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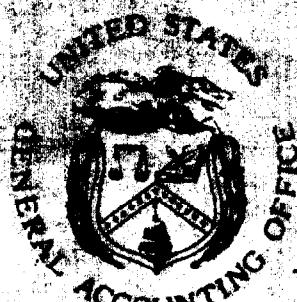
BY THE GENERAL ACCOUNTING OFFICE
**Report to The Honorable
Pete V. Domenici
United States Senate**

**Medicare Home Health Services
A Difficult Program to Control**

A GAO review at 37 home health agencies
found that 27 percent of the visits reviewed
were not covered under the Medicare program
and their coverage status was questionable.
State processing systems generally failed
to meet the standards of care and GAO attributed
this to the lack of information on which
to make informed judgment.

GAO found that the information used to
make coverage decisions was difficult to
obtain and that the criteria to determine
eligibility for home health services were
not clearly defined.

GAO found that the Medicare program
is a complex benefit and that the
costs could be substantially reduced
if the Secretary of Family and
Health Services would have provided the
information required.





UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-204802

The Honorable Pete V. Domenici
United States Senate

Dear Senator Domenici:

This report responds to your August 6, 1979, request regarding Medicare home health services. We made an assessment of the reasonableness and medical necessity of skilled nursing care and therapy, the need for the home health aide services, and compliance with the homebound and other requirements of the program.

We found many cases in which claims processing systems failed to detect noncovered care. Also, determining whether beneficiaries were homebound was difficult because the criteria were unclear. Finally, we believe there is potential for reducing the use of aide services by shifting responsibility for personal care to the beneficiary or family and friends.

This report contains recommendations to the Secretary of HHS. At the request of your office, we did not take the time to obtain agency comments. However, we have discussed our findings with representatives of the Health Care Financing Administration.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of the report. At that time we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Gregory J. Ahart".

Gregory J. Ahart
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE
HONORABLE PETE V. DOMENICI
UNITED STATES SENATE

MEDICARE HOME HEALTH
SERVICES: A DIFFICULT
PROGRAM TO CONTROL

D I G E S T

In fiscal year 1981 nearly \$1 billion will be spent under Medicare for home health care services provided primarily by nurses, therapists, and home health aides. To be eligible for such care, beneficiaries must be homebound, in need of medical attention, and under the care of a physician.

At the request of Senator Pete V. Domenici, GAO made an assessment of the reasonableness and medical necessity of skilled nursing care and therapy, the need for the home health aide services, and compliance with the homebound and other requirements of the program.

NONCOVERED CARE
GOES UNDETECTED

With the assistance of nurse consultants, GAO reviewed a sample of beneficiary medical files at 37 home health agencies and found 27 percent of the home health visits were not covered under the program or were "questionable" (see p. 10). Two major reasons were that beneficiaries were not homebound and the services provided were not reasonable or medically necessary. GAO noted that other studies also disclosed similar results (see p. 17).

In contrast to the noncovered care disclosed, GAO found that Medicare contractors, or intermediaries, such as local Blue Cross plans who administer the home health benefit, deny few claims for payment. This is because the contractors receive from home health agencies little information on which to base a judgment. To provide the Medicare contractors additional information and at the same time provide a balance to the additional administrative cost involved, GAO recommends to the Secretary of Health and Human Services (HHS) that national home health utilization guidelines required by the Omnibus Budget Reconciliation Act of 1981 serve as a basis for determining when a copy of the medical file is to be submitted with a claim for payment (see p. 24).

HOMEBOUND REQUIREMENT
DIFFICULT TO ADMINISTER

GAO found the homebound requirement of the program to be especially difficult to administer. "Occasional," "infrequent," and "short" visits away from the home do not necessarily mean that an individual is not homebound; however, these terms have not been defined. Also in the same vein, to be considered homebound an individual must have a "normal inability" to leave home and consequently leaving home would require a "considerable and taxing effort" or "undue effort." "Feebleness," however, does not qualify an individual as homebound (see p. 12). GAO also noted that, while absences from home and how well an individual ambulates are key factors in determining an individual's homebound status, observations in this regard are not required to be documented as part of the beneficiary's medical file (see p. 12). GAO recommends that the homebound criteria be clarified and that the ambulatory status of beneficiaries and the nature and frequency of absences from home be required to be documented as part of the beneficiary's medical file (see p. 24).

AIDE SERVICES SUPPLANT SUPPORT
PROVIDED BY FAMILY AND FRIENDS

Aide services provide for the personal care of the beneficiary (i.e., bathing, grooming, assistance with medications, etc.) and represent about one-third of all visits provided under the program. Family and friends also provide similar services to the elderly and consequently GAO visited 150 beneficiaries in their homes--those who received aide services and had a live-in partner--to determine if the use of home health aides was supplanting the support provided by family and friends (see p. 40). For 42 or 28 percent of the cases, GAO was of the opinion that the beneficiary was capable of self-care or family or friends were willing and able to provide the services required (see p. 42).

To provide assurance that aide services do not supplant the use of family and friends, HHS should develop a standard aide's need assessment guide which considers the availability and capability of family and friends to provide personal care services. Further, GAO recommends that home health

agencies be required to use it and submit a copy of it with their claims for payment (see p. 50).

GAO also recommends that a policy be established governing the use of aides in situations where beneficiaries or family members are capable of providing personal care but may be in need of some help. Further, GAO recommends a policy be established for situations where family members are capable but appear unwilling or reluctant to provide personal care.

OTHER FACTORS AFFECTING THE
PROPER USE OF HOME HEALTH
SERVICES

GAO found several other factors which were adversely affecting proper utilization of the home health benefit. Specifically,

- physicians who authorize program services do not appear to be taking a very active role in the home health program (see p. 25),
- Medicare contractors had little specific comparative information about the utilization practices of home health agencies (see p. 30),
- the medical documentation in agency case files was often not complete (see p. 31),
- home visits with beneficiaries are needed to verify various program requirements as part of the onsite coverage audits planned by HCFA (see p. 32), and
- contractors have little incentive to make proper coverage determinations (see p. 34).

To address each of these problems, GAO makes recommendations to the Secretary of HHS (see p. 36).

GAO did not obtain HHS comments on this report, at the request of Senator Domenici's office.

C o n t e n t s

	<u>Page</u>	
DIGEST	i	
CHAPTER		
1	INTRODUCTION	1
	Authority and funding	1
	Program administration	1
	Program benefits and eligibility requirements	3
	Objectives, scope, and methodology	4
2	MANY CLAIMED SERVICES ARE NOT COVERED UNDER THE PROGRAM	6
	Home health utilization--an overview	6
	Agency and beneficiary selection	8
	Results of patient case file review	10
	Other studies	17
	Claims processing systems	20
	Conclusions	23
	Recommendations	24
3	OTHER FACTORS ADVERSELY AFFECTING PROPER UTILIZATION	25
	Physicians are not actively involved	25
	Intermediary knowledge of HHA utilization is lacking	30
	Improved medical documentation is needed	31
	Home visits are needed as a part of onsite coverage audits	32
	Quality of intermediary coverage decisions should be evaluated	34
	Conclusions	35
	Recommendations	36
4	GREATER USE OF FAMILY AND FRIENDS COULD REDUCE PROGRAM PAYMENTS FOR AIDE SERVICES	37
	Aide utilization--an overview	37
	Objective and methodology	40
	Results of home visits	41
	Need to strengthen and clarify program requirements	45
	Conclusions	49
	Recommendations	49

	<u>Page</u>
APPENDIX	
I Intermediaries and home health agencies reviewed	51
II Home health manual definition of homebound	54
III Activities of daily living excerpt from the Duke University multidimensional functional assessment questionnaire	56

ABBREVIATIONS

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHA	Home health agency
HHS	Department of Health and Human Services
JCAH	Joint Commission on Accreditation of Hospitals
VNA	visiting nurse association

CHAPTER 1

INTRODUCTION

This report focuses on the utilization controls established for the home health benefit under Medicare 1/ and was prepared at the request of Senator Pete V. Domenici. Controls over the cost of the home health benefit was the subject of an earlier General Accounting Office (GAO) report to the Congress entitled "Home Health Care Services--Tighter Fiscal Controls Needed" (HRD-79-17, May 15, 1979).

AUTHORITY AND FUNDING

Title XVIII of the Social Security Act makes available a broad health insurance program--known as Medicare--for most Americans age 65 and over and certain individuals under 65 who are disabled or have chronic kidney disease. Medicare provides two insurance protection programs for the aged and disabled--hospital insurance (part A) and supplemental medical insurance (part B). Hospital insurance is generally financed by social security payments from employers, employees, and the self-employed. Medical insurance is a voluntary program financed by general tax funds and monthly premiums collected from participating beneficiaries. Both insurance programs cover health services provided to eligible beneficiaries in their homes (home health care).

As of December 30, 1980, 3,022 agencies--1,312 government; 506 visiting nurse associations (VNAs); 420 facility based; and 884 proprietary, private nonprofit, and others--had been certified by Medicare to provide home health care. VNAs predated other home health care organizational forms. Essentially, they were community-based agencies which were supported by philanthropy and patient fees. Government providers consist mostly of county or local public health departments. Facility-based agencies are those agencies that are affiliated with a hospital, a skilled nursing facility, or a rehabilitation facility.

Medicare home health care outlays nationally have increased from \$287 million in fiscal year 1976 to an estimated \$964 million for fiscal year 1981.

PROGRAM ADMINISTRATION

The administration of the Medicare program has been delegated by the Secretary of Health and Human Services (HHS) to the Administrator of the Health Care Financing Administration (HCFA). HCFA

1/In-home assistance is also authorized under title XIX and XX of the Social Security Act and title III of the Older American Act.

administers the program with the assistance of organizations such as Blue Cross and Blue Shield plans and commercial insurance companies such as Aetna Life and Casualty and Mutual of Omaha. Those organizations who help administer part A of Medicare are called intermediaries while those who help administer part B are called carriers.

Home health benefits are authorized under parts A and B of the Medicare program, but intermediaries are responsible for the administration of the home health benefit regardless of which part pays for it. As of December 31, 1980, there were 77 such intermediaries which, among other things, are responsible for: (1) making reasonable payments for services provided by home health agencies (HHAs), (2) serving as a channel of communication between HHAs and HCFA, and (3) assisting in establishing and applying safeguards against the unnecessary use of program services. 1/

HHAs also have the option of dealing directly with the Federal Government through HCFA's Office of Direct Reimbursement. As of September 30, 1980, 469 HHAs did so.

The Social Security Act requires that Medicare payments to HHAs be based on the lesser of reasonable costs or customary charges. HHAs are paid during the year based on estimated costs, but final settlements are limited to those costs found by intermediaries to be proper, reasonable, and related to patient care. The HHAs' annual cost report is the basis for determining allowable costs for furnishing services and determining the share of those costs which are attributable to Medicare. The HHA cost report is subject to a desk review and field audit by the intermediaries.

