s ownership and involvement with a private, nonprofit health agency.

In the Miami hearing, Senator Chiles raised the question of conflict of interest with Dr. Samuel Leone, a doctor involved with several home health agencies in south Florida.

Senator CHILES. The issue of doctors owning home health care agencies has come up. There is a feeling that when doctors own agencies, they tend to make referrals to those agencies which they own, therefore, creating a conflict-of-interest situation.

What is your response to that?

Dr. LEONE. My response is direct: I am an orthopedic surgeon. I refer my patients to the Hollywood Home Health Agency unless there is a geographic problem.

I do this because my patients need good physiotherapy and rehabilitation, and this is my forte. My physiotherapist is a registered physiotherapist, is excellent in his field. These are my patients who need this service. Rather than keeping them in the hospital at $200 a day, I can let Hollywood Home Health Agency refer them there, because I discuss with my therapist. So, what you are asking me and referring to agencies, yes, I refer them to my agency, as I would eat in the same restaurant that I own if I know what I am doing is good.

Senator CHILES. Well, when you eat in a restaurant that you own, you are using taxpayers’ dollars.

Dr. LEONE. The reason for it, as I told you, I know what my agency can do and my therapy department can do for my patients.

Senator CHILES. Is there a potential for conflict?

Dr. LEONE. Yes, I can see a potential conflict. I can see a conflict.

Senator CHILES. If we are going to allow it to happen, if we are going to allow doctors to involve themselves how do we protect the public and how do we convince the public that there is no conflict?

What kind of guidelines or code do you need if you are going to allow it to happen?

You know, it was not sufficient that Caesar's wife was chaste; she had to appear to be chaste.

(80)
Dr. Leone. Well, I am prejudiced by saying I have faith in the doctor who refers to the agency he is “owning.”

Senator Chiles. But I have got to protect the taxpayers. That is the job I am supposed to handle.

Dr. Leone. I would like to say that the agency is doing the job and doing it the way it should be done, and then I would see no reason why that doctor, if he owns the agency—I do not like the word “ownership,” because I own nothing but notes in a bank that I have to pay.

Senator Chiles. If we were dealing, you know, in a private arm’s-length issue where people are paying for these services, and where there is competition and all, then I would not see particularly the problem, maybe.

But now, we are dealing with taxpayers’ funds, and we are dealing with the potential of a doctor—you are taking $14,000 a year out, but we have people that are taking, you know, much, much more than that.

Dr. Leone. I believe I should take more for the time I put in, too, but it is not there.

Senator Chiles. Maybe you are going to start doing it. Did you get yourself enough coordinators around? [Laughter.]

Dr. Leone. No, no, Senator. I practice in the same area that this agency of Hollywood practices, on the same floor of the building. My income, my livelihood has been orthopedic surgery. I am not going, for $15,000 a year, to jeopardize my $85,000-or-better salary as an orthopedic surgeon.

Senator Chiles. Doctor, I want you to understand I am not trying to cast aspersions on you personally or your own ethics are. I am only here looking at a problem and trying to determine which controls and guidelines need to be placed on that; and, if so, what kind of guidelines.

Is there a potential for conflict? If the potential is there, how do you cover it and that is the reason for me asking you these questions.

Dr. Leone. Honestly do not see a conflict or problem developing in a situation where a doctor refers his patients to an agency that he has input. I cannot see a problem there; I really cannot.

If he was overutilizing it, just for the sake of sending a patient to the agency, then you are talking about a patient who does not need any agency; you are talking about a patient who has no need for it.

Then, yes, there is a conflict.

Senator Chiles. When you tell me you are an orthopedic surgeon, I know you are probably paying so much money in taxes, and you do not want to spend much more money; but every doctor does not exactly fit into that field and would not necessarily be an orthopedic surgeon.
THE PROPRIETARY AGENCIES

Because the implementation of Florida's new licensure law will make proprietary agencies eligible to receive payments for Medicare patients, the subcommittee in each of its hearings invited representatives from the proprietary agencies in Florida so that a view of their operation and expectations could be ascertained. There are approximately 45 proprietary agencies in Florida. Home-makers Upjohn with 18 offices is by far the State's largest corporate concern.

Mr. William E. Madsen testified on behalf of Homemakers Upjohn in the Tampa hearings. In presenting the case for proprietary agencies, Madsen stated:

I think the prime consideration is our availability of service, quality of service and cost of service. I think that service should be bought on a bid basis. If somebody can do it better and less expensive and more economically than Home-makers Upjohn, they should do it.

Senator CHILES. You are talking about competition and putting the element of competition into it?

Mr. MADSSEN. Yes, sir, and I have been driving Chevrolets since 1949, and I like Chevrolets. I like General Motors products.

Senator CHILES. How many agencies does Homemakers-Upjohn have in Florida, and would this increase with the application of the new law?

Mr. MADSSEN. We have 18 agencies located throughout the State of Florida. If they did increase it would not—they would not increase appreciably. Specifically by appreciably I doubt there would be any more than two or three.

Senator CHILES. What about your charges?

Mr. MADSSEN. What do you want to know about them, sir?

Senator CHILES. Would they increase?

Mr. MADSSEN. No, sir. I don't see why they would, sir.

Senator CHILES. What are your charges for a nurse's visit now?

Mr. MADSSEN. We charge by the hour. We charge approximately $6.65 an hour for an R.N., $4.05 for an L.P.N., $3.65 for a nurse aide per hour.

Senator CHILES. How about a physical therapist?

Mr. MADSSEN. In the State of Florida we are not currently using physical therapists. We will in the future. I anticipate we will.

During the hearings in Miami, Ms. Diane Feinzig of Dade County Home Health Services, Inc. testified before the subcommittee along with Mr. John Smith of Medical Services Personnel Pool.

Ms. Feinzig commented on total services provided by her agency and salaries of their personnel thusly:

I would like to point out that our company does not require a minimum of service. We provide service to any patient for a total of from 1 hour to a maximum of 24 hours, day and night, per week or for an indefinite period of time.

The salary levels of our personnel ranges from $2.50 per hour for a homemaker-nurse's aide, to $4.75 for a L.P.N. and $5.50 for an R.N.

Our charges for these comparable services to an individual would be $4 for the homemaker or nurse's aide, $7.60 for the L.P.N., and $8.50 for the R.N., which is a legitimate mark-up in order to run a proprietary.

Senator CHILES. Do you charge transportation fees?

Ms. FEINZIG. No, they deliver themselves.

The insurance companies, I heard it mentioned under major medical will pay 80 percent if people have that kind of coverage, but only for an L.P.N. or an R.N., but nothing for a nurse's aide.

You have asked if I have any suggestions. Well, I will skip this part because I know you are in a hurry but I would like to go into something that to me is very important, a methodology of correcting some of the problems I have been listening to all day.

I have always been a great believer in purchase of service as opposed to bureaucratic spending.

On January 5, 1976, the Federal Medicare and Medicaid Guide No. 165, page 2, states that, "Nonprofit home health agencies will be allowed to make arrangements with proprietary agencies for the provision of such services as physical, speech, and occupational therapy; social services, or home health aides.

With this in mind, I have approached most of the nonprofit agencies in Dade County with a third-party contract, and four agencies have signed this contract with Home Care Services; but to date, I have had very little response. The contract price for a home health aide is $4 an hour. It is my belief that instead of having 30 or 40 home health aides on staff for a 40-hour week, when they perhaps work only 4 to 6 hours a day, it would be more economical to pay only for the hours worked.

How can the nonprofit justify a charge of $15 per hour for this service when they only pay $4?

Should a third-party contract between nonprofit and proprietary agencies be made mandatory to best utilize existing personnel?

You have heard a lot about existing personnel. The amount of office space required for a home health agency operating under third-party contract would be cut in half. The need for rental space at $1,500 to $1,600 a month is totally unnecessary.
There is an abundance of qualified home health aides, registered nurses and L.P.N.’s registered with proprietary agencies to fully utilize this arrangement.

Mr. John Smith of the Medical Service pool testified on the visits that his agency was concerned with.

Mr. Smith. We have been in business since 1966, and we presently have 100 nursing service offices throughout the country.

We have 12 in the State of Florida, and we do not presently participate as a certified medicaid provider in Florida.

Now, with the passage of the Florida Licensing Law, we will welcome licensing and maybe we will become medicaid-certified in some of our offices, but we do not intend to leap into the program with both feet at this time.

In 1975, we employed approximately 5,000 people in the State of Florida and provided approximately 1½ million hours of patient care.

Since the private patient pays out of pocket for our services, we truly must have reasonable costs or we would lose our clientele.

For example, in one of our large offices in Fort Lauderdale, our administrator is paid $21,000 a year. Our director of nursing is paid $14,000, our bookkeeper is paid $8,000, and we developed what we feel is to be a very effective manual, bookkeeping and billing system to avoid the additional expenses of computerization.

Senator Crites. What are your charges for a nurse’s visit, R.N.?

Mr. Smith. For a registered nurse the charge is $7.95.

Senator Crites. Is that a minimum?

Mr. Smith. In many cases, we anticipate a 4-hour visit, but we are very flexible.

We do bend a little.

Senator Crites. Do you anticipate or do you require a 4-hour minimum?

Mr. Smith. Normally, we look in terms of a requirement of normal would be a 4-hour visit.

You see, we are dealing with a private client and actually, these people are interested in long term visits, even around-the-clock care; so that for the most part, our visits, of course, do average longer than medicaid provides.