HCFA has also established prospective cost reimbursement limits on home health services as authorized under section 223 of the Social Security Amendments of 1972. 2/ These limits are by type of home health visit (skilled nursing, home health aide, physical therapy, etc.). Separate limits for urban and rural geographic areas are established for freestanding agencies (generally VNAs, nonprofits, etc.) and facility-based agencies. For

1/Under the law, with HHS approval, Professional Standards Review Organizations (PSROs) can review the use of home health services. However, in the main PSROs have concentrated on reviewing hospital admissions and length of stay.

2/We made an evaluation of these limits at the request of the Chairman of the House Ways and Means Oversight Subcommittee and Senator Bob Packwood. The reports are entitled "Evaluation of the Health Care Financing Administration's Proposed Home Health Care Cost Limits" (HRD-80-84 and HRD-80-85, May 8, 1980).

example, the limits in effect for the year ended June 30, 1981 (exclusive of consideration for the wage level in the area in which the agency is located and other factors), for home health aide visits provided by freestanding facilities in rural and urban areas was \$31.49 and \$32.26, respectively. For facility-based agencies, the limit was \$42.95 for rural areas and \$47.36 for urban areas.

Program regulations governing the home health benefit are embodied in Part 400 of Title 42 of the Code of Federal Regulations. Additional instructions and guidance to HHAs are contained in the Medicare Home Health Agency Manual (home health manual).

PROGRAM BENEFITS AND
ELIGIBILITY REQUIREMENTS

Home health care is health care prescribed by a physician and provided to persons in their homes. Medicare home health care services include

- part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
- physical, occupational, or speech therapy;
- medical social services, which include services necessary for assisting the patient to adjust to social and emotional conditions related to the patient's health problem; and
- part-time or intermittent services from a home health aide, which include helping the patient to bathe and care for the mouth, skin, and hair; to the bathroom and in and out of bed; to take self-administered medications ordered by a physician; and to exercise.

The program also authorizes medical supplies (other than drugs and biologicals) and appliances.

To be eligible for home health coverage under Medicare, a person must essentially be confined to his/her residence (home-bound), be under a physician's care, and need part-time or intermittent skilled nursing care and/or physical, speech, or occupational 1/therapy. Such care must be prescribed by a physician, and the services furnished must be provided by a participating HHA (either directly or through arrangements with others) in accordance with the physician's treatment plan.

1/The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) eliminated occupational therapy as a qualifying service, effective December 31, 1981.

- a 100-visit limitation was eliminated under part A and B,
- a 3-day prior hospitalization requirement under part A was eliminated, and
- a \$60 deductible under part B was eliminated (for home health services only).

The act also eliminates the requirement that proprietary agencies could participate in Medicare only if they were established in States that had licensure laws for proprietary agencies. In addition, the act requires HCFA to designate regional intermediaries to administer the home health benefit.

The elimination of the \$60 deductible under part B coupled with the elimination of the part B co-insurance by the Social Security Amendments of 1972 makes home health services a unique benefit under Medicare. The benefit is available to the beneficiary at no cost.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of this review were to assess (1) the reasonableness and medical necessity of the skilled care provided by HHAs, (2) the need for the home health aide services provided, and (3) the adequacy of controls established to prevent unnecessary utilization of both aide and skilled services. Additionally, the review was designed to assess compliance with the homebound and various other requirements of the program.

The review was performed at HCFA headquarters in Baltimore, six HHS regional offices, 12 fiscal intermediaries and HCFA's Office of Direct Reimbursement, and 37 home health agencies. The names of the offices, intermediaries, and HHAs are listed in appendix I.

The HHS regions were selected primarily to provide coverage of a wide geographic area. The intermediaries were selected mainly because of the relatively large number of HHAs serviced within their respective HHS regions. Also, coverage was desired for commercial insurance companies as well as Blue Cross plans. The specific factors considered in selecting the HHAs is discussed on page 8.

The work at the intermediary locations focused on reviewing their claims processing systems. The work at each of the HHAs keyed on the review of case files of randomly selected beneficiaries; a total of 433 cases were reviewed. The medical aspects of the case file review were performed by registered nurse consultants on loan to us from HCFA and an intermediary.

As part of our review, we also talked with a total of 85 physicians who authorized home health services and we visited a total of 150 beneficiaries in their homes. The purpose of the physician contacts was to discuss the authorizing plan of treatment relative to the services actually provided. The purpose of our visits to beneficiary homes was to observe first-hand the physical condition of the patient and the environment in which he/she lived. More specifically we were interested in determining whether aide services could be performed by either the beneficiary or a live-in partner.

Statistical data developed during this review cannot be projected. We believe, however, the data, along with other studies and evidence presented in the report, supports our conclusions and recommendations.

At the request of Senator Domenici's office, we did not obtain comments on this report from HHS.

CHAPTER 2

MANY CLAIMED SERVICES ARE NOT COVERED

UNDER THE PROGRAM

About 20 percent of the home health services reviewed by the nurses who assisted us are not covered 1/ under the program because in their judgment the services were not reasonable or medically necessary or because they failed to meet other program requirements such as being homebound. Also the coverage status for an additional 7 percent of the services was considered "questionable." Other HCFA and intermediary studies have also shown high rates of noncovered care provided by HHAs. However, only about 2 percent of home health claims are denied by intermediary claims processing systems.

Intermediary payment systems generally are not capable of detecting noncovered services because sufficient information on which to base a decision is not included on the claims forms or other documents sent to intermediaries. HCFA needs to take a number of steps to increase the capability of intermediary claims processing systems to detect noncovered care. Specifically, where utilization exceeds an established norm, HHAs should be required to submit to intermediaries a copy of the beneficiary's medical file. Also, the regulations regarding homebound status need to be clarified and nurses and aides should be required to document the beneficiary's ability to ambulate and the nature and frequency of absences from the home.

HOME HEALTH UTILIZATION-- AN OVERVIEW 1/

The use of home health services has increased dramatically. Between 1974 and 1978, the number of Medicare enrollees using home health services increased from about 393,000 to 770,000. Over the same time, the total number of visits increased from 8.1 million to 17.3 million while the average number of visits per person served increased from 20.6 to 22.5. Since 1974, the Northeastern part of the country has had the highest user rate (39.6 of every 1,000 enrollees received home health services in 1978). For the other parts of the country, in 1978 the user rate ranged from 23 to 28 per 1,000 enrollees.

1/The term not covered as used in this report means that the services are not normally reimbursable for any of several reasons, e.g., services are not reasonable or medically necessary; the patient is not homebound; and services exceeded the plan of treatment.

Selected demographic data show that urban populations, women, and older individuals use more home health services. Enrollees living in metropolitan areas have a user rate (31.5 per 1,000 enrollees) that is 45 percent higher than those living in nonmetropolitan areas (21.7 per 1,000). The user rate among women (31.4 per 1,000 enrollees) was 30 percent higher than for men (24.2 per 1,000). Finally, among the aged, the user rate increases from 11.6 per 1,000 among those 65 to 66 years of age to 61.1 per 1,000 among those 85 and older.

In 1978, VNAs served nearly 40 percent of the persons receiving services under the program and provided and more than a third of the visits. Private nonprofit HHAs on the average provided more visits per beneficiary served than any other type of HHA. The following table compares home health utilization by type of HHA.

1978 Home Health Utilization Data

<u>Type of agency</u>	<u>Beneficiaries served</u> (thousands)	<u>Visits</u>	
		<u>Number</u> (thousands)	<u>Per beneficiary served</u>
VNAs	297.6	6,335	21.3
Private nonprofit	160.9	4,464	27.7
Government	152.2	3,053	20.1
Hospital-based	87.8	1,877	21.4
Proprietary	37.5	925	24.7
Combined government and voluntary (note a)	21.3	391	18.4
Other (note b)	<u>12.5</u>	<u>300</u>	24.0
All agencies	<u>c/769.7</u>	<u>17,345</u>	22.5

a/Usually these HHAs are jointly administered by a State or local health department and a VNA.

b/Includes rehabilitation and skilled nursing facility-based agencies.

c/Does not add exactly because of rounding.

1/Utilization data presented in this section were developed by HCFA's Office of Research, Demonstrations, and Statistics and are the most current data available.

The following table shows that 42.6 percent of the users accounted for only 8.6 percent of the visits made under the program-- on the average 4.6 visits per user. Conversely, 12.1 percent of the users accounted for 46.3 of the visits made and about 25,000 users in this group received on the average 135.1 visits.

1978 Visit Rates for Home Health Users

<u>Number of visits</u>	<u>Persons served</u>		<u>Visits</u>		
	<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent</u>	<u>Per beneficiary</u>
	(thousands)		(thousands)		
1-9	328.1	42.6	1,496	8.6	4.6
10-19	173.4	22.5	2,403	13.9	13.9
20-29	88.8	11.5	2,139	12.3	24.1
30-39	52.6	6.8	1,792	10.3	34.1
40-49	33.9	4.4	1,500	8.7	44.2
50-99	68.3	8.9	4,693	27.1	68.7
100 and over	<u>24.6</u>	<u>3.2</u>	<u>3,323</u>	<u>19.2</u>	135.1
Total	<u>769.7</u>	<u>a/100.0</u>	<u>a/17,345</u>	<u>a/100.0</u>	22.5

a/Do not add exactly because of rounding.

AGENCY AND BENEFICIARY SELECTION

We selected three HHAs 1/ from each of 12 intermediaries reviewed. For HCFA's Office of Direct Reimbursement, five agencies were chosen. The total number of HHAs reviewed was 37.

In selecting HHAs, our principal selection criterion was the extent of the use of home health aide visits, that is, percentage of aide visits to total visits and the percentage of beneficiaries receiving aide visits. The greater the use of aides, the greater the likelihood that the agency would be selected. Our reason for giving weight to aides was that we were particularly interested in determining the availability of family and friends to perform the personal care services provided by aides. This particular point is discussed in more detail in chapter 4 of this report. Also, overall we attempted to give coverage to all types of agencies that participate in Medicare's home health program, i.e., VNAs, proprietaries, nonprofits, etc. Finally, we did not select any HHAs that were included in our May 1979 report (see p. 1) or any HHAs which were under investigation by HCFA or HHS.

1/Only two HHAs were reviewed at four intermediaries because of low aide utilization and/or time constraints.

Generally we selected 12 case files for review at each agency; overall, 433 cases were reviewed. The selections were random from the universe of the HHA's Medicare patients who 1/

- were receiving services at the time of our visit,
- had their services billed for reimbursement,
- were receiving aide visits, and
- had been provided at least 2 months of services.