Our charge for a licensed practical nurse is $6.45 an hour.

Our total office staff consists of 10 employees. In 1975 we employed 857 nurses and home health aides.

Now, you might ask about the service charges, whether our services include the same components of care that typical home health agencies might include.

I wish to assure you, Senator, and the committee that our services include the same components of care that typical home health agencies might include.

Our services include supervisory visits to our private patients. We perform written patient care audits. We have written employee evaluations and we keep a full scope of current records wherever that is required.

Senator Crites. We thank you very much and we will incorporate your statement in full in the record.

The testimony given by the proprietary home health agencies would suggest that the “for-pay” agencies at this time are operating on a far less expensive basis than are the so-called nonprofit home health agencies. However to suggest that the proprietary agencies would not put their companies on a parity with other home health agencies in terms of cost and salaries is to virtually ignore human nature.

Still, the supposition that higher prices and salaries would naturally evolve with medicare certification is still only a supposition.

Regulations and legislation must be adequately enforced or any newly certified agency will be left to devise its own salaries, costs and mode of operation. That includes proprietary agencies.

James Rutherford, in his testimony before the subcommittee in Tampa, raised the prospect of a large proprietary company limiting competition and creating a monopoly in the health delivery industry.
GENERAL FINDINGS AND RECOMMENDATIONS

The subcommittee found that the additional action which should be taken included the following provisions either to be instituted through proper legislation or guidelines from the Bureau of Health Insurance:

(1) That there should be adequate formal—education—training for full-time administrators in the health care agency of less than administration of a health facility. Many of the agency administrators interviewed in hearings and through the investigation had backgrounds in totally unrelated fields to that of health care service.

(2) That the membership of the governing body or the advisory committee of a home health agency be comprised of legal residents within the geographical area served by the home health agency. This action would eliminate administrative expenses such as transportation and lodging which are now charged to medicare.

The number of high-salaried administrators must be limited. One agency in the survey by the subcommittee defined nine persons in an agency of less than 100 as top administrative personnel.

Medical directors who can be classified as “in-house” should be restricted in the percent of the total clients that he can refer to his agency. No more than 25 percent would be reasonable.

(3) Special investigation by the fraud and abuse section—should include careful scrutiny to identify those agencies which:

(1) Knowingly provide services to patients not truly “home-bound,” which also add services to those initially requested by the patient’s doctor, and permit personnel to do those things not included in needed services.

(2) Solicit discounts and kickbacks.

(3) Arbitrarily add “administrative markups” to bills for goods purchased by them or services performed for them.

Agencies that are identified as conducting these abusive practices should be penalized either by immediate nonacceptance of claims or by placement in a probationary status for a stipulated time period which could result in a “nonacceptance” status. Where actual attempts at fraud is obvious the administrator should be quickly prosecuted.

The subcommittee thoroughly investigated the situation and found that the inter-relationship of durable medical equipment suppliers and home health agencies often led to abusive practices.

Acceptable legislation should result in the following results:

(4) 100 percent reimbursement for durable medical equipment under part B either to the patient or to the dealer accepting assignment when the patient’s request and authorizes the need for the equipment and is entitled to and receiving home health care from a licensed agency.
Durable medical equipment to be sold or rented

Alternating pressure pads and mattresses

Bed side rails

Gel rotation mattresses

Hospital beds

Pneumatic appliances

Pneumatic compressor (lymphedema pump)

Lymphedema pumps (nonsegmental therapy type)

Mattress, with hospital bed only

Patient lifts

Rollabout chairs

Trapese bars

Water and pressure pads and mattresses

Wheelchairs

Further, the subcommittee found that in instances where sales are made, those sales should carry restrictions and conditions similar to those previously listed. Sales should be made as follows:

1. Dealers should be required to offer to the patient to sell or rent.
2. Intermediaries should be required to notify dealers the allowable sales price on all items of equipment.
3. Lumpsum payments by the intermediary should be made to the dealer or to the beneficiary at the time of sale, and that payment should not be subject to the annual deductible or coinsurance.
4. The patient should be allowed to use an amount up to the prevailing price disclosed by the intermediary toward the purchase of any quality of equipment that the patient wants.

Example 1—The Medicare allowable price for a wheelchair is $175. The patient could use $50 of this and buy and pay in full for a used chair.

Example 2—The patient could apply this $175 toward the purchase of a new, $350 wheelchair and pay the difference to the dealer himself.

5. The dealer should be required to document the offer of sale and the transaction.
6. The determination of the validity of the sale should be the patient or the patient's own physician.
7. Provision should be made for repairs on items previously sold through Medicare.

FINDINGS AND CONCLUSIONS

Finding No. 1

As evidenced by the committee's report and testimony heard by the subcommittee, the subcommittee submits that there is a decided absence of heard, specific guidelines and instructions from the Bureau of Health Insurance (Social Security Administration).

The fact that many agencies seized the opportunity caused by the absence of specific guidelines to raise salaries to unreasonable levels was totally indefensible.

The private nonprofit administrators set salary levels for themselves and other supervisory personnel at those high levels because they (the administrators) could not show the funds received as "profit."

Conclusion

The Bureau of Health Insurance (SAA) should develop guidelines which would limit or place a "cap" on the charges that the Home Health Agency can impose for skilled nursing care, home health aide visits, as well as those for physical therapist, speech therapist, et cetera. Limits which should be placed on the salary for administrators of private, nonprofit home health agencies could be based on the comparison of the executive directors of visiting nurses associations or the administrators of 50-bed hospitals.

Unquestionably, the salary of administrators and top personnel should completely be divorced from the gross revenue that the agency takes in.

Changes in present system

This change would not demand changes in legislation but would demand guidelines from the Bureau of Health Insurance (SSA).

Finding No. 2

Gross irregularities in administrative procedures were alleged by home health care personnel, backdating and alterations of records by home health personnel with the primary purpose of defrauding the U.S. Government, were claimed to be fairly common occurrences. General administrative coverups included the forging of client records, claims being billed for visits never made, diagnosis being made by unqualified persons, nurses aides and general office staff—general abuses of car allowances and gas allotment.

Conclusion

The need for aggressive monitoring of the administrative claims by the Bureau of Health Insurance is paramount. The prevailing feeling among many private nonprofit home health agencies was that any cost could be charged because the present monitoring system would not pick up the irregularities that occur.
Changes in the present system

An enlargement in the fraud and abuse section of the Bureau of Health Insurance so that investigators could closely monitor alleged abuses. The system for checking and auditing records should not involve 3 weeks to a month prior notice. Auditing should be done on short notice so that tampering with official records could not be adequately accomplished.

**FINDING NO. 3**

Pension plans for the employees of private nonprofit home health agencies are not designed to conform to any specific guidelines and limitations.

**Conclusion**

Pension plans should have ceilings imposed to assure that conditions the subcommittee learned about are not continued nor repeated. The subcommittee feels that an 8 percent limit would be more than sufficient but would defer the Bureau of Health Insurance guidelines on the matter.

**Change in the system**

No guidelines on pension plans presently exist. The Bureau of Health Insurance should develop those guidelines and submit recommendations for legislation.

**FINDING NO. 4**

Private nonprofit agencies do not have to establish financial stability on order to start soliciting clients and go into business. Franchise fees, initial consulting fees, should not be reimbursable items from medicare.

**Conclusion**

Either a proper bonding procedure should be established or a private, nonprofit home health agency should have to document the existence of substantial permanent capital to cover possible overpayment to the agency.

**Change in the system**

The basic change in the reimbursable system to accommodate the above conclusion must be achieved by statute.

**FINDING NO. 5**

Under present legislation a private, nonprofit home health agency generally excludes all patients except medicare eligibles.

Currently, all administrative expenses are charged to medicare. The committee found that some of the expenses billed to medicare were very dubious.

**Conclusion**

By statute, a requirement that at least 25 percent of the patients of a provider be other than medicare eligibles in order for certification to be granted. Justification for such legislation can be found in the statutory requirement relating to the formation and operation of health maintenance organizations—30 percent of the participants in an HMD must be under the age of 65.

Changes in the present system

The significant change in the system to conform to the above conclusion must be by statute.

**FINDING NO. 6**

The subcommittee found that many items were rented to patients at a total cost for in excess of the total cost of the item in many cases. This abuse has been documented through appropriate records in the SSA as well as interviews with suppliers and clients.

**Conclusion**

Provisions should be made for the lump sum reimbursement for the purchase of durable medical equipment where long-term need has been clearly documented by the attending physician.

**Changes in the present system**

By the appropriate statute.

**FINDING NO. 7**

The subcommittee found that durable medical equipment suppliers and some private nonprofit home health agencies have entered into agreements to circumvent the law, particularly in providing for an administrative markup on items sold by the suppliers on referral by the agencies.

**Conclusion**

The actual cost for items should be documented by having a copy of such items attached to claims submitted.

**Changes in the present system**

Guidelines could be established by the Bureau of Health Insurance, or appropriate legislation.

**FINDING NO. 8**

The subcommittee found that proliferation of private, nonprofit home health agencies to be a definite problem.

The tremendous growth of this type of agency—private, nonprofit—with little or no controls attached to their certification requirement doubtlessly led to some of the abusive practices that occurred.

**Conclusion**

A certificate of need provision must be included in the requirement for certification by the private, nonprofit home health agencies.

**Changes in the system**

By statute, the certificate of need should be required on a national basis.