Twelve nurse consultants made the case reviews--11 registered nurses employed by HCFA and 1 registered nurse employed by an intermediary.

The major program requirements for which the nurses assessed HHA compliance were

- the patient is homebound;
- skilled care is needed;
- the services provided are reasonable and medically necessary;
and
- the primary function of a home health aide is the personal care of the patient, but homemaker services can be provided if they are incidental to the personal care and do not substantially increase the time spent by the home health aide.

The findings of the nurses were based on their review of the patient case files. These files are supposed to contain all information pertinent to the medical condition of the patient, the services actually provided, and the progress made by the patient. Also, for 150 of the cases reviewed, the nurses accompanied us on our visits to the patients' home and accordingly had the opportunity to observe the patients' condition firsthand.

Recognizing that there is necessarily an element of judgment involved in making such assessments, the nurses recorded their findings in two categories

- those visits where, in the nurses' opinion, the services clearly were not covered under the program and
- those services where the nurses felt the services to be "questionable," that is, on the basis of the available

1/In some cases, particularly involving smaller HHAs, we were unable to meet all of our selection criteria.

records, the nurse could not make a conclusive coverage determination.

RESULTS OF PATIENT CASE FILE REVIEW

Our nurse consultant reviews disclosed a significant number of visits claimed that were not covered under the program. 1/ The following table summarizes the findings.

Noncovered and Questionable HHA Visits for 433 Beneficiaries

<u>Reason</u>	<u>Non-covered</u>	<u>Questionable</u>	<u>Total</u>
Not homebound	432	422	854
Services not reasonable or medically necessary	1,706	480	2,186
Aide visits ineligible because skilled care requirement was not met	1,177	348	1,525
Aide visits--no personal care given or care primarily homemaker services	487	87	574
Other	<u>795</u>	<u>244</u>	<u>1,039</u>
Total	<u>4,597</u>	<u>1,581</u>	<u>6,178</u>
Unduplicated total			5,070
Total visits reviewed			18,586
Unduplicated total as a percent of total visits reviewed			27%

The rate for the visits considered to be noncovered and questionable for HHAs reviewed ranged from zero percent to 87 percent of the visits. Further, 98 percent of the noncovered and questionable services were claimed by 28 of the 37 HHAs reviewed. The following table presents a frequency distribution of the noncovered and questionable care found by the nurses.

1/As discussed on p. 21, nearly all of the services claimed were paid by the intermediaries.

Frequency Distribution for HHA
Visits Not Covered and Questionable

<u>Percent of</u> <u>visits reviewed</u>	<u>Number of HHAs</u>
less than 5	9
5-10	2
11-20	7
21-30	5
31-40	4
41-50	5
over 50	<u>5</u>
Total	<u>37</u>

The following discusses in more detail the nature of the nurses' findings. Also discussed is the HCFA guidance on coverage of home health services.

Not homebound (854 visits)

The 854 visits involved 33 or about 8 percent of the cases reviewed by our nurse consultants. Two of the most common reasons given for the noncovered or questionable homebound status of the beneficiaries are that either the patient can ambulate or the patient in fact does leave the home. Some examples follow:

- Has dinner out daily and goes shopping 2 times a week.
- Patient has been working in yard.
- Walks independently indoors, outdoors, and climbs stairs with and without cane.
- Nursing care plan indicated ambulation goals were met.
- Aide indicates patient ambulates well.
- Attends day care center full time.
- Ambulatory with minimal or no assistance.
- Patient not home.

III

The requirement that an individual be homebound to be eligible for home health services is the characteristic that makes home health care unique from all other health services. Because the individual cannot leave his or her home to receive needed health services, the health care must be brought to the individual. Assuring that beneficiaries meet the homebound requirement, however, is

extremely difficult. Further, given HCFA's vague definition and guidance on what constitutes being homebound, we believe an HHA could successfully challenge many nonhomebound determinations, including those of our nurse consultants.

HCFA's homebound criteria have key undefined terms and require HHAs and intermediaries to make value laden judgments. Further, the criteria--which is shown in appendix II--are indicative of the complexity and difficulty of administering this aspect of the home health benefit.

The criteria state, for example, that the individual is to be confined to his or her home but that this does not necessarily mean that the patient is bedridden. At the same time, the criteria state that an individual must have a "normal inability" to leave home and consequently leaving their home would require a "considerable and taxing" or "undue effort." The criteria point out, however, that an individual who does not often leave his/her home only because of "feebleness" and "insecurity" cannot be considered homebound. We believe that in many cases (particularly for the elderly) it would be extremely difficult to distinguish between what is meant by "feeble" (defined by Webster's New Collegiate Dictionary as "markedly lacking in strength") and a condition which--to leave the home--would require "undue effort" or a "considerable and taxing effort."

The criteria state that "generally" an individual can be considered homebound if he or she uses supportive devices, such as canes, crutches, wheelchairs, walkers, special transportation, or requires the assistance of another person to leave the home. While such situations may generally result in a person being homebound, at the same time, it is not uncommon to observe individuals outside their home who use supportive devices or who are walking with the assistance of another individual.

The criteria also state that the beneficiary can be considered homebound even if he or she leaves the home, but does not specifically state under what circumstances. The criteria state that such absences must be "occasional" or "infrequent," of "relatively short duration," and must "not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home."

Even with more specific criteria, determining the homebound status of beneficiaries would be difficult. At present there are no specific requirements to document how easy or how difficult it is for beneficiaries to ambulate. Nor are there any specific requirements to document the frequency and nature of absences from the home. Consequently, in some cases, for an intermediary to independently validate a beneficiary's homebound status--which can and does change over time--we believe a visit to the beneficiary's home would be required.

A patient's capacity to obtain medical services outside the home is a critical issue in trying to control program costs. While home health services have been frequently cited as cheaper than hospitalization or nursing home care, a visit to a doctor's office or a doctor's home visit is often cheaper than a skilled nursing visit or for that matter an aide visit. A physician summed it up this way: "* * * the doctor doesn't get that much money for a better exam in the office." The following table shows selected 1980 physician charging patterns.

Physician Prevailing Charge Summary Data
for the Year Ended June 30, 1980 (note a)

<u>Procedure</u>	<u>General practitioners</u>	<u>Specialists</u>
Followup office visit:		
Minimal	\$10.86	\$11.48
Brief	11.23	16.30
Limited	14.89	17.12
Intermediate	18.26	20.83
Extended	27.60	28.91
Complete	38.86	45.59
Followup home visit (note b):		
Brief	18.49	22.13
Limited	(c)	25.04
Intermediate	20.93	23.20

a/Under part B of Medicare, reimbursement to physicians is based on the lower of the billed amount, the customary charge, or the prevailing charge. The customary charge represents the charge for a given procedure that a physician "customarily" or usually bills. The prevailing charge is the lowest charge on an array of customary charges which is high enough to include 75 percent of all physician customary charges for a given geographical area or locality. The prevailing charges in the above table represent the weighted average of the prevailing charges for all Medicare carrier localities for the year ended June 30, 1979. To convert the data to a 1980 charge level, we increased the 1979 data by 8.1 percent which represent the maximum percent increase in physician prevailing charges permitted in accordance with the Medicare legislation.

b/For the year ended June 30, 1979, about 1.7 million followup home visits were billed under part B of Medicare.

c/Insufficient data.

The Medicare reimbursement limits for skilled nursing visits for the year ended June 30, 1980, were \$41.80 for urban areas and \$38.05 for rural areas. ^{1/} Comparing these limits to the physician charging patterns shown above shows that physician charges are greater for only one procedure--a complete followup office visit. Also, in comparing the cost limits for aide services--\$33, urban; \$27.70, rural--physician charges are greater for only extended and complete followup visits.

Services not reasonable or medically necessary (2,186 visits)

The vast majority of services in this category were skilled nursing visits and aides services. To provide some insight into the nature or reasons for the coverage problems the nurses disclosed, we analyzed their review sheets and notes, the results of which are shown below.

Services Not Reasonable or Medically Necessary

<u>Reason</u>	<u>Visits</u>		
	<u>Skilled nursing</u>	<u>Aide</u>	<u>Total</u>
Frequency should be decreased	362	368	730
Patient or family is able to provide care		456	456
Patient does not need skilled care or no skilled care given	297		297
No specific reason given or specific reason not clear (note a)	125	159	284
Visits extended beyond period of need or the patient's condition is stable	<u>258</u>	<u>12</u>	<u>270</u>
Total	<u>1,042</u>	<u>995</u>	<u>2,037</u>

^{a/} For these visits, the nurses classified the services as "not reasonable or medically necessary," however, we were not able to identify a precise reason. Either no specific reason was given or the stated reason was not clear.

A typical example where the frequency of visits could be reduced is a situation where a beneficiary is receiving three skilled visits per week but where two visits are sufficient. There is

^{1/} HCFA subsequently modified its method for establishing reimbursement limits for home health care (see p. 2 of this report).

little guidance in HCFA's home health manual on the frequency of skilled nursing visits. Whether an individual needs three or two visits per week is largely left to the judgment of HHA and we believe that it would be extremely difficult to "manualize" hard and fast criteria in this respect.

Concerning the frequency of aide visits, in March 1981, HCFA revised the home health manual to require HHAs to justify those situations where aide services are provided more than 1 to 2 hours per day, two or three times per week. Prior to the revision and at the time of our review, the manual was unclear about the frequency of aide visits and was interpreted by some intermediaries to mean that aide services would have to be justified only if they exceeded 100 hours per month.

Using aides to provide services where the beneficiary or a family member can perform such services is the issue addressed in chapter 4 of this report. In brief, we believe program expenditures could be reduced significantly if appropriate consideration were given to the availability of family and friends to provide personal care services.

A basic program requirement for coverage under Medicare is that the beneficiary needs skilled care and that the care must in fact be provided. There were 297 visits where this basic requirement was not met.

Finally for the last category, where visits extended beyond the period of need, an example is a beneficiary whose vital signs (blood pressure, pulse, etc.) have been monitored following treatment for a thyroid condition. The nurse's notes show that the vital signs have stabilized but monitoring continues unnecessarily in the judgment of the nurse.

Aide visits--no personal care given
or care primarily homemaker services
(574 visits)

The Medicare law authorizes the part-time or intermittent services of a home health aide "to the extent permitted in regulations." Concerning homemaker type services, the regulations state that the services of housekeepers or food service arrangements, such as those of "meals-on-wheels" programs, are not considered as home health services (CFR 405.237) but "household services essential to health care at home" are permitted (CFR 405.1227).

The home health manual states that the primary function of a home health aide is the personal care of the patient. Personal care duties include assistance in the activities of daily living, e.g., helping the patient to bathe, to get in and out of bed, to care for hair and teeth, to exercise, and to take medications. The manual also states, however, that

"While the primary need of the patient for home health aide services furnished in the course of a particular visit may be for personal care services furnished by the aide, the home health aide may also perform certain household services which are designated to the home health aide in order to prevent or postpone the patient's institutionalization. These services may include keeping a safe environment in areas of the home used by the patient, e.g., changing the bed, light cleaning, rearrangements to assure that the beneficiary can safely reach necessary supplies or medication, laundering essential to the comfort and cleanliness of the patient, etc., seeing to it that the nutritional needs (which may include the purchase of food and assistance in the preparation of meals) of the patient are met, and washing utensils used in the course of the visit. If these household services are incidental and do not substantially increase the time spent by the home health aide, the cost of the entire visit would be reimbursable. Housekeeping services which would materially increase the amount of time required to be spent by the home health aide to make the visit above the amount of time necessitated by care for the patient are not reimbursable." (Underscoring added.) * * *

The manual implies that household services are permitted under the condition that they prevent or postpone institutionalization. Conceivably, we believe all or any service could contribute to this goal and consequently the criteria are too general. The manual also provides that household services are permitted if they are "incidental" and do not "substantially" or "materially" increase the amount of time for the visit; these terms, however, are not defined. Finally, the manual provision implies that--where the services provided are primarily household services--the time spent for personal care is reimbursable but that the household services or the time spent for the household services are not reimbursable. This aspect of the criteria presently cannot be administered--most HHAs bill on a visit basis and not on an hourly basis. Further, while HCFA allows HHAs the option of billing on an hourly basis, HCFA does not require that HHAs breakout the time spent on homemaker type services.

Other (1,039 visits)

This category represents those visits judged to be noncovered or questionable for a wide variety of reasons or where the reasons given by the HCFA nurses were not clear. Some of the reasons are

- medical social services were not covered because the program's skilled care requirement was not met;
- visits exceeded plan of treatment;
- visits were not documented;
- visits were billed in instances when the patient was not home or where the patient refused services;
- aide visits were questioned or not covered apparently because maids, attendants, or live-in companions were available and did provide personal care to the patient;
- the services provided duplicated those of a physician; and
- occupational therapy appeared to duplicate physical therapy services.

OTHER STUDIES

Other reviews of HHA claims paid by intermediaries have disclosed results similar to the findings of our nurse consultants.

As early as June 1976, a HCFA study of HHA claims processed by 35 intermediaries disclosed that 13 percent of approved claims should have been denied. The claims (representing the 20 most common diagnoses) were reviewed by medical staff and were randomly selected from claims generally processed in February of 1975.

In August 1978 testimony before the Subcommittee on Oversight, Committee on Ways and Means, the Blue Cross Association ¹/ spoke of inappropriate and excessive home health utilization. Specifically, the Association representative said that the following problems were prevalent and significant among the Blue Cross plans:

- "1. Provision of home health services when no medical need was indicated.

¹/The Blue Cross Association is the prime Medicare contractor for Blue Cross plans and in turn subcontracts with individual local Blue Cross plans throughout the country.

2. Continuation of home health services beyond a reasonable period of time for the patient's condition.
3. Termination of services to Medicare beneficiaries when home health benefits were exhausted, but the patient required continued care.
4. Provision of skilled nursing observation and monitoring for extended periods, although not required because the patient's condition had stabilized.
5. Excessive use of home health aide services.
6. Submission of medical information which, upon investigation, failed to provide a true picture of the patient's condition or medical needs."

During 1979 and 1980, HCFA's San Francisco Regional Office conducted evaluations of eight intermediaries to see if they were effectively applying Medicare coverage criteria when reviewing HHA claims. Randomly selected claims were reviewed by a registered nurse who disagreed with the payment decisions made for 39 percent of the claims decisions made by the intermediaries. The rate of disagreement ranged from 13 percent to 86 percent; a detailed breakdown follows.

HCFA Regional Office Home Health Claims Review (note a)

<u>Intermediary</u>	<u>Number of claims in sample</u>	<u>Number of claims disagreed with by Regional Office (note b)</u>	<u>Percent of disagreement</u>
Blue Cross of Northern California	55	19	35
Kaiser Foundation	21	18	86
Hawaii Medical Service Association	25	12	48
Aetna Life and Casualty Novato, California	23	3	13
Blue Cross of Southern California	20	5	25
Aetna Life and Casualty Reno, Nevada	20	5	25
Office of Direct Reimbursement	<u>20</u>	<u>10</u>	50
Total	<u>184</u>	<u>72</u>	39

a/Data not available for Blue Cross of Arizona.

b/Data do not indicate the number of visits denied and include both partial and complete disagreement.

Several 1981 reports prepared by HCFA's Bureau of Quality Control found significant problems. A March 1981 report disclosed that for five HHAs in Mississippi, 75 of 163 cases reviewed, or 46 percent, were fully or partially noncovered. In another March 1981 report on four HHAs in Florida, the Bureau did not specify the extent of the problems found but nonetheless recommended that intensified onsite medical reviews be conducted by the intermediary. A January 1981 study of nine California HHAs disclosed that 24 percent of the 4,363 visits reviewed for eight of the nine HHAs were noncovered. Finally, a HCFA official informed us that a review of a sample of claims processed by three intermediaries in Pennsylvania, New Jersey, and Ohio showed that

--where medical records were reviewed, 26.6 percent of the visits were noncovered and

--where claims (and not medical records) were reviewed 21.3 percent of the visits were questionable; that is, a review of the medical records would be required to ensure the proper program payment was made.

HCFA's Office of Direct Reimbursement carried out six medical audits. Five of these disclosed that 2,356 of the 5,441 visits (43 percent) reviewed were deniable or questionable. The percentage of disallowance ranged from 17 to 73 percent. For the other audit, 6 of 20 beneficiaries had received services which were noncovered.

In fiscal year 1980, HCFA started a pilot program in its Atlanta region whereby Aetna, Florida Blue Cross, and the Office of Direct Reimbursement were to perform intensified onsite medical audits at all "mainly-Medicare" agencies plus any other agencies for which problems had been detected. Later that year, the program was expanded to the HCFA Dallas and San Francisco regions. The results of these audits as of December 31, 1980, follow.

Results of Intermediary Audits

<u>HHS region</u>	<u>Number of audits</u>	<u>Period covered</u>	<u>Percent denials</u>
Atlanta	80	FY 1980	6.2
Dallas	33	July - December 1980	8.9
San Francisco	<u>2</u>	October - December 1980	<u>a/13.7</u>
Total	<u>115</u>		

a/Includes claims not yet reviewed by intermediary.

The overall denial rate based on intermediary medical audits is about three to four times the denial rate resulting from intermediary claims processing systems but the rate is generally considerably less than the denial rates shown by our nurse consultants and other HCFA and intermediary studies. To try to explain these differences, we talked with officials of Florida Blue Cross. The intermediary performed 41 or about 50 percent of the audits in the Atlanta region and also reviewed three HHAs which were reviewed by our nurse consultants. The intermediary did not find any noncovered care at the three HHAs while our nurse consultant found 12 percent of the visits reviewed in one agency to be noncovered, 34 percent in another, and none in the third.

Blue Cross officials generally agreed with our nurse consultants but felt that the Medicare regulations were too vague and general to support many of the denials. Further, they stated that for the HHAs they reviewed, the agencies essentially determined which case files would be reviewed and accordingly HHAs would select the sickest patients.

CLAIMS PROCESSING SYSTEMS

Intermediary claims processing systems identify little non-covered care in contrast to that identified by onsite audits of medical records. The reason is that in processing claims reviewers have little information on which to base a judgment. Conversely, the medical records, especially nurse and aide notes, are supposed to contain all information pertinent to the beneficiary's medical condition, the particular care given, and the beneficiary's response to the treatment given. To provide greater assurance that Medicare pays for only covered care, intermediaries need to routinely receive more information from HHAs.

Existing processing systems

Intermediary claims processing systems vary considerably. Generally, however, the systems can be described in terms of the use and/or nonuse of coverage screens or guidelines. Screens or guidelines are parameters used to identify during initial claims review those claims that are to be paid and at the same time those that are to be reviewed at a higher level. Most intermediaries use some type of screen or combinations of screens which can take on many forms. For example, a claim would be reviewed at a higher level if

--for a given diagnosis, skilled nursing visits exceeded a norm on either a weekly, monthly, or bimonthly basis;

--a patient has a certain diagnosis, such as diabetes, which in itself would not establish his or her homebound status;

--treatment exceeded a given number of months since care was initiated; or

--the claims were being submitted by a new provider.

In contrast to the noncovered care disclosed as the result of reviewing medical records, few claims or visits are denied during claims processing. For example, for fiscal year 1980, only about 2 percent of the home health claims processed were partially or totally denied. Also, for the home health visits questioned or considered to be noncovered by our nurse consultants, nearly all of them were paid by the intermediaries. ^{1/} For example, for 17 HHAs our nurse consultants reviewed paid claims. For the five HHAs served by the Office of Direct Reimbursement, of the 1,616 visits judged to be noncovered or questionable, only 14 were denied payment.

The documentation received by intermediaries generally consists of a start of care notice, a bill for reimbursement, and a plan of treatment or medical information summary. For the most part, the documentation provides little information on which to base coverage decisions.

The start of care notice provides beneficiary, provider, and physician identifying information and indicates the date care has started. The notice basically is used by the intermediary to establish the Medicare beneficiary's eligibility and the only medical information required on the form is a brief statement of the patient's diagnoses. The billing form contains much of the same information contained on the start of care notice but also provides by type of visit the total number of visits made.

The plan of treatment or medical information summary, while not a Medicare requirement, is required or received by most intermediaries that we reviewed, including the Office of Direct Reimbursement. In terms of medical information, nearly all of the 22 different forms used by HHAs we visited showed the frequency of services per week by type of visit. Also, most provided some type of narrative or description of the types of services (check vital signs, change dressings, and provide personal care) that were to be given. Finally, most forms provided a description of the patient's medical problem; some were fairly detailed while others were brief.

^{1/}Given the overall low denial rates of intermediary claims processing systems and because of time constraints, we did not verify that payment was made for claims submitted by eight HHAs. Also, for seven other HHAs, we verified payment on a sample basis.

The advantages of medical information in summary form is that paperwork requirements are reduced. The disadvantage, however, is that the use of summaries permits the disclosure of information on a selective basis, and, because the principal purpose of medical information submitted is to establish Medicare eligibility or justify payment, there is an incentive not to disclose information which could jeopardize eligibility or payment.

In discussing the type of noncovered care disclosed by our nurse consultants, the intermediaries we reviewed told us that they did not routinely receive from HHAs the information needed to make those kinds of judgments. As noted earlier, our nurse consultants reviewed beneficiary medical files. Most of the intermediaries we reviewed estimated they received or requested aide and nurse notes for 5 percent or less of HHA claims processed. Asked why they did not request aide and nurse notes more frequently, the most common reason given by intermediaries was that it was too costly.