**FINDING NO. 9**

The subcommittee found that normal investigative procedures for the fraud and abuse section of the Bureau of Health Insurance depend
solely upon responding to a complaint. The section does not, it seems, allow investigators to act on their own initiative.

Conclusion

The fraud and abuse section does not presently have the manpower capability to properly investigate instances of alleged abuses and illegalities that have been reported in the home health care field.

Conclusion

The fraud and abuse section does not presently have the manpower capability to properly investigate instances of alleged abuses and illegalities that have been reported in the home health care field.

Conclusion

By guidelines from the Social Security Administration or appropriate legislation.

Finding No. 10

The subcommittee found that many problems existed in determining which services were truly needed that were being administered to clients under the guise of needed services. Many agencies overprescribed services and had no accountability to the State after certification.

Conclusions

In order to help restore public credibility in the area of home health care, private nonprofit home health agencies must be required to:

Undergo periodic review of a State home health agency advisory council, appointed by the Governor, which would also advise the public nursing section or any other official health agency in matters relating to regulations, standards of care, policies governing services, and expansion of home health care programs in the State.

The Council would be composed of a licensed physician, a registered nurse, a physical therapist, a speech pathologist, a medical social worker, an occupational therapist and three citizens interested in the development of home health care programs. Such a council will provide representation from the various disciplines rendering service who have expertise in these areas and are knowledgeable about standards of care and operational procedures for their professions.

Agencies should also organize their board of directors to conform to having at least seven members, no more than two of which are relatives.

Final Recommendations

Additional recommendations that the subcommittee found include the following:

(1) The administrative records of an agency that does not deal with the individual patient should be open to public inspection, such as administrative salary levels, charges for visits, amount paid the agency by the intermediary, etc.

(2) The utilization review program performed by the intermediary be expanded to conduct, not only onsite inspections but a complete followup concerning assurances from the patient's doctor as well as a comprehensive number of patients that the services rendered were both needed and requested by the patient's doctor.

(3) The large body of regulations and guidelines that are established, and will be established, be made available to every agency licensed by the State so that the limitations placed on cost can be uniformly applicable. Agencies can only adhere to "reasonable" cost when they (the agency) know what "reasonable cost" are.

(4) Rental arrangements between doctors and laboratories or doctors and home health agencies or doctors and pharmacies or any other above combination should be carefully reviewed by the Bureau of Health Insurance with the stated power of the Bureau to terminate such agreements when Medicare payments are in any way involved.

(5) That any form of compensation in terms of rewards, prizes, gifts, and so forth shall be considered a kickback when it involves a medical supplier and/or a home health agency receiving Federal funds for medical care.
The image of a nonprofit home health care agency has historically been that based on the actions of organizations such as the Visiting Nurses Association. Characteristically, the public nonprofit organizations like the VNA and the County Nurses Association have operated on the principle thesis of providing services to the poor and the elderly at minimal cost to community and the taxpayer.

The supreme dedication of many of these public spirited and highly motivated persons has led to not only a high level of care for many patients, but also a firm appreciation for the worth of these agencies to the communities in which they serve.

From all the evidence presented by the subcommittee, I have been extremely impressed with the quality of services provided by the public, nonprofit organizations and even more impressed with the sincerity of effort put forth by the public nonprofit agencies. The subcommittee investigators held hours of interviews with clients and other personnel involved in home health care and generally conceded that those persons who staffed and maintained the public agencies were of high caliber and expertise.

Although I was not in the Congress during the enactment of the original medicare bill, I am assured that Congress had the image of public agencies involved when they wrote the provision for the private, nonprofit agencies.

During the almost year-long investigation of home health agencies, the continuing story of gross irregularities and administrative coverage by agency administrators was repeated over and over again. We heard evidence of records were forged, claims were billed for visits never made, personnel were diagnosed for patients before they were seen and reports prepared for doctors who merely signed sheets depicting actions never taken.

Medicare officials were billed for some expenses that defy explanation—such as the Christmas party by Unicare, Inc. of Miami. While the total expenses of some $4,000 was not a tremendous amount it represents the idea that as long as medicare pays it doesn't matter what the expense is billed for.

The entire question of the interrelationships of persons involved in home health agencies must be clearly defined. Doctors who own home health agencies must allow for complete disclosure of that ownership and the patient and medicare officials must take special note of that ownership. Monitoring procedures by the intermediary must be particularly stringent for these agencies. Because of the abuse in overutilization and referrals by doctors themselves, medical firms, hospitals and/or nursing homes should be restricted to involvement in only one area of patient care which is reimbursed by the medicare program or National Health Insurance Act.

The subcommittee investigated the entire scope of involvement and interrelationships of medical supply companies of medical supply companies and home health agencies. The abuses concerned with central billing procedures, signed and/or oral agreements to actually circumvent the law by forgiving the 20 percent co-insurance and annual deductible were widespread and accepted practices. Any medical supply company thatblankly forgiven the deductible or co-insurance to a specific category of patient or agency should be considered guilty of an abuse of the act and subject to the penalties provided by the act.

Intermediate agencies should be carefully instructed to insure against incorrect payments to chain medical supply companies using central office billing procedures.

The subcommittee lends its support to a certificate of need requirement as developed by the Florida Department of Health and Rehabilitation Services.

Medicare officials must begin to establish some limits on salaries, pension plans and charges that are uniform and reasonable. The Bureau's current policy is much too lenient and leaves too much to agencies to decide.

The practice of comparing private, nonprofit agencies to one another is not practical. First of all, it establishes a false charge and salary rate. Normal competition practices do not apply because the private nonprofit agencies do not have to justify costs to the customer but rather to the Government which is not the customer but is the payee. So as long as agencies are allowed to set their own rates, those rates will be excessive.

It is the imperative that the governmental agency responsible for correct monitoring is allowed to establish proper rates for charges and salaries.

The private, nonprofits, or so-called 100 percenters, have absolutely nothing to lose by going into business at total government expense. The current system of cost reimbursement provides no incentive for efficiency. In order to establish some type of financial security, a bonding process must be established. In the present situation, private nonprofit agencies may manipulate charges and submit cost estimates that are far out of the realm of reasonableness and secure funds under interim payments that can be used by them for any purpose. The repayment of those funds is interest-free and comes from a deduction of their medicare account. This entire process can lead to definite abuses.

The beneficiaries receiving the services have no idea as to the amounts reimbursed since notices to the beneficiaries list only the number of visits and no amount of reimbursement per visit. Therefore, the beneficiaries do not as a damper on overutilization.

The obviously profit-motivation of the so-called nonprofit agencies has been more than substantiated in testimony and other inquiries made before the Subcommittee on Federal Spending Practices, Efficiency, and Open government. I am now more convinced than ever that real reform has to be properly instituted if the program is to be saved for those persons most in need—the elderly—by those most concerned—the taxpayers.

Specific guidelines and regulations along with legislation may not eliminate all of the problems we face with the administration of this
program. However, I feel that public support and credibility can be restored if public officials and Medicare administrators implement the desired changes in the program recommended in this report.

Further, I want to reiterate my support for quality health care for the elderly through the Medicare program. Such care is vital to the well-being of many of the elderly in the state of Florida and across the nation. The very fact that this care is so vital makes it even more important that it becomes as fraud-free as possible.

The subcommittee is indebted to those persons whose primary interest goes beyond job security and cooperated with subcommittee investigators on this inquiry.

If the projection for Medicare as a program is to be a healthy one, then abuses and illegalities have no place in this prognosis.

LAWTON CHILES.

SUPPLEMENTAL VIEWS OF CONGRESSMAN
CLAUDE PEPPER

[Taken from testimony given before the Subcommittee on May 5, in Miami, Fla.]

My subcommittee has held joint hearings with Senator Moss' Subcommittee on Health in the Senate, and I am particularly honored on behalf of my subcommittee to meet in joint sessions with you.

About 19 percent of the population of Dade County consists of people over 62 years of age.

One of our—The House Committee on Aging—points of principal emphasis is this matter of home care for the elderly, the support of a comprehensive plan that will provide all necessary services in the homes of the elderly, avoiding the necessity and in many instances if not most, of those people having to go into a hospital or having to go into a nursing home.

Without intending in any way to disparage the quality and the character of nursing homes, in general, my beloved mother many times said to me in her late years, "Son, don't ever let them put me in one of those nursing homes."

What she meant was, she was accustomed to her own bed, her own room, her own home, her own neighborhood, her own environment, and to have to be uprooted from those accustomed environmental associations and put into the necessary discipline of a strange institution, with strange people at a very much advanced age, is obviously a great shock to the individuals in that category.

As has been said, our own committee has confirmed exactly what your hearings have confirmed, that in the long run, it would be cheaper in all probability for the Government to provide home care for the elderly rather than to have them have to go to hospitals or nursing homes where they have to be cared for at great expense.

So, our committee joins you and will join you in every way we can in the promoting of legislation which you offer to implement the hearings and the recommendations of your committee.

When we mean home care, we do not exclusively refer to home health care, although that is primarily the concern of our committees in these inquiries, but I think it should include home services that will provide companionship, primarily somebody to provide a meal if necessary, to clean up the house, to render either practical nursing as well as registered nursing care, and the other services that are necessary for the care of people in their respective homes.

So, it is very unfortunate, as I am sure you are going to emphasize here, Senator, that circumstances for today's inquiry result from some unfortunate practices which have been to emerge in providing these services in the very important home health field.
I know that you, as well as all of us are interested and active in nurturing this rather infant field of medical and other services to many of our people in need. We want to see these unscrupulous practices corrected and ended at once.

It was shocking for me to discover, as you have discovered, that some of those private agencies providing home health care services may have improperly collected $1 out of every $2 paid to them by Medicare for reimbursement last year.

It was equally shocking for me to discover through the news media that these overpayments in some cases went toward extremely high executive salaries and other benefits not consistent with the aims and goals of proper home health care programs.

The spotlight of publicity focused on your earlier hearing in Tampa and this one today in Miami will, I am sure, serve to erase these abuses in a very short time.

My own subcommittee on health and long-term care will take note of your findings and assist in every way in the House of Representatives to see to it that corrective action is taken legislatively to protect those in need of home health care services from the abuses which are coming to light.

Organized home health care is a young industry—if we should call it that—even if the concept dates back to the beginning of man. Home health care agencies began to flourish and grow from 1967, the year that Medicare and Medicaid became operative and, as with any new concept, it has suffered growing pains.

Unscrupulous people now threaten to set back the noble goals that responsible committees in the House and Senate are trying to achieve.

As you know, my subcommittee recently introduced a package of 15 bills in the House to implement the recommendations of our subcommittee's recent report entitled, "New Prospectives in Health Care for Older Americans."

We will look forward to the findings from the Senate hearings to determine areas of safeguards which may be necessary to insulate a comprehensive program against abuses.

APPENDIX

...
The Honorable Lawton Chiles  
The United States Senate  
Washington, D.C. 20510  

March 26, 1976

The Visiting Nurse Association Hospital Coordinator, Mrs. Rooney, and I were privileged to meet your very fine administrative assistant, Mr. Robert Harris, at the Visiting Nurse Association office on 25 February. Mr. Kramer, who has been interested in trying to bring some of the abuses of Medicare into focus, also was present. He had a constructive discussion and suggested we make some input into possible legislation which might help.

A situation has risen which points up very strongly to me the need for Federal controls being strengthened on certification of Home Health Agencies. The Visiting Nurse Associations have been trying for over three years to get legislation requiring a Certificate of Need and licensing for Home Health Agencies at the state level. Much work was done and legislation drawn up toward this end. It contained quality control criteria which is badly needed when care is given in the home. The legislation was written to start in July 1975, but I now understand that it has been called back into committee for further study, leaving the way open for more agencies in this area.

Until June of 1974 there were two agencies serving Broward County. The Visiting Nurse Association of Broward County established in 1952 to serve all citizens of all ages, under all types of funding and Gold Coast Home Health Agency established around 1971 to serve Medicare patients only, were adequately serving the County. Since then 10 to 12 more agencies, serving Medicare reimbursable patients only, have been certified. They have met the Medicare requirements for certification and without a control, such as a Certificate of Need based on population needs instead of the $100,000 requirement made of institutions, they are presenting many of the problems we face. I would like to suggest that with the implementation of Regional Health Systems Agencies in April 1976 that such a Certificate of Need could be required as part of the certification process. This would eliminate the tremendous over concentration in urban areas and hopefully increase home care in smaller and rural areas where it is so badly needed.

A UNITED WAY AGENCY
Thank you for your attention to these matters and we would be pleased to have yourself and/or your Administrative Assistant visit with us.

Very sincerely yours,

Purcell,
For any years we were the only agency providing Community Health Care, servicing the "any H. D.'s and hospitals and we hope to continue to do so. We are asking you to please reconsider eliminating us from your list for Medicare patients, so that we may continue to serve the Community and your hospital. We cannot understand why an agency such as ours, who serves all people regardless of race, color or creed, or ability to pay has been removed from your rotation list. Trust that we will hear from you soon.

Enclosure

Very sincerely yours.

(Rns.) Doris Rooney, R.N.
Public Relations and Hospital Coordinator
MEMORANDUM

July 26, 1974

TO: Home Health Agencies

SUBJECT: Home Health Service Referrals

We are finding that the referral systems we have been using for home health services is not as effective as previously hoped. The system of calling a day for each nursing coordinator to visit the Social Work Department and pick up any available referrals has resulted in uneven distribution of referrals, considerable disruption of our department and insufficient services is not sufficient for our department.

We are finding that the referral system we have been using for home health services is not satisfactory. This will also allow us to keep track of referrals so as to save our time and effort as well as...to advise you that the Medical Staff Committee of BROWARD General Medical Center recently voted against establishing a policy allowing representatives from home health care agencies to review an in-patient's medical record prior to discharge. This is to advise you that the medical staff committee of...Medicare referrals will be honored.

For this reason, the Social Service Staff will continue to work closely with you and serve as a liaison for them...to our staff's time if there are no new referrals...

We are also in the process of an in-service education program for all physicians on staff and our nursing personnel to make them more aware of the services you can provide for our patients...We feel this will increase the number of referrals and that, of course, will take time and we ask your continued cooperation.

Sincerely,

[Signature]

(Mrs.) G. Davis, RN
Director of Social Work

Dr. M. A. Schering, Administrator

Mr. J. C. Davis, ACSW
Director of Social Work

[Address]

VS

BROWARD GENERAL MEDICAL CENTER

1800 SOUTH ASHEVILLE AVENUE

FORT LAUDERDALE, FLORIDA 33315

August 13, 1974

Visiting Nurse Association of Broward County

1000 S. Federal Highway

Ft. Lauderdale, Florida 33315

Ref: Hospital Evaluation of Home Health Care Patients

This is to advise you that the medical staff committee of BROWARD General Medical Center recently voted against establishing a policy allowing representatives from home health care agencies to review an in-patient's medical record prior to discharge. If the attending physician leaves an order for your...review of his patient's chart, this of course, would be honored.

For this reason, the Social Service Staff will continue to work closely with you and serve as a liaison for each referral. It is still permissible for you to visit the patient in our hospital and also to discuss specific details of home care with the charge nurse.

We are also in the process of an in-service education program for all physicians on staff and our nursing personnel...We feel this will increase the number of referrals and...will take time and we ask your continued cooperation.

Sincerely,

[Signature]

(Mrs.) N. S. Schev, RN
Social Service Director
April 21, 1976

Editor
Tampa Tribune
Tampa, Fla. 33608

Dear Sir:

I have read with great interest your report and editorial on Medicare reimbursement to some Home Health Agencies. It is disheartening to learn that these agencies, who serve the sick and elderly on behalf of a worthwhile program, have been required to submit service back to them as professionals, above approach. However, it appears they must and shall continue even this service to seniors.

One cannot help but question, why can't the Department of Health, Education and Welfare recover this money if these agencies are defending the government, they should be expected to make full reparation. This kind of organization can make the good work and reputation of other Home Health Agencies and Medicare doesn't have enough people to police the many agencies of state.

The Florida Association of Home Health Agencies, Inc. has recently enacted a Code of Ethics. This will be helpful in self-policing. However, this can only be effective when agencies belong to the association. Those who claim to be the Medicare Agencies and are receiving Federal funding to provide Medicare services should be directly under government scrutiny. It would seem the "Non-Profit" corporations are anything but that. Instead, have developed a pathetic attitude of "not to while the getting is good." What has happened to the integrity of people?

Senator Lawton Chiles predicted that unless new regulations are drawn that will put an end to this abuse, the Medicare Home Health Program would end and would there be left the people who so desperately need and depend on it.

Countless age, my mother suffered a serious illness. After months of hospital and nursing home care, she improved enough to come home. In seeking help, we were informed that Visiting Nurse Association of Hillsborough County, Inc. was a Medicare agency. I contacted their office and was assured they would be available for as long as my mother had need of their services. We have found V.N.A., very approachable, with a dedicated staff to help with instructions and care of an invalid patient.

I feel sure there are many agencies who render the same service. It takes only a few to give a bad name to all. Hopefully, the government will have these "few" get their act together or get out, so that others can get on with the program of caring for those who need them.

Sincerely,

[Signature]

Anne Villerot, R.N.
Inservice

ARH/34

06: J. Schack
L. DeGraaf
The Ad Hoc Home Health Services Advisory Committee will reconvene December 1, to review the revised rules. This committee has been expanded to include other concerned groups, namely the Florida Board of Nursing, Housekeepers-Upjohn and Home Care, Inc., and the West Coast Comprehensive Health Planning Council. A second public hearing will be scheduled.

The objections of the two proprietary agencies are rooted in a conceptual difference in determining what services constitute home health services. Companionship, homemaking and "baby-sitting" are important supportive services to dependent persons and are sometimes essential adjuncts to health services. Agencies that provide only these services on a continuing or intermittent basis are not home health agencies. Those agencies that provide both supportive and health services should seek licensure for only that unit within the agency that provides health services.

Home health services has been the major and often the sole interest of voluntary and public health nursing agencies for the past 75 years. The census is now 80 and they have collectively developed nationally in the proposed rules for Chapter 75-22. The staff ratios, for example, reflect common practice in Florida as well as a national sample.

The question of continuous care presents some questions. Mr. Toth describes a professional registry or employment agency other than a home health agency. Medical Pool Personnel assigns nurses and nursing assistants to hospitals and nursing homes as well as to private pay patients in their homes. The General Rules and Regulations cite the need to observe and respect the rules and regulations of the hospital, nursing home, or retirement home. This is incredibly expensive for hygiene and comfort services that could probably be met more successfully and less expensively in a nursing home. At least in that setting the patient would be visible and have greater access to professional services when needed. I'm sure that the problem Mr. Toth describes affects very few people. It would be irresponsible to expend public money on such selective, expensive, and less expensive alternatives are available except in the most unusual circumstances. Under these conditions home health services are not a reasonable alternative to nursing homes. Home health services become an important alternative only when services can be provided on an intermittent basis or when continuous care would be confined to a specific limited period.