Additional information needed

Intermediaries need more information on which to base coverage decisions. The results of our review of services provided by HHAs, and the results of other similar studies, indicate that claims for too many noncovered and questionable services are being paid. We believe that section 2152 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) provides HHS with the opportunity to provide the intermediaries with such criteria and require the intermediaries to obtain and use the additional information necessary to make adequate coverage determinations. Section 2152 requires HHS to establish utilization guidelines to be used for home health service payment purposes and to provide for the implementation of such guidelines through postpayment coverage review by intermediaries or through other means.

HHS could establish the required guidelines on the basis of norms like those discussed on page 20. These norms could then be used as thresholds; that is, whenever a norm is exceeded HHAs could be required to justify the provision of the services by submitting to the intermediary medical records and other information on which the intermediary could base a coverage determination. Also, intermediaries could be required to make the same review for a sample, of a predetermined size, of services provided to beneficiaries which do not exceed the norms.

A system such as that described above would ensure that the most questionable claims for payment would receive a coverage review based on the medical circumstance surrounding the beneficiary. It would also provide a deterrent to providing noncovered services just up to the norms because a sample of claims below the norms would also be reviewed. Also, it would help minimize the paperwork

HHAs would be required to submit because the additional information would only have to be submitted on an exception basis. Finally, it would provide an incentive to HHAs to improve the quality of their records (see p. 31) because HHAs would know that their records will be used as a basis for determining whether claims will be paid.

Whatever norms are developed they could be made available to HHAs so that they understand the criteria being used. This would also expedite claims processing because HHAs could submit the required documentation when submitting the claims for services exceeding the norms.

CONCLUSIONS

The utilization of Medicare home health services needs to come under much closer scrutiny by HCFA and its intermediaries. At present, a wide gap often exists between the utilization practices of HHAs and the coverage requirements of the program.

Onsite audits of HHA case files have traditionally disclosed significantly more noncovered care than intermediary claims processing systems. The reason is that HHA medical files provide a much more complete and accurate description of the patient's condition and treatment than is provided by the information routinely submitted by HHAs to justify reimbursement.

Intermediaries need more information on which to base payment decisions. To achieve this end and at the same time a balance between improved administration and the additional administrative costs involved, HCFA should use the national utilization screens mandated by the Omnibus Budget Reconciliation Act of 1981. Where utilization exceeds the norm, HHAs should be required to submit a copy of the medical file to justify payment. To detect unnecessary utilization under the screens or norms, intermediaries should be required to sample a fixed percent of these claims and require HHAs to submit a copy of the medical file.

Establishing the homebound status of beneficiaries is especially difficult and at the same time critical. The criteria require value laden judgments and contain undefined key terms. Further, the ambulatory status of the beneficiary and the frequency and nature of absences from the home are not required to be documented as part of the medical file. The critical aspect is that alternative sources for needed medical care are often less expensive. Program outlays for a visit to a physician's office often are less than the cost of a nurse or aide visit to a beneficiary's home. HCFA needs to clarify and make more specific the homebound criteria and also require HHA nurses and aides to document the ambulatory status of beneficiaries and the nature and frequency of absences from the home.

The manual provisions on the use of aides for household or homemaker services should be clarified. Specifically, the criteria should specify more clearly when such services are authorized and how much time an aide can spend in providing them.

RECOMMENDATIONS

We recommend that the Secretary of HHS direct the Administrator of HCFA to

- require HHAs to submit a copy of the beneficiary's medical file where utilization exceeds the national guidelines mandated by the Omnibus Budget Reconciliation Act of 1981;
- require intermediaries to obtain from HHAs a copy of the medical file for a fixed percent of claims that do not exceed the national guidelines;
- clarify and make more specific the criteria for determining homebound status;
- require HHA nurses and aides to specifically document the ambulatory status of beneficiaries, including the nature and frequency of absences from the home; and
- clarify the criteria on the use of aides for homemaker type services.

CHAPTER 3

OTHER FACTORS ADVERSELY AFFECTING

PROPER UTILIZATION

Our review disclosed several other issues that need to be addressed to assure that appropriate controls exist over the use of home health services. Specifically,

- physicians who authorize program services do not appear to be taking a very active role in the home health program,
- intermediaries had little specific comparative information about the utilization practices of HHAs they serviced,
- the medical documentation in HHA case files was often not complete,
- home visits with beneficiaries are needed to verify various program requirements as part of the onsite coverage audits planned by HCFA, and
- intermediaries have little incentive to make proper coverage determinations.

PHYSICIANS ARE NOT ACTIVELY INVOLVED

The intent of the authorizing legislation was that physicians would play an active role in the home health care program. In practice, however, this does not appear to be the case. For example, it appears that generally HHAs and not physicians determine the nature and extent of services provided. HCFA needs to take a number of steps to provide for greater and more meaningful involvement by physicians.

Legislative intent and program regulations

Senate Report 89-404--which accompanied the Social Security Amendments of 1965--states that the Congress intended to pay for "* * * visiting nurse services and related home health services when furnished in accordance with a plan established and periodically reviewed by a physician." According to the report, "* * * the physician is to be the key figure in determining utilization of health services * * * Since the nature and extent of the care a patient would receive would be planned by a physician, medical supervision * * * would be assured." The Congress also intended that the Medicare conditions of participation for HHAs be "* * * designed primarily to assure that participating agencies are basically suppliers of health services."

Medicare program regulations require that items and services must be furnished under a plan of treatment established and periodically reviewed by a physician. Generally, the plan must be put into writing by the physician and provided to the HHA which has accepted the patient as a client. According to the regulations, the plan must include the diagnosis and a description of the patient's functional limitations resulting from the illness or injury, the type and frequency of needed services, supplies and appliances necessary for the care of the patient, and, as far as possible, provide a long-range forecast of likely changes in the patient's condition. The regulations also provide for the plan to be developed in consultation with the HHA so that the physician has the benefit of the HHA evaluation of the patient's home environment. Finally, the plan is to be reviewed and recertified in writing by the attending physician at least every 60 days.

Preparation of plan of treatment

Both HCFA and intermediary officials told us that HHAs were preparing the plans of treatment and the physicians were signing them with little or no review. HHAs told us that the plans are developed by them and/or in-consultation with the physician. HHAs further stated they were often in a better position to develop a plan because HHAs had the benefit of directly assessing the situation in the patient's home. Also, most of the 85 physicians we contacted acknowledged that HHAs in fact developed the plan of treatment, either with or without consulting them. A Director of Nursing at an HHA summed it up this way: "The physicians do not want to be bothered with the paperwork and would rather the agency develop the plan."

While there is a consensus that HHAs--and not physicians--are in many cases preparing the plan, almost all plans are in fact signed by physicians. The question then is--what is the extent and quality of the consultation between the physician and HHA and/or how carefully does the physician review the plan he or she signs? Although it is very difficult to assess the quality and extent of physician review or consultations, evidence suggests that in many cases physicians are not that actively involved. Specifically,

--in discussing with physicians the services they authorized and those actually provided by HHAs, 73 or 86 percent of them said they were not aware of or did not realize the total number of visits involved or the cost of the services rendered;

--of the 1,112 plans and recertifications we reviewed as part of the nurses' medical review (ch. 2), only 45 or 4 percent had any evidence that they were modified by a physician during his/her review;

--HCFA statistics show that as of December 30, 1980, 164 or 5 percent of the 3,022 certified HHAs did not meet the Medicare conditions of participation for periodic review of plans of treatment. The condition states

"The total plan of treatment is reviewed by the attending physician and home health agency personnel as often as the severity of the patient's condition requires, but at least once every 60 days. Agency professional staff promptly alert the physicians to any change that suggest a need to alter the plan of treatment."

--our review of plans of treatment showed that some plans were signed by others on behalf of the physicians while, in some other cases, rubber signature stamps were used; and

--some HHAs deliberately request more services than needed to avoid having to prepare plan modifications, according to the Office of Direct Reimbursement.

Some specific examples also highlight the fact that some physicians have limited involvement with the home health program. For example:

--One physician we visited did not know that his patients were receiving home health aide visits and acknowledged that he had not monitored the home health services adequately. He told us that an agency nurse would bring in plans and tell him that all he had to do was sign them for his patients to receive services. The physician said the agency nurse never explained what specific services were being provided.

--One physician told us that he prepares the plan but he does not instruct the agency as to the frequency of visits. He stated that home health care is a good service, but any "free" service is going to be abused. Furthermore, he said he would like to discontinue about half of the services being received but was unaware that he was supposed to actually authorize the frequency of visits.

--On August 4, 1980, a physician ordered two skilled nursing visits and two aide visits per week for a patient; 2 days later--for the same patient but a different HHA--he ordered two more skilled visits and two more aide visits per week plus two visits by a medical social worker.

--Another physician stated that he usually does not see the patient but he is aware of their diagnosis. He said he trusts the judgment of the agency and is more concerned with patients that are in or are going to the hospital and those he sees in his office. He added that agencies might send an aide to someone who is not in great need of one to keep their people busy.

Finally, we noted that in many cases physicians appeared to have little contact with their patients. In discussing this matter with physicians, about 50 percent of them said they relied on the agency to provide them with the patients' status and did not see the patient every 60 days. Also, 164 of the 438 1/ HHA beneficiaries' files we reviewed (38 percent) did not show any indication of physician contact with the patient.

HCFA's home health manual states

"Although it is appropriate, where a patient's condition warrants, for the physician to have a nurse supplement his personal contacts with the patient for the purposes of evaluation and to determine the need for changes in the level and type of care which has been prescribed, such visits may not replace those of the physician. It is expected that an individual requiring a level of care which would make him eligible for home health benefits would need to be seen by the physician at least once every 60 days. Consequently, where the physician sees the patient less frequently than once every 60 days, a question would be raised as to whether the individual is really in need of the level of care which qualifies him for home health benefits."

In a December 1979 memorandum to the New York Regional Medicare Director, HCFA addressed a similar issue and pointed out that:

"The situation in which * * * the physician who establishes a plan of treatment [but] has not examined the patient does not appear to meet the intent of the law. The physician has the primary responsibility for overall patient care. He assesses the patient's medical needs, based on his findings after taking a history and performing a physical examination on the patient. In the absence of a physical examination, the physician would lack the knowledge concerning the patient's illness or injury and would be unable to make informed decisions about the beneficiary's needs in the home health setting."

1/The nurses only reviewed 433 cases because of the lack of time.

What has been done and
what should be done?

The lack of active involvement by many physicians in the home health program has been a problem for some time, 1/ but little has been done about it. We believe that HCFA should take several steps of an educational nature to address the problem.