It is my hope that the problems related to developing home health agency standards will be resolved without sacrificing or undermiring the quality of care that is presently available.
There are two overall responsibilities of the Public Health Nursing Section: improvement of health personnel competence and administration of the Home Health Services program.

Components of the programs to improve health personnel competence include consultative visits to county health departments and health related agencies; planning and evaluating resources, programs and needs through scheduled conferences, meetings and contact with personnel of other bureaus, sections, divisions, and health related groups and agencies; planning, conducting and/or participating in continuing education programs included orientation and maintaining, updating and upgrading professional skills by participating and attending professional seminars, conferences and educational programs. These activities are performed in both generalized and specialized approaches. The professional staff deliver generalized public health nursing services in assigned regions and their particular specialties on a statewide basis. There were seven Public Health Nursing Consultants during this year. The program activities of the Administrator and Assistant Administrator are included in the following data:

<table>
<thead>
<tr>
<th>Consultant visits</th>
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<tbody>
<tr>
<td>Survey Visits</td>
<td>70</td>
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<tr>
<td>Planning &amp; Evaluation Meetings</td>
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<td>Continuing Education Programs Offered</td>
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<tr>
<td>Continuing Education Programs Attended</td>
<td>143</td>
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<tr>
<td>Total</td>
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Distribution of Public Health Nursing Consultants Activities

**Home Health Services**

The program staff consists of a Program Specialist, 1/10 FTE Public Health Nursing Consultant, 5/12 FTE Public Health Nurse Supervisor and a fiscal assistant. This staff coordinated Medicare certification of and consultation to 49 home health agencies, 12 outpatient physical therapy facilities, 8 outpatient speech therapy facilities, and 46 physical therapists in independent practice.

Total Number of Activities in Home Health Services

- Home Health Agencies
  - Survey visits for certification: 56
  - Consultation visits: 171
- Outpatient Rehabilitation Agencies
  - Survey visits: 14
  - Consultation visits: 3

During this past year, there has been a decline in the number of county health departments certified for Medicare with a steady growth in private home health agencies.
ANNUAL REPORT, 1974

Number of Certified County Health Departments, Voluntary Nursing Agencies and Home Health Agencies

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<tr>
<th>CHDs</th>
<th>VNAs</th>
<th>HHAs</th>
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<td>24</td>
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<td>21</td>
<td>8</td>
</tr>
<tr>
<td>1974</td>
<td>20</td>
<td>8</td>
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</table>

Comparative Growth Rates of Certified Home Health Service Agencies from 1970-74

The Public Health Nursing Consultants review, evaluate and counsel about all program services during their generalized activities. These data are reported in trip reports and other memorandums. However, they are not readily retrievable for reporting purposes. Therefore, the unassigned general activities have been prorated among the major program areas including Home Health Services and added to the designated program activities to demonstrate public health nursing activities in these programs. It must be noted that in many instances, the activities and goals of one program may be absorbed or integrated in another program e.g. the Nurse-Midwife Consultant conducted 20 teaching sessions on the correct way to do Pap smears. This activity was counted as Maternal Health but it is readily seen that both Adult Health and Chronic Disease and the Laboratory can gain through this effort.

As mentioned before, efforts in the Immunization Program are submerged in Child Health. Counseling and advisement on Home Health Services are frequently illustrated through the principles and nursing standards of Adult Health and Chronic Disease. The following graph depicts the distribution of the activities in the major program areas and the full-time equivalents of consultants needed to perform these activities:

Distribution of Public Health Nursing Consultants Activities in Major Programs

Accomplishments

30 per cent of the county health departments report that the standards for Public Health Nursing in Schools are being phased into practice.

The Nursing Information System has been tested in four counties and is ready for selective operational implementation.

The Public Health Nurse Orientation Program is being redeveloped as a joint project with Florida Regional Medical Program.

Careful scrutiny of county health department time and cost study reports as related to Blue Cross audits has resulted in saving close to $49,000 among at least seven county health departments.

School Health Services were interpreted sufficiently well to secure the assignment of that program for the Division of Health.
ANNUAL REPORT, 1974

57 lay midwives licensed to practice, a decrease of six from last year. 17 certified nurse-midwives registered, the same number as last year.

The rules and regulations concerning midwifery were re-promulgated January 1, 1975, after public hearing.

24 family planning nurse practitioners have been trained through the joint efforts of the Section, Bureau of Maternal Health and Family Planning and University Hospital.

14 orientees were trained in the orientation centers.

The reclassification of the Public Health Nursing series with the elimination of advanced academic preparation for administrative positions has made inordinate demands on the administrators of this Section. Distortion of Section recommendations for staff position reclassifications has resulted in many problems.

Massachusetts Association of Community Health Agencies

90 DIMOCK STREET • BOSTON, MASSACHUSETTS 02119 • (617) 445-1826

June 8, 1976

Senator Lawton Chiles
P.S. Senate
Washington, D.C. 20510

Dear Senator Chiles:

The Massachusetts Association of Community Health Agencies (MACHA) represents the interests of home health care providers. It strongly opposes the suggested deletion of home health agencies from the certificate of need requirement under PL 93-641.

We believe that controls such as the certificate of need requirement must be encouraged to ensure proper distribution of home health services. Effective home health service programs must be distributed so that agencies serve the needs of the consumer. Such distribution would ensure or assist to, in some instances, over-distribution of services with the resultant loss of cost containment.

We are further concerned as to why congressional intent was not followed when the Department of Health, Education, and Welfare rose to reconsider its position. We strongly urge the inclusion of home health services in the certificate of need provisions required by the National Health Planning and Resources Development Act (PL 93-641).

We seek to enlist your support in encouraging the inclusion of home health care in the certificate of need requirement under PL 93-641.

Sincerely,

Alexine L. Janiszewski
President, Board of Directors
April 21, 1976

Mr. Bob Harris
Office of U.S. Senator Lawton Chiles
Room 2107 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Dear Mr. Harris:

Attached hereto is information requested per your letter of April 7, 1976. I apologize for its late arrival, and hope it will be beneficial to your subcommittee research.

As I previously stated in our conversation, there are problems within our industry which need to come to light, good or bad be the outcome. My co­horts and myself in this area of the state are trying to provide the best care available at the most reasonable cost possible. The remainder of the state I can only make supposition of the same attitude.

If I can be of further assistance, please call me.

Very truly yours,

J. C. Parmar, Jr.
President

JCP/bh

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<table>
<thead>
<tr>
<th>SALARIES</th>
<th>FULL TIME EQUIVALENTS</th>
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<tr>
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<td>Social Services Director</td>
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<td>Physical Therapist</td>
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<td>Home Health Aide</td>
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<tr>
<td>Clerical</td>
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<td></td>
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<td></td>
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<td>2</td>
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<td>2</td>
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</tbody>
</table>
Bay Home Health Care Agency, Inc., 1975 W. 15th St., Suite 19, Panama City, Florida was incorporated in 1974. The Agency accepted its first patient on March 5, 1975, and during the fiscal year ending December 31, 1975, accepted a total of 130 patients, some 125 Medicare beneficiaries. The idea entered up mind to establish the agency following eight years as hospital administrator at one of the local hospitals. It was evident there was little followup on patients being discharged from the hospitals in the area. The readmission rate for the Medicare age group was considerably higher than for other groups. Much of this readmission problem was related to the lack of followup post institutional care.

Our agency is a not-for-profit corporation. Subscribers to the corporation includes myself as President, Dr. James A. Poynor, M.D., as Vice President and Medical Director and Rowlett W. Bryant, Attorney, as Secretary-Treasurer.

In addition to the above, the agency operates under an Advisory Board as required by the Department of Health, Education, and Welfare, and the State of Florida Division of Health. These advisors include members of the community, health related organizations and representatives from the various state and federal agencies coming into contact with persons in need of our services. Our Utilization Review Committee consist of myself as Administrator, our Medical Director, Nursing Service Administrator, and a community health oriented nurse not employed by the agency.

Our schedule of charges is as follows:

Skilled Nursing Visit: $35.00
Physical Therapy Visit: $43.00
Home Health Aide Visit: $20.00 per hour

These charges resulted in excess revenue of some $82,000 for the year ending December 31, 1975. Based on the Medicare Cost Reimbursement system, we are due to refund Blue Cross of Florida, our intermediary, in excess of $29,000 which resulted from a larger patient demand than expected. In accordance with this, we are being reduced effective June 1, 1976, to result in a lesser amount of surplus. The Medicare cost reimbursement system, the amount can be determined without difficulty and refund can be made in one payment, one check, to one of the intermediary agencies. If the patient load of two hundred patients were equally divided between private and Medicare patient, and if charges amounted to $22.00 per patient visit overcharge, we would have to compute amounts for each patient and write 100 checks for the private patients but only one check for as Medicare patients. The $22,000 refund previously mentioned relates to 125 Medicare patients, but will be written on one check against our account.

Examples of handbooks are outlined, as are financial statements.

The question then arises, "how can I justify the charges on Medicare patients?"