Intermediary officials told us that in administering the home health benefit they communicate primarily with HHAs and not physicians. Under Part B of Medicare, carriers are required to keep physicians informed periodically of the requirements and changes under Part B, however, no similar requirement exists for informing physicians about the home health program. We believe that intermediaries themselves or through the carriers should be specifically required to keep physicians apprised of the home health benefit. Specifically, all physicians should be informed about program requirements, their role in the program, and the nature of the overutilization that is occurring. 2/

We also believe that apprising a physician of overutilization as it relates to services provided under plans of treatment he or she signed is an effective way to educate physicians and can have a direct impact on the authorization of unnecessary services. The following are two examples disclosed in our review.

--A physician we visited had 13 patients that were receiving services from an HHA. We discussed the plans for four of his patients and explained the services that were being provided. The physician was shocked at the extent of the services that had been provided and, consequently, he reduced the services for 10 of the 13 patients.

--In April 1980 another physician, in responding to an intermediary inquiry, stated "The patient has not returned for followup since last fall and I am afraid that I have renewed authorizations for the visits without further investigation." The physician after learning the cost (\$2,048) and extent of the services (51 visits) from October 1979 to February 1980 advised the HHA that he was withdrawing his authorization for home visits.

1/Lack of physician involvement in the home health program was disclosed as early as 1974 in a GAO report entitled "Home Health Care Benefits under Medicare and Medicaid" (B-164031(3), July 9, 1974).

2/In this respect we noted that in April 1980 the HCFA Regional Administrator sent a letter to Florida physicians to request their cooperation to bring overutilization under control.

Most of the physicians we contacted did not know the cost of the home health benefit. In fact one physician said that he was surprised that a home health agency received more money for a home visit than he did--a not uncommon occurrence (see p. 13). An encouraging result of our contacts with physicians is that more than 25 percent of them said that the cost of the services would have influenced their decision on the scope of services authorized had they been aware of it. Consequently, we believe physicians should be informed of the cost of the home health benefit by requiring HHAs to include on the plan of treatment an estimate of the total cost of the services to be provided, and on the recertifications the cumulative and projected cost of the services.

INTERMEDIARY KNOWLEDGE OF HHA UTILIZATION IS LACKING

Comparing the utilization pattern of an HHA with a norm is a useful technique for identifying aberrant utilization patterns for further analysis or investigation. The utilization practices of an HHA would be suspect, for example, if its average number of visits provided per beneficiary was double that of the average of all HHAs of a particular intermediary or region. Such comparative techniques have been in place for some time in Medicare, most notably for analyzing hospital length of stay and physician utilization under part B; their use, however, for the home health benefit has been limited.

Because intermediaries process and pay home health bills, they have access to information on the utilization of the home health benefit. Nonetheless, the intermediaries we reviewed generally had little specific knowledge of the utilization practices of HHAs they serviced. For example, they were not able to provide us basic information, such as the average number and types of visits per beneficiary and/or HHA.

HCFA has the capability to generate comparative data on home health utilization but does not use this capability to its full potential. In January 1981, for example, HCFA published various program data on the use of the home health benefits in 1977 which included the average number of visits per person served on a regional (northeast, south, etc.) and national basis and by type of agency (nonprofit, proprietary, etc.). Also, in August 1979, on a one-time basis, HCFA published 1976 utilization data by type of visit for 21 high frequency diagnoses and the data were presented on a national and regional basis (each of the 10 HHS regions).

The above efforts give some insight into the types of information that can be generated through the use of existing data systems and provide some basis of comparison for monitoring the utilization practices of HHAs. The August 1979 effort is particularly noteworthy in that utilization data were arrayed by

diagnosis, a refinement which we believe to be highly desirable. We believe, however, that the data can be made more useful.

First, the data developed were about 2 years old. We believe the information can and should be made much more current. To avoid cash flow problems, we would expect most HHAs to submit their bills to intermediaries within 2 months from the date of service. Also, intermediaries are required to submit 98 percent of the bills to the HCFA central office within 2 months.

Second, agency specific data should be developed. National, regional, or intermediary wide data provide the basis for comparison, but to identify aberrant utilization patterns, the utilization practice of individual HHAs must be shown.

Finally, the types of comparisons (such as average number of visits) can be expanded considerably. For example, we developed utilization data which showed by HHA (1) the average number of visits by type of visit and (2) the percent of beneficiaries that received aide services.

IMPROVED MEDICAL DOCUMENTATION IS NEEDED

HCFA should take steps to improve the quality of the clinical records of HHAs. Specifically, HCFA should emphasize to HHAs the documentaion requirements and strengthen them as well.

Records are inadequate

HCFA statistics as of December 1980 show that 246 or 8 percent of the certified HHAs failed to maintain adequate clinical records. HCFA's conditions of participation require that

"A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of treatment * * *, the record contains appropriate identifying information; name of physician; drug, dietary, treatment and activity orders; signed and dated clinical and progress notes (clinical notes are written the day service is rendered and incorporated no less often than weekly); [into the medical record]: copies of summary reports sent to the physician; and a discharge summary."

We noted similar problems during our review. Overall, about 7 percent of the visits reviewed by HCFA nurses were questionable because the nurses could not make a conclusive coverage determination on the basis of the available records. Also, for about half of the HHAs reviewed, the nurses rated the HHA records as

having "moderate" or "more serious" deficiencies. Some of the nurses pointed out that the notes did not reflect the medical condition or progress of the patient and that there were no or only poor quality HHA discharge summaries.

Concerning progress notes, one nurse stated that the documentation of the care provided by HHAs must include the problems and needs of the patient, the services given to meet those needs, and the evaluation of the responses of the patient and the family to the services, including both the positive and negative responses. Further, she said that notes showing the progress of a patient over a period of multiple visits were lacking.

Documentation requirements
could be strengthened

The Joint Commission on Accreditation of Hospitals (JCAH) has established clinical documentation standards for hospital based HHAs. In comparing the JCAH standards to the current Medicare standards, we found the JCAH standards tended to be more comprehensive. For example, in addition to the Medicare requirements, they required hospital discharge summaries, laboratory test results, and specific designation of the physician having primary responsibility for the patient's care.

We believe Medicare's documentation requirements would be strengthened if the above JCAH standards were incorporated in the Medicare requirements. We found, for example, patients who received laboratory tests, the results of which, however, were not made a part of the patient's records. Also, we found a number of cases where it was not clear just which physician had primary responsibility for the patient's care. Finally, as noted by one of our nurse consultants, we believe the Medicare requirements should be clarified to state that progress notes reflect both positive and negative patient and family responses to the treatment provided. We believe this clarification to be particularly important because claims processing systems--which tend to invite justifying reimbursement--create an incentive to emphasize only the negative or lack of progress.

Additional documentation requirements are also discussed in chapters 2 and 4. Specifically, they deal with the homebound status of beneficiaries and the assessment of beneficiaries' home environment.

HOME VISITS ARE NEEDED AS A
PART OF ONSITE COVERAGE AUDITS

Intermediaries are required to verify HHA cost claimed for reimbursement by making audits of HHA records; however, no similar requirement currently exists for verifying whether the services

provided are covered under the program. We believe such audits should be made and the need and rationale for them is summed up best by an Office of Direct Reimbursement official in a February 1981 letter to HCFA's Director, Division of Operations, Bureau of Program Operations. The letter states

"I do not believe that the intermediary * * * (in house) medical review of claims submitted by any type of provider or supplier of services * * * can offer reasonable assurance that we are only paying for covered services. In fact, not providing for field review in order to verify the appropriateness of services is tantamount to having a cost report settlement process without audit."

Plans for coverage audits

HCFA appears committed to requiring intermediary coverage audits. In October 1979, HCFA started an audit pilot program in the HHS Atlanta region and later expanded the program to include the HHS Dallas and San Francisco regions. ^{1/} Also, HCFA has developed an audit guide (not final as of August 31, 1981) which officials told us all intermediaries will be required to implement starting in the latter part of fiscal year 1982. The reason for waiting until then is that, according to HCFA officials, by that time many of the existing intermediaries will no longer be involved with the administration of the home health benefit because the number will be reduced from 77 to about 50 to implement the regional intermediary mandate of the Omnibus Reconciliation Act of 1980 (see p. 4).

In addition to HCFA's initiatives, section 2152 of the Omnibus Budget Reconciliation Act of 1981 requires the Secretary of HHS to implement home health utilization guidelines "through a process of selective postpayment coverage review of intermediaries or otherwise." Along with our recommendations in chapter 2 concerning the utilization guidelines, we believe HCFA's planned action for onsite medical audits would satisfy the requirements of section 2152.

Need to visit beneficiaries

In reviewing HCFA's proposed audit guide, (draft in circulation on August 31, 1981) we noted that the proposal does not provide for visiting beneficiaries in their home. We believe such visits are worthwhile for several reasons, that is, to (1) confirm the medical condition of the beneficiary, (2) validate beneficiaries' homebound status, (3) assess the home environment

^{1/}The results are discussed on p. 19.

(particularly the availability of family or friends to perform personal care services--see ch. 4), and (4) obtain firsthand information on the nature and quality of care provided.

In discussing the matter with HCFA officials, they said that there is a question about the right of access to enter a beneficiary's home. In our visits with beneficiaries, the right of access never surfaced as an issue; generally, we found beneficiaries and live-in partners to be extremely cooperative. Also, another official said that visits to beneficiary's homes are planned, but budget constraints will preclude them from being made as part of the first audits.

QUALITY OF INTERMEDIARY COVERAGE DECISIONS SHOULD BE EVALUATED

Coverage decisions can have a significant impact on the accuracy and amount of benefit payments made, however, HCFA gives scant attention to the quality of the coverage determinations made by intermediaries. We believe the quality of coverage determinations should be included as part of HCFA's intermediary performance evaluation program.

HCFA's current evaluation program--which was mandated by the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Public Law 95-142, enacted October 25, 1977--assesses intermediary performance in terms of certain statistical standards and functional performance criteria. The statistical standards cover (1) unit cost, (2) timeliness of claims processing, and (3) timeliness of cost report settlement. The functional performance criteria cover (1) bill processing, (2) provider reimbursement, (3) beneficiary services, (4) fiscal management, and (5) general administration. Under each of these criteria, there are a number of subcriteria which contain one or more specific elements to be evaluated.

Under the bill processing criteria, one element of a subcriteria provides that intermediaries be evaluated on how well they "process bills to ensure that coverage requirements are met." In discussing the evaluation methodology to be used, the evaluation guidelines state:

"The test of this element will not question level of care or medical necessity but will look for exclusion of noncovered services (e.g., routine dental services, custodial care)."