My justification centers around the hypothesis that more collected from the private patients, refund to a large number of patients upon demonstration of lower costs would be impossible. With the Medicare cost reimbursement system, the amount can be determined without difficulty and refund can be made in one payment, one check, without any discrimination between private and Medicare patient. The only other element I can think of relates to the patient load of two hundred patients were equally divided between private and Medicare patient. If charges amounted to $22.00 per patient visit overcharge, we would have to compute amounts for each patient and write 100 checks for the private patients but only one check for as Medicare patients. The $22,000 refund previously mentioned relates to 125 Medicare patients, but will be written on one check against our account.

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Examples of handbooks are outlined, as are financial statements.
Determined that there was a need in the county for such services and determined the sufficiency of services in Broward County. He investigated restricted services (it should be of interest to you that

Senator Dewey Chiles
Wisconsin Department of Health
1950 W. 49th Street
Miami, Florida

Dear Senator Chiles,

This is in reply to your letter of April 7, concerning the department operation and policy on Federal Spending Practices, Efficiency and Open Government.

I will take the items one by one you requested.

Our agency was incorporated in 1970 as a non-profit, charitable and educational institution under the laws of Florida. It was founded by Dr. Richard Schultz who is a surgeon in this area, at this time approximately 40 years ago. We heard about home health agencies at a medical meeting in New Orleans and realized that there was an insufficiency of services in Broward County. He investigated and talked with his colleagues and determined that there was a need in the county for such services and determined the sufficiency of services in Broward County. He investigated and talked with his colleagues and determined that there was a need in the county for such services and determined the sufficiency of services in Broward County.

Dr. Schultz hired a man for Executive Director, a Director of Nursing, a Director of Physical Therapy, a Director of Occupational Therapy, a Director of Speech Pathology, and a Director of Social Services. He interviewed several nurses association in Broward County that was working on a very limited budget with a very limited staff and highly restricted services. He believed that the VNA of Broward County still has only telephone service from the opening of the agency in June of 1970. An unaudited report for 1975 was submitted to the intermediary government for approval of the Advisory Board.

We made 9,700 visits. Other notes of historical interest are that we have served in the past five years 8,300 patients, 5,000 of which were 65 years of age. We had 50 patients in 57 hospitals and 44 nursing homes.

The legal corporate body of the agency is the Board of Directors, consisting of Dr. Schultz as President. Paul as Vice President, Mrs. Schultz as Secretary and Dr. Schultz as Treasurer. However, as you probably know home health agencies are required to have an additional Advisory Board consisting of professionals and consumers. Actions affecting the agency either fiscal or medical or legal are not approved by the Board of Directors without the prior approval of the Advisory Board. At the present time this board consists of a hospital credit manager, a cancer volunteer, an emergency room physician from a hospital, a Red Cross volunteer, a pharmacist, a social worker, a local physical therapist, a psychiatric nurse, two practicing internists, a speech pathologist and a hospital director of nursing service. It should be noted that the three hospital personal come from three different hospitals. This Advisory Board meets at least quarterly and does a complete annual financial and Utilizational Review to assure the medical corporate body of the agency policy manual are followed by the staff.

Since October 1, 1974, we have been under what is called the PIP (Periodic Interim Payment) Program for reimbursement purposes. This program lists all costs and divides by the number of visits and pays you at the average rate for Medicare patients. This resulted in a reduced charge of $27.83 for the next three months under the Periodic Interim Payment Program and are looking for ways to cut that for the balance of the year.

We anticipate a slightly increased number of visits and pays you at the average rate for Medicare patients. This resulted in a reduced charge of $27.83 for the next three months under the Periodic Interim Payment Program and are looking for ways to cut that for the balance of the year.
I have enclosed a copy of the booklet which gives detailed information which is handed out to physicians and the folder which is given to the general public. We have also cooperated with the Social Security Administration in distributing the Medicare handbook which is printed by them.

I have charted below for the years 1970-1975 the cost per visit and the number of visits for the skilled services and for aide services. You will note that we did increase costs through 1973 until all of the competition came into the county and the opening of many new agencies in combination with the price freeze general; this meant higher salaries and increases in benefits which are the major increases in costs. This was first felt in 1971 with increases in salaries and additional benefits including a pension plan. Another factor was the necessity of hiring supervisors in addition to the number of visits and the size of staff increased.

I have also charted the principle employee's salaries from New Year's, 1970 to 1975 in comparison of the salary of an R.N. on an aide salary in that same period. Another considerable factor in the cost increase was the necessity of opening offices in Hollywood and Delray, again to meet the competition of all the new agencies.

### Cost per Visit

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<td>1973</td>
<td>$31.97</td>
<td>$20.69</td>
</tr>
<tr>
<td>1974</td>
<td>$32.10</td>
<td>$21.87</td>
</tr>
<tr>
<td>1975</td>
<td>$32.94</td>
<td>$22.61</td>
</tr>
</tbody>
</table>

### Number of Visits

<table>
<thead>
<tr>
<th>Year</th>
<th>Skilled</th>
<th>Aides</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>10,663</td>
<td>11,963</td>
</tr>
<tr>
<td>1971</td>
<td>11,196</td>
<td>12,950</td>
</tr>
<tr>
<td>1972</td>
<td>11,887</td>
<td>13,093</td>
</tr>
<tr>
<td>1973</td>
<td>12,003</td>
<td>13,196</td>
</tr>
<tr>
<td>1974</td>
<td>12,447</td>
<td>13,250</td>
</tr>
<tr>
<td>1975</td>
<td>12,900</td>
<td>13,950</td>
</tr>
</tbody>
</table>

### Principal Employee Salaries

<table>
<thead>
<tr>
<th>Year/Head/Dir</th>
<th>Professional Staff (Nursing)</th>
<th>Vice Pres.</th>
<th>Staff Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>$5,800 (Nursing)</td>
<td>$6,000 (me)</td>
<td>$7,000</td>
</tr>
<tr>
<td>1971</td>
<td>$6,000 (me)</td>
<td>$6,500 (me)</td>
<td>$7,000</td>
</tr>
<tr>
<td>1972</td>
<td>$6,500 (me)</td>
<td>$7,000 (me)</td>
<td>$7,500</td>
</tr>
<tr>
<td>1973</td>
<td>$7,000 (me)</td>
<td>$7,500 (me)</td>
<td>$8,000</td>
</tr>
<tr>
<td>1974</td>
<td>$7,500 (me)</td>
<td>$8,000 (me)</td>
<td>$8,500</td>
</tr>
<tr>
<td>1975</td>
<td>$8,000 (me)</td>
<td>$8,500 (me)</td>
<td>$9,000</td>
</tr>
</tbody>
</table>

### Benefits

Benefits which are the same as included a pension plan also the Board felt that in order to retain our staff during a period of increasing costs, they asked the planner that the benefits were necessary to install a pension plan and the cost on the Federal Retirement Program. It is in individual cases and when the appeal is settled through the appeals procedure, they asked the planner that the costs be able to come up with a range that is understandable and they know. The planners have thought it was necessary. I also understand, because that is understandable and I will come up with a range that is understandable and they know. The planners have thought it was necessary. I also understand.

Another problem, and I'm sure it's true in other states, is the provision of the Certificate of Need requirement through to those agencies so that you do not have 7,000 sets of rules and guidelines to determine their Certificate of Need or their Certificate of Need. The Certificate of Need requirement of DH and Social Services is still running in order to determine their Certificate of Need levels and perhaps reasonable for the Congress.
There is one other point that I would like to refer to, the point we brought up in the hearing in Tampa that the private non-profit agencies are running out visits and then referring patients who needed care to VNA's or to public health agencies. In the past five years we have had over 6,500 patients and of these only 8 used maximum number of visits, none of these required a referral for further care. This would make it clear that we are neither over-utilizing nor dumping people out on the street. On the other hand, we have had numerous instances where we have referred patients to other agencies because those agencies had run out of patients because they are Canadians or English or South Americans and did not have the eligibility in that way, or were in a geographical area where we did not cover.

A further point relative to the testimony in Tampa is that no one connected with this organization has any financial interest in any agency or service which we use. I have mentioned that in the case of rental average 15-25% below that of what Medicare B allows these to charge patients.

I hope that this information will be useful to you and your committee. I shall be glad to answer further questions if you desire.

Sincerely yours,

H. Ron Corwin, Jr.
Vice President/Executive Director
in compliance with medicaid regulations when applicable. However, when not applicable, no interval should exceed two months.

Non-professional personnel should meet the training requirements specified in the medicaid regulations. Assignments of tasks should be in keeping with their training, the scope of potential impact, and the condition of the patient. For example, assisting a partially paralyzed patient out of bed may be a reasonable assignment since no untoward reactions would be anticipated. However, a patient with advanced osteoporosis may require very careful handling to avoid a spontaneous fracture while being assisted out of bed. In this instance, it would be inappropriate to assign this task to an aide. Patients and families must also be apprised of the aides would be attending to. Patients and families must also be apprised of the aides limitations so that they do not make inappropriate demands nor entertain unrealistic expectations.

Administration of medications by non-licensed persons is presently being studied by the Attorney General. It would be premature to predict his opinion but it is safe to say that the limitation of the decision lies in the safety of the patient. Therefore, the factors to be considered are the patient's condition, the nature and effect of the medication, and the understanding of the one to administer it. For example, in one instance an alert self-directing patient having taken his pulse may request his housekeeper to hand him a digitalis tablet. The patient is knowledgeable and assuming responsibility for the act. In another instance, a patient or confused patient would not assume this responsibility. The patient must therefore be under nursing supervision or need professional direction and supervision of medication administered.

There must be a careful distinction between home health aide services and housekeeper services. Home health aides are authorities who provide sub-professional nursing care to the sick at home under nursing supervision. They may perform light housekeeping tasks for the patient. A curriculum guide for a 60 hour course is available in the Public Health Nursing Section. However, on the other hand, here a simpler shorter preparation to perform housekeeping tasks for patients or families who are unable to do so for themselves. This does not apply to health services.

HOME HEALTH AGENCIES

Agencies who deliver health services should receive a certificate of need and meet the following standards:

1. Staffing patterns and ratios conform to regulations as established by the Division of Health, Public Health Nursing Section.
2. Services should be available to the public-at-large and not limited to one group of patients.
3. Services should be delivered according to patient needs and not terminated when third party payments are exhausted.
4. The agency must be eligible for Medicare certification.
5. The administrator of such an agency must have completed formal education in one of the health fields.

6. Corporate boards of such agencies must be composed of at least seven members no more than two of whom are relatives.
7. Funds for new agencies should cover expenses for at least six months of operation. Final reports should be a matter of public record.
8. Referrals for service should come through professional channels. Solicitation for patients through direct contact is prohibited.

**See Appendix I**

**ADMINISTRATION OF LICENSURE OF HOME HEALTH AGENCIES**

In the event that licensure of home health agencies is deemed advisable, administration of the program should be vested in the Public Health Nursing Section. This section is already responsible for surveys agencies for medicaid certification. Therefore a separate licensing agent would duplicate services. In addition, the section staff is well versed in the evaluation of home health services and delivery systems, nursing performance, goals, records, and reports. It would be anticipated that survey procedures for medicaid certification and state licensure would be telescoped into one operation which would constitute a full certification process. Therefore, a survey cost of $100 for the average 3 1/2 visits and clerical support needed for a full certification process are largely borne by Social Security Administration.

The enactment of a home health services licensure law would necessitate the appointment of a Home Health Agency Advisory Council to advise the Public Health Nursing Section in matters relating to regulations, standards of care, and services. Such a council would be composed of a licensed physician, a registered nurse, a physical therapist, a speech pathologist or therapist, a medical social worker, an occupational therapist and three citizens who do not have financial interest in a home health agency.

**May 27 1965**

D. B. Hollywood

Chairman

Advisory Committee on Administration & Practice
HONORABLE LAWTON CHILES
UNITED STATES SENATOR
WASHINGTON, D.C. 20510

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
BUREAU OF HEALTH INSURANCE
SOCIAL SECURITY ADMINISTRATION
WASHING rON D.C. 20201

May 11, 1976

Dear Senator Chiles:

During the Miami HRA hearing last week, you questioned Mr. Hanley of Gulf Coast Home Health Agency about a $40,000 monthly repayment schedule. He responded to the effect that your information was incorrect and the repayment was about $21,500 monthly.

The actual amount of monthly repayment is $21,500. As the attachment indicates, $208,567 is in dispute. The issue (reasonableness of salary and reasonableness of pension costs) has been heard by the Provider Reimbursement Review Board. I am awaiting the decision of the Board in this case with more than usual interest. Should the decision go against the government, our ability to cope with the all-Medicare HRA problem will be damaged.

As you probably know, this case represents one of the first efforts we've made to reduce what appeared to us to be "unreasonable" costs by making our action on the specific language of the statute that compels us to pay only "reasonable" costs. We've gone into this knowing it will be difficult in the absence of specific guidelines. However, as I told you in Tampa, while I can't always say what is "reasonable" I can at times say with a fair degree of certainty what is not reasonable. And it did not and does not and will not seem reasonable to me to assume that an HRA operator has more responsibility and should receive more reimbursement (particularly from public funds) than the Mayor of Atlanta, the Commissioner of Social Security, or a United States Senator.

Because newspaper reports of my comments in Tampa and, I believe your opening statement in Miami indicated I "did not wish to get involved in court cases because they would be costly," I would like (as a matter of personal pride, I suppose) to offer this:

As a result of action by this office, the first termination in the country of a hospital's Medicare participation because of "bad motives" took place. This was in Florida in or about 1970. There may have been other terminations on that basis since but I'm not aware of them. The termination caused the hospital to go out of business, which was a blessing. The physician-owner was indicted, tried, convicted, and served time in a Federal institution.

Further, a case that has recently been turned down for review by the Supreme Court—a case involving Mt. Sinai Hospital at Miami Beach and some $5,300,000 in overpayments—came about as a result of action taken by this office. We haven't won that one yet (it's back in district court for hearing of other issues) and perhaps we won't win it. But I am compelled to believe that publicity resulting from our refund demands and the subsequent court action has had a strong and beneficial deterrent effect on other hospitals. Not enough, I'm sure, but certainly some.

Finally, in the Miami area alone (we SST) are defendants in eight court cases, and plaintiffs in at least twelve others. This could hardly have come about had I been unwilling to take the kind of action I took. Knowing some cases would then wind up in court, I would add that the Tierney, Director of the Bureau of Health Insurance, has consistently supported my efforts, including my attempts to base action on the "reasonableness" provision of the statute, even in the absence of the precise regulations or guidelines that would be helpful.

I trust the above narrative will not appear unevenly to you. I send it along, as I indicated, in part because I obviously did not express myself well on the subject in Tampa. More importantly, it is an attempt to show you that this Bureau does not act from a base of bureaucratic timidity but rather—considering the resources available to it and the magnitude of the program—from a base of administrative responsibility and stewardship.

Your hearings have been most beneficial, and I hope you will let me know whenever we can help you further with Medicare problems.

Sincerely yours,

Douglas A. Richard
Regional Representative
The original overpayment for August 31, 1974 was $465,005.00. This amount was reduced to $479,469.24 on March 4, 1975 because of a disallowance for salary costs not incurred based upon a calendar, rather than fiscal year.

The original overpayment on tentative settlement for August 31, 1975 was $127,781.00. This amount was increased to $208,567.00 as a result of disallowing pension costs.

The total overpayment, after revisions for both years was $40,005.92, collected through April 1976, total $413,405.92, leaving a balance outstanding of $403,807.00.

As of January 25, 1976, the outstanding overpayment of Gulf Coast HSA for the period ending August 31, 1975 (revised final settlement) was $403,807.00 and $403,807.00, adjusted at (tentative) rate of 10% per annum, for the period ended on February 14, 1976, and 11 payments of $36,793 each, with the final payment due January 25, 1977.

The payment due February 14, 1976 was not received. On March 4, 1976, as previously mentioned, the overpayment for August 31, 1975 was reduced. This reduction was based on further documentation received from the HSA.

As a result of the pending hearing, Florida Blue Cross was instructed to collect the liability resulting from audit adjustments which were not in dispute. These items, in dispute (salary and salary adjustments) amounted to $26,904.57, leaving a balance of $254,904.57, to be collected over a 12-month period. This equated to $21,005 per month.

The payments due by the 15th of February, March, and April in the amount of $21,005 each were received. Therefore, the total outstanding debt has been reduced to $301,407.00 to date. The unadjusted amount remaining is $194,000.

22. Program Integrity
   A. On May 7, 1976 in the United States Court, Middle District of Florida, Orlando Division, Judge D. Brown, President of Florida Respiratory Centers, Defendant in a civil complaint, was convicted of three (3) counts (18 U.S.C. 930) of Medicare fraud. On May 13, 1976, Judge Hood sentenced Dr. Brown to three (3) years imprisonment, three (3) years probation, and fined him $20,000. All but four (4) months of the sentence were suspended.

   B. On May 13, 1976 in United States Court, Middle District of Florida, Naples Division, a 30 count indictment (2 conspiracy and 28 fraud) under 18 U.S.C. 930 was returned on the following: Ernest White, Edward Whitley, Joanne Whitley, and Alan Ousden. A trial date has not been set, but this case is expected to go to trial in July. These defendants submitted fraudulent bills for a variety of services involving a hospital, an independent laboratory, and orthopedic services.
C. On May 17, 1976 in the United States District Court for the Middle District of North Carolina (Minton-Gillon Division), May T. Campbell (M/T/VA Pulmonary Associates, Inc., Winston-Salem, North Carolina) and Med-A-Rent (Chair, Regional Office Coordinator, Division), Roy T. Campbell (d/b/a Pulmonary Associates, Inc., Winston-Salem, North Carolina) pled guilty to three (3) counts (42 U.S.C. 1395nn(a) misdemeanor of Medicare Fraud before Judge Gordon in Salisbury, North Carolina. The remaining counts (14) were dropped in accordance with plea negotiations. Judge Gordon sentenced Mr. Campbell to 15 months imprisonment and three years probation.

B. On April 4, 1976 in the United States District Court, Southern District of Florida, Harold R. Formanek, D.V.M., entered a plea of guilty to fifteen (15) misdemeanor counts (42 U.S.C., 1395nn(a)). On May 21, 1976, Dr. Bernstein was sentenced to one year imprisonment, 12 months imprisonment and three years probation to run concurrently. All of this was suspended except for 60 days, which he is to begin serving on June 17, 1976. Dr. Bernstein was placed on three years probation. There was no fine.