Given the nature of the noncovered services identified by our nurse consultants in chapter 2, we believe this assessment falls significantly short of the type of review that is needed. The quality of intermediary medical reviews was also expressed by HCFA's San Francisco Regional Director of Program Operations in

a July 1980 memo to HCFA's Director, Bureau of Program Operations. Specifically, he stated:

"The CPEP [Contractor Performance Evaluation Program] package has become the contractor's guide of Medicare Program priorities. Medical review related activities represent approximately 5-1/2 percent of Part A administrative budgets and perhaps the single most effective way to ensure the quality of the benefit payments being made. Yet, the current CPEP does not have any significant element to assess intermediary's medical review performance."

Concerning the program priorities mentioned in the Regional Director's letter, generally intermediaries told us they view HCFA's priorities to be unit cost and timeliness. The statistical standards tend to bear this view out and accordingly, at present there would appear to be little incentive for an intermediary to challenge and question the judgments made by HHAs concerning the appropriateness of services claimed for reimbursement. From an administrative standpoint, it is much easier to pay a claim than deny payment.

CONCLUSIONS

Physicians are expected to play a key role in the authorization and use of home health services; however, in administering the program intermediaries deal with HHAs, not physicians, and physicians are not routinely provided with information about their roles and responsibilities related to the provision of home health care. Several initiatives of an educational nature should help.

Physicians in general should be informed of their role in home health services, program requirements, and the nature of the overutilization that is occurring. Also, physicians should be apprised of the cost of the home health benefit; a good way this could be accomplished is by requiring HHAs to place the estimated cost of services on the plan of treatment. Finally, where overutilization is detected, the physicians who authorized the services involved should be apprised of the situation.

The use of comparative analysis techniques to identify aberrant utilization patterns should be expanded and improved upon. Past efforts, while helpful, could be improved by using more current data and also more detailed analyses, including agency specific data for each of the intermediaries.

Crucial to the integrity of any system of reimbursement is proper documentation. Further, given the emphasis placed on the proper utilization of home health services by the Omnibus Budget Reconciliation Act of 1981, the adequacy of documentation is all

the more important. Adherence to the documentation requirements, as well as the requirements themselves, should be improved. HCFA should emphasize to HHAs the documentation requirements and strengthen them as well.

As part of the onsite coverage audits, home visits to beneficiaries should be made. Visits to beneficiaries are worthwhile for several reasons, including verifying the homebound status of the patient and the availability of family and friends to assist with patient care.

Given the potential for unnecessary program expenditures caused by incorrect payment decisions, the intermediary performance evaluation program should provide for an assessment of the appropriateness of home health coverage decisions. At present there would appear to be little incentive for an intermediary to challenge and question the judgments made by HHAs concerning the appropriateness of services claimed for reimbursement. Furthermore, from an administrative standpoint, it is much easier to simply pay a claim than deny payment.

RECOMMENDATIONS

We recommend that the Secretary of HHS direct the Administrator of HCFA to

- require that the estimated cost of the home health services to be provided be placed on the authorizing plan of treatment and recertifications;
- inform physicians of the overutilization of the home health benefit, program requirements, and their role in authorizing services;
- require intermediaries to apprise physicians of the non-covered services provided under plans of care they approve;
- expand and improve on the use of comparative analysis techniques to identify aberrant home health utilization patterns;
- emphasize to HHAs the documentation requirements for clinical records and strengthen them as well;
- include home visits to beneficiaries as part of the onsite coverage audits of HHAs; and
- revise the intermediary contractor evaluation program to provide for an assessment of the appropriateness of home health coverage determinations.

CHAPTER 4

GREATER USE OF FAMILY AND FRIENDS

COULD REDUCE PROGRAM PAYMENTS FOR AIDE SERVICES

The use of home health aides has increased significantly over the years and at present about one-third of all visits under the program are for aides who help beneficiaries with their personal care. Our review of case files and visits with beneficiaries indicates that the cost of a large number of these services could be avoided if the responsibility for them were shifted from the program to other available sources of support. For example, our review shows that live-in partners frequently are willing and able to provide for the personal care of beneficiaries but are not asked or encouraged to do so.

In March 1981, HCFA endorsed the concept that the Medicare program should not pay for aide services where family and friends are willing and able to do so. We believe that, to effectively implement such a policy, an aide needs assessment guide should be developed and HHAs should be required to use it and submit a copy with their claim for reimbursement. Such assessment should (1) serve as basis for determining which personal care activities a beneficiary cannot perform and (2) consider the availability of family and friends to provide the needed help.

In addition, there are two policy issues related to aide services which we believe HCFA needs to address. First, in a number of cases we reviewed, family or friends were able to provide aide-type services, and often did on days when an aide did not come, but said they needed aide services to provide them with a respite from the responsibility of caring for the patient. HCFA needs to determine if such respite visits by aides are covered and, if so, under what circumstances. Second, we found a number of cases where family members were able to provide aide-type services but where they appeared unwilling or reluctant to do so. HCFA needs to address the extent of family responsibility for providing aide-type services.

AIDE UTILIZATION--AN OVERVIEW 1/

Aide services consist of various personal care services and household services that are incidental to the personal care given. Common personal care services consist of sponge and/or tub baths, hair and teeth care, and helping the patient to get in and out of

1/ Except where noted, utilization data presented in this section were developed by HCFA's Office of Research, Demonstrations, and Statistics.

bed. Incidental household services include changing the bed, light cleaning, and laundering essential for the comfort and cleanliness of the patient.

The use of home health aides under Medicare currently represents a significant portion of the total program. For calendar year 1978, 30.7 percent of all the visits provided were for aide services which is second only to skilled nursing visits at 55.7 percent. Physical therapy visits were a distant third at 10.0 percent. The growth in the use of home health aides is also significant. From 1974 through 1978, the use of aides as a percent of total visits steadily increased from 23.4 to 30.7 percent.

Relating the use of aide visits to charges shows that the 30.7 percent aide usage in 1978 represents 26.0 percent of all charges under the home health program in that year. Estimated total budget outlays for the home health program in fiscal year 1981 are nearly \$1.0 billion and reimbursement for aide services could be in the neighborhood of \$250 million for the year.

Agencies' use of aide visits varies widely. For the agencies serviced by the intermediaries we reviewed, in 1978 the average number of aide visits per patient served ranged from 10.1 to 43.3. On a percent of total visits basis, the range was 19 to 70 percent, and on the basis of the percent of beneficiaries receiving aide visits, the usage ranged from 13 to 87 percent.

The aide utilization patterns by type of HHA show that proprietary and private nonprofit agencies generally use aides to a greater extent than other agencies. The schedule on the following page provides three measures of 1978 aide utilization by type of agency.

For the categories "percent of persons served receiving visits" and for "percent of total visits," proprietary and private nonprofit HHAs are the highest users of aide services while combined government and voluntary and hospital-based HHAs utilize aides the least. In considering the "Average Number of Visits Per Person Served," however, all HHAs are clustered around the overall average of 20.4.

Finally, according to the data we developed, the use of aides varies considerably among intermediary overall HHA caseloads. For example, the percent of aide visits to total visits for HHAs served by the intermediaries we reviewed range from 9 and 21 percent for Mutual of Omaha and Blue Cross of Wisconsin, respectively, to 46 and 47 percent for Blue Cross of Minnesota and Blue Cross of Louisiana, respectively.

1978 Aide Utilization by Type of Agency

Agency Type	Combined government and voluntary (note a)	Government	Hospital based	Proprietary	Private non-profit	Total (note b)		
All agencies	34.0	31.0	26.8	28.6	27.6	49.3	45.9	27.2
Visiting nursing association	30.7	30.2	27.1	31.2	25.1	36.4	33.2	23.3
	20.4	20.7	18.8	21.9	19.5	18.3	20.0	20.4

are jointly administered by a State or local health department and a VNA.

ation agency and skilled nursing facility-based agencies.

OBJECTIVE AND METHODOLOGY

Many of the elderly receive a wide variety of support from family and friends. Consequently, given the relative high use of aides among many agencies and the nature of the support provided by aides, we wanted to determine if the beneficiary or live-in family or friends could and were willing to perform the aide-type services provided by HHAS.

A number of studies/data suggest that family and friends are often available to provide aide-type services to the elderly. As we reported in 1977, ^{1/} the value of support provided the elderly in their homes by family and friends greatly exceeds the value of services provided by various public and private agencies. Also, according to the Federal Council on the Aging, for those 65 and over, 59 percent of women and 85 percent of men have a live-in partner. Also, for the 79 percent of the elderly who have surviving children, 34 percent of them live within 10 minutes of their children and another 21 percent live 11 to 30 minutes away. Finally, 53 percent of the elderly see their children at least once every 2 days.

To meet our objective, we visited a total of 150 home health beneficiaries in their homes. The beneficiaries selected were from the 12 cases selected at each HHA for detailed medical review by our nurse consultants. In making our selections from the case files, two factors were considered. First, there had to be some evidence that the home health recipient in fact had a live-in partner. The other consideration was location. To keep travel and logistical problems to a minimum, cases were selected which were close to each other and/or close to the HHA office.

As discussed in chapter 2, generally three HHAs were selected from each of 12 intermediaries reviewed and five agencies were selected from HCFA's Office of Direct Reimbursement. Further, in selecting agencies, the primary consideration was high aide utilization, that is, a high percentage of the persons served received aide visits and a high percentage of total visits were aide visits. Again, as with the utilization data discussed in chapter 2, aide utilization was based on 1978 program data which were the most current data available when our selections were made in the Spring of 1980.

Although our selection criteria were intentionally biased toward high aide utilization, the agencies selected were not necessarily the highest users of aides. Florida Blue Cross and HCFA's Office of Direct Reimbursement in particular have an especially

^{1/}"Home Health--The Need for National Policy to Better Provide for the Elderly" (HRD-78-19, Dec. 20, 1977).

large number of HHAs with higher aide utilization than those we visited. In Florida, we excluded many agencies from consideration because Florida agencies in general have received a great deal of attention over the past few years by HCFA and its intermediaries, as well as by GAO. ^{1/} For the Office of Direct Reimbursement, our selection criteria restricted most agencies we visited to HHAs located on the East Coast.

In making a judgment on whether the beneficiary or someone else could provide the personal care provided by aides, we considered a number of factors, including the following

- the personal care activities that the aide performed;
- the daily activities of the patient, including absences from home;
- the willingness of the live-in partner;
- the physical capability of the live-in partner, as evidenced by their own assessment as well as the daily activities they performed;
- the availability of the live-in partner and in particular whether he or she worked;
- who performed the aide activities on days the aides did not visit; and
- the specific personal care activities that the beneficiary and live-in partner said they could not perform.

RESULTS OF HOME VISITS

Our visits with beneficiaries in their homes showed that aide visits were needed in about half the cases but for the other half, it appeared they might not be needed. The following table summarizes the results of our home visits.