III. State Operations

With the amount of current interest in home health agencies in Region IV, it is interesting to note that Public Law 94-83, Section 422-h has made available $2 million to be used as seed money to facilitate the development of new home health agencies and the addition of new services to existing agencies. Region IV has been allotted about 40 percent of the available monies. The funding will not be limited to developing agencies in the rural areas but will be made available to any area that has a high density of medically indigents. Ed Sharpe, Chief, Provider Certification Branch, BQS, has been appointed to begin serving on the grant project. He has recently met with agencies in general. Home health services are an essential part of the health care system and we cannot afford to have the further development of this sector stymied by fear of abuse. We believe that most home health agencies are providing good home health services and that the abuses which have been identified in a few agencies will not be characteristic of agencies in general. Home health services are an essential economical part of the health care system and we cannot afford to have the further development of this sector stymied by fear of abuse. We know you are in agreement with this thinking.
Mr. Gene Tischer, Director  
Bay Area Home Health Services  
62 West Miller Street  
Suite 402  
Orlando, Florida 32806

May 18, 1976

Dear Mr. Tischer:

In the March/April 1976 issue of Home Health Line, it is reported that during recent hearings held by Senator Lawton Chiles on home health agencies, your testimony included a statement saying that no salary guidelines are available and that such guidelines are needed.

The Council of Home Health Agencies and Community Health Services of the National League for Nursing, through our Yearly Review, has collected salary information in home and community health agencies since the 1920s. The Yearly Review is an annual survey of policies, practices, and trends in home and community health agencies. The data are collected in April each year from a representative and largely identical sample of official and voluntary agencies of all sizes throughout the country. (The sample is not limited to CHHA/CHS member agencies.) Over the past few years private home health agencies have been included but the small number of returns and the incomplete nature of responses did not permit inclusion in the final survey results.

I am sure you are aware that salary guidelines are set on the basis of 'what is'; therefore, the Yearly Review does, in fact, yield salary guidelines.

Also included in the annual survey is information on cost and charge for home care-of-sick services. A flyer for the CHHA/CHS publication with the 1976 survey results is enclosed. If you have any questions or need further information, please do not hesitate to contact us.

Sincerely,

(Hrs.) Joan E. Caserta, Director

Leah Brock, Statistician

JECET:cb

cc: J. Rutherford
The latest chapter in the Medicare ripoff deals with windfalls of as much as $125 million that have landed in the private hands of persons operating home health agencies in Florida. Once again it is revealed that government's attempts to provide a social service the people desperately need wind up costing exorbitant sums because of inefficiency and unbridled greed.

As with Medicare in general, the home health aid program threatens to topple under its own financial weight, perhaps because the price paid to get the legislation through Congress was too high. The lawmakers had to tread gently around the medical profession, which is capable of throwing up numerous barricades to government programs that by any stretch of the imagination could be called "socialistic." Such programs that do get passed must be seen.to be on the assumption that all persons in health and medicine are honest and do not have to be watched very carefully. In all of Florida there are but two inspectors in the home health field.

Investigations by Herald Staff Writers James Savage and Andy Rosenblatt show that the taxpayer is being stuck for huge salaries, plush furnishings and other non-essential costs that the nation winds up with is programs ex- Chapman.

The entry of entrepreneurs more interested in easy money than in patient care also has threatened to undermine the programs that by any stretch of the nation cannot long afford, regardless of what increases congress may make. It is ridiculous enough.

What the nation winds up with is programs exhibiting the worst features of both socialism and capitalism without any of the benefits of either system. If the system were truly "socialistic," and we certainly are not saying here that it should be, it at least would have the advantage of being better planned. If it were truly capitalist, it would be fraught with so much competition that only the agencies which offered the best service at the lowest price would survive.

Many of its health programs the nation cannot long afford, regardless of what labels are put on them and regardles.s of whether they are response to real needs. If they are to survive they will have to be cleaned up. As a starter the home health mess could be improved by allowing the FBI to investigate the obvious fraud in it. The task was wrongly left to HHS and the U.S. Attorney.

Requiring more honesty is a good policy for any government program, and the least the taxpayers should expect.

[Editorial from the Miami Herald, Apr. 14, 1976]

As LONG AS FRAUD CONTINUES, MEDICARE WILL BE UNHEALTHY

The national ripoff in Medicare is scoundrel enough. What's worse is that Congress is doing nothing about it. Medicare is a creature of Congress—30 years ago. But Congress seems not to know the worst costs of treating Medicare patients, the wide disparity in Medicare charges and outright fraud in many instances.

A Tampa hearing into Medicare practices by Florida's U.S. Sen. Lawton Chiles produced some examples of what Congress should have been investigating years ago:

(114)
appears that they may never get out of them. Renting offers them a psychological

Subcommittee is reviewing the resources and procedures utilized by the Depart-

ments of waste involving excessive rental costs, but they said

stop making monthly reimbursement payments,

ready paid in advance.

lon~

others are not, and the physicians can offer only an educated guess as to

this year to test new methods of eliminating abuses and waste.

In any event, officials anticipate that any major revisions will require new

legislation. According to officials in Keppe's office and to other Medicare experts, several

factors compel beneficiaries to rent aids from the fact that they simply cannot

cannot afford to purchase.

The problem, the officials said, begins with the physicians who treat the Medi-

care patients and then prescribe the kind of medical equipment required at home. While

the duration of some disabilities is relatively easy to determine, others are not, and the physicians can offer only an educated guess as to how long a lesion or a wheel chair will be required.

In cases where there is an unexpected quick recovery, the physician can no

longer rent the equipment, and the government is required under the law to

stop making monthly reimbursement payments to the physician after the aid has al-

ready paid in advance.

Moreover, most patients, except perhaps amputees or persons with similar

permanent afflictions, psychologically tend to reject the permanence of their ill-

nesses. To purchase a bed or a wheelchair, they feel, is to confirm in their minds that they may never get out of them. Renting offers them a psychological

swearing.

The Subcommittee is reviewing the resources and procedures utilized by the Depart-

ment of Health, Education, and Welfare to prevent and detect fraud and abuse in its programs. In connection with this inquiry, the subcommittee requested background information in March of this year and held public hearings in April, May, and June.

A formal report on the subcommittee's continuing investigation is now being prepared, and it is expected to be ready in the near future. It is also my expectation that the subcommittee will give consideration in the near future to the establish-


The report now being prepared will contain a detailed account of the sub-

committee's findings, conclusions and recommendations. However, in view of the

many serious deficiencies discussed by the subcommittee's investigation, I thought it advisable to write to you in advance of the report to urge that corrective action be initiated as soon as possible.

Since the subcommittee's report has not yet been completed, it would be

inappropriate for me to try to speak for other members of the subcommittee at

this time. However, in my judgment, the subcommittee's investigation clearly

disclosed that:

Fraud and abuse in HEW programs are causing enormous losses and greatly

reducing the effectiveness of HEW programs. Resources used to combat fraud and abuse are no inadequate and disorganized that HEW officials have had no way of knowing how large the fraud and abuse problem is or of adequately estimating the losses involved.

3. According to the charter, as published in the Federal Register, the Office of Investigations and Security has departmentwide responsibility and authority for policy direction, planning, coordination and management of investigations.

However, HEW has not complied with this stated policy. Instead, there evidently

is an unwritten agreement that OIS shall take no part in investigative matters

involved the Social Security Administration, even though SSA programs account

for more than 80% of all HEW expenditures.

3. The Office of Investigations and Security is responsible for reporting
directly to the Secretary on fraud and abuse in HEW programs. However, even

though HEW programs involve more than 120,000 employees and expenditure

of $118 billion annually, OIS has only 10 investigators to investigate allegations of fraud. Five of HEW's ten regional offices do not have a single professional investigator assigned. When the subcommittee began its hearings in April, OIS

had a four-year backlog of uninvestigated cases; that backlog has now grown
to approximately ten years.

4. There are thirteen additional professional investigators working for HEW, who do not report to the Secretary. These investigators are assigned to

the Investigations Branch of the Social Security Administration's Office of Admin-

istrative Law and work only on cases referred to them by SSA program units. These investigators currently have no backing—primarily because very few cases

are being referred to them.

5. There are also a number of squad-investigative units which report to the

administrators of some HEW programs. These units do not report to the Secretar-

y, and apparently were established on an individual basis rather than as a part of a coherent and coordinated overall plan. They are currently responsible for investigative operations within their programs and have no responsibility for investigating fraud and abuse in HEW programs. Although they have indicated a willingness to assist the subcommittee, the subcommittee has thus far been unable to determine whether these units can indeed provide the needed assistance.

The subcommittee's report will undoubtedly go into considerably more detail,

but I am sure the above points are more than sufficient to illustrate the basis for my conclusion.

Preliminary issuance of the subcommittee's report, I want to urge that you give

immediate personal attention to strengthening the procedures and resources

used by HEW to prevent and detect fraud and program abuse, and to suggest

specifically that:

1. Immediate action be taken to make the SSA Investigations Branch a part of Department's overall anti-fraud effort, thereby bringing HEW's investigative operations into compliance with the Department's stated policy. This would also make presently utilization of SSA investigatory resources available to meet the pressing needs of the Department much more effective.

2. An immediate review be made of personnel and resources being used for the prevention and detection of fraud and program abuse, for the purpose of evaluating Departmental needs and available resources, and taking appropriate action to assure a high degree of cooperation and coordination among auditors, investigators and program managers.
3. Immediate action be taken to assign at least one qualified investigator to
each regional office; if necessary, this could be accomplished by transferring
qualified investigators from program units to OIS.

I hope these comments and suggestions will be helpful to you. If you would
like any additional information concerning any of the matters discussed above,
please feel free to have the appropriate member of your staff contact the sub-
committee Counsel, Mr. Naughton.

Best personal regards.

Sincerely.

L. H. FOUNTAIN, Chairman.