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

Results of Visits with
Beneficiaries in Their Homes

<u>Results</u>	<u>Number</u>	<u>Percent</u>
Beneficiary or live-in partner not able	74	49.3
Live-in partner not able because of modesty considerations	4	2.7
Live-in partner (friend) not willing	1	0.7
Beneficiary able or live-in partner who is willing and able	42	28.0
Family members who appear able but who are unwilling and/or need respite	20	13.3
Live-in partner not present during visit	<u>9</u>	<u>6.0</u>
Total	<u>150</u>	<u>100.0</u>

For the 74 cases where the beneficiary or live-in partner was not able, the vast majority of the cases involved situations where the tasks were considered to be too physically demanding. For nine cases, the live-in partners were not present at the time of our visit, and a judgment could not be reached on their willingness to help the beneficiary with personal care. The cases involving modesty were situations, for example, where a son would not want to bathe his mother.

The following provides examples of situations where the beneficiary or live-in partner was willing and able to provide the personal care required. Also provided are examples where family members appear to be able to provide such care but appear unwilling and/or need respite or help.

Beneficiary able or live-in
partner 1/ willing and able

The following are examples where the live-in partner was willing and able to provide the personal care.

- One beneficiary received aide visits three times a week, although she lived with a daughter, son-in-law, and a 16-year-old granddaughter. The daughter who was a nurse's aide gave the patient personal care.

1/In some cases, the "live-in partner" was hired help or an attendant who were not actually living with the beneficiary.

- One beneficiary received aide visits twice a week, although she lived with two daughters who were giving her personal care. The daughters felt the aide would only be of value if she gave them some respite, but this was not the case. According to the daughters, the aide asked that they be present during the visit to assist.
- In another case we talked to a patient's wife in August 1980. She advised us that taking care of her husband took a lot of time but she had quit her job in 1979 so she could care for him.
- A patient had a sitter 7 days a week who told us that she performed the aide's functions with the help of the husband on days the aide did not come and assisted the aide during the three weekly visits.
- One beneficiary was hoeing his garden at the time of our visit. The beneficiary's spouse said she was very pleased with the aide services and would like for her husband to receive them more often. We made our visit in October 1980 and the beneficiary had been receiving two aide visits per week since April 1980. The spouse said she liked having the aide present when her husband was getting in and out of the tub in case he fell. At the time of our visit, this seemed to be an insufficient justification for aide services, since the beneficiary was able to work outdoors and was able to climb over a fence in order to get from the garden to where we were talking with his spouse. The patient appeared capable of caring for himself at the time of our visit.
- A beneficiary was out shopping with her daughter when we first arrived at the home in October 1980. The agency had provided continuous aide service since March. The first 2 months an aide visited three times per week and from May through the time of our visit, the aide had been visiting two times per week. The beneficiary's daughter was able and willing to care for the patient.
- A beneficiary had been receiving two aide visits per week for about 3 months, although he lived with family members who were able and willing to provide the personal care needed. The beneficiary's spouse, who did not work outside the home, took care of essentially all the beneficiary's personal needs. Also, the beneficiary's working son, who lived in the same home, assisted in caring for the beneficiary.
- An 85-year-old woman was in the care of a day and night attendant and received 19 aide visits over a 7-week period. When we visited the patient's home, the day attendant said

that both she and the night attendant were willing and able to perform the aide's functions and, in fact, had been bathing the patient and taking care of her other personal needs on the aide's days off. The attendant added that the home health aide spent less than an hour performing her duties and spent the remaining time lounging in the home or occasionally walking the patient's dog.

Respite care/unwillingness

The following are examples where family member(s) appear to be able to provide personal care services but (1) where the point is made or could be made that either help or respite is needed or (2) where family members appeared unwilling or reluctant.

- A sitter and relatives who live close by perform aide duties when the aide is not present; patient said she did not need aide services and would not get them if she were paying for the services.
- Wife (65) says the aide provides a break so she can shop for groceries; aide visits are made twice per week.
- Patient received one aide visit per week and lives with husband (46) and three children, ages 20, 19, and 17; patient said they are often busy and cannot always help.
- Patient lives with her working daughter (a registered nurse) and her daughter's working husband (a physician); the patient is at home during the day with her daughter's baby and a sitter who takes care of the baby.
- Aide visits twice a week for 20 to 30 minutes; daughter who lives upstairs and does help with patient care said she was unwilling to perform aide duties (sponge bath and shampoo).
- Husband would provide the personal care only if there was no alternative; he added that the aide provided better personal care.
- Daughter (50) and son-in-law (51) are capable but do not want aide services stopped; the daughter feels the aide services are therapeutic.
- Husband (74) says he needs relief; aide visits once a week for 1-1/2 hours.
- Daughter (64) and son-in-law (64) are not willing to perform aide duties; daughter said she does not feel comfortable dealing with sick.

--Patient lives with working daughter (40), working son-in-law (41), and grandchildren ages 10, 13, 16, and 20; daughter said she could not move the patient by herself.

Intermediary views

Intermediaries we reviewed generally were in favor of the concept of considering the availability of family and friends to perform aide services. At our request, Blue Cross of Mississippi reduced to writing its views on the use of family and friends to provide aide services. The intermediary stated:

"Aide services should be supportive to the patient and his family. The frequency of visits should be decreased when the patient is able to assume his own self care or the family has learned how to care for his personal needs. When there are others, i.e., family, sitters, or maids, able and willing to participate in the patient's care, even though they may be absent from the home for a portion of the day, it should be reasonable to assume that personal care needs could still be met by these people. This would eliminate the home health aide services or decrease her services to a minimum."

In support of the above proposal, the intermediary cited the following examples to illustrate situations where the patient, family members, or others did or could provide personal care services.

- "1. The home health aide arrives later than usual and finds that the patient has already received personal care and was placed in a wheelchair by his family or others.
2. The patient rises earlier than usual, becomes impatient, and takes his own bath before the aide arrives.
3. Relatives sit by and refuse to help the patient because they believe it is the responsibility of the home health aide."

NEED TO STRENGTHEN AND CLARIFY PROGRAM REQUIREMENTS

Recently HCFA has taken some action to preclude Medicare payment for aide services where family and friends are willing and able to provide personal care assistance; however, additional action is needed.

Family and friends

HCFA's views on the use of family and friends have been inconsistent in recent years.

Section 218.3 of the home health manual states that where an HHA makes an initial evaluation visit, it is to consider among other things, the " * * * attitudes of family members and availability of family members to help in the care of the patient." Also, in an August 3, 1978, response to an inquiry from the Blue Cross Association, HCFA's Bureau of Program Policy stated that:

" * * * we believe that the home health aide services * * * i.e., a weekly visit by an aide simply to bathe him, could be performed by his wife during her non-working hours or by another family member. Therefore, we believe it would be unreasonable and unnecessary for the program to pay for such visits * * *."

Later that year, however, HCFA specifically prohibited intermediaries from denying aide visits on the basis that family or friends are available to provide such services. In a December 11, 1978, letter to the Blue Cross Association--which requested clarification on a number of coverage issues--HCFA stated:

* * * * *

"With respect to the coverage of home health aide services, you asked whether any consideration should be given to the availability of family members living with the beneficiary who are capable of providing the services rendered by a home health aide. We believe a coverage decision or policy which would prohibit Medicare payment for home health services * * * cannot be supported under present law and would, moreover, be discriminatory to the beneficiary. Since Medicare is an insurance program, insured individuals who meet the home health coverage requirements are entitled by law to have reimbursement made for any covered home health services they need. Accordingly, when a physician orders home health aide services for a beneficiary, that beneficiary is entitled to have the costs of such services reimbursed under the program without regard to whether there is someone available in the home to furnish them."

Finally, in March 1981 HCFA reversed its position presented to the Blue Cross Association. Section 203 of the HHA manual was amended and includes the following provision.

"* * * where it comes to the attention of the intermediary that a family member or other caring person is or will be providing services that adequately meet the patient's needs, it would not be reasonable and necessary for home health agency personnel to furnish duplicative services. For example, if on the evaluation visit the agency determines that a family member has been or will be bathing the patient several times a week and this family member is or will be continuing to meet the patient's personal needs, it would not be reasonable and necessary for the home health agency to furnish such services."

HCFA's March 1981 manual issuance is a step in the right direction, however, we believe additional action is needed. With few exceptions, 1/ the HHAs told us (prior to the manual issuance) that they do consider the availability of live-in partners to perform aide services. As pointed out earlier, however, generally, the live-in partners were not asked by HHAs if they were willing and able to assist the beneficiary with his or her personal care. Consequently, we doubt that the March 1981 manual issuance by itself is likely to have any significant impact on aide utilization by HHAs. Also, the manual issuance uses the phrase "where it comes to the attention of the intermediary" and we do not believe this is likely to occur. First, intermediaries rarely review patient records on file at HHAs. Second, the information in these files on the availability and willingness of family or friends to perform aide services is sketchy at best. For example, for the most part the only evidence that we saw in the files was the name and address of an individual that could be contacted in an emergency; if the address of the individual and the beneficiary were the same, we concluded that the beneficiary had a live-in partner.

We believe HCFA needs to develop a standard aide needs assessment guide and require HHAs to use it. Such an instrument should provide for an assessment of:

- (1) Which personal care services the beneficiary can not perform without assistance.
- (2) The availability and capability of live-in partners and nearby family or friends to assist or perform for the beneficiary those services which he or she cannot do without help.

While we did not specifically consider the availability of other than live-in family or friends, during our visits to beneficiaries

1/One agency told us it would use aides even if there were eight or nine people living with the beneficiary who were willing and able to provide the personal care services.

it was apparent that family or friends living outside the home but nearby represent a potentially significant resource. As stated earlier on page 40, many of the elderly have children who live within a 10-minute journey from their parents.

There are several methods available to measure the ability of an individual to care for him or herself. For example, the Duke University Center for the Study of Aging and Human Development has developed an instrument to measure the overall well-being of older people. The instrument or questionnaire measures a person's status in five areas of functioning--(1) social, (2) economic, (3) mental, (4) physical, and (5) activities of daily living. The latter assesses many activities that closely parallel the personal care services provided by aides. For example, the ability to

--dress and undress;

--take care of appearance, combing of hair, shaving, etc.;

--get in and out of bed; and

--take a bath or shower.

That portion of the Duke University questionnaire addressing the activities of daily living is presented in appendix III.

The Texas Medicaid program uses an assessment very similar to the Duke University questionnaire. A State Medicaid official told us that use of the assessment resulted in a decrease in aide utilization and that it was also useful in establishing the homebound status of individuals.

Respite care/family responsibility

As discussed on page 15, the Medicare law permits the use of aide services as provided in regulations and HCFA has developed some guidance on the use of aides. Two policy issues that need to be addressed, however, are respite care and family responsibility.

Respite care is the provision of aide services for providing the individual (family or friend) who normally furnishes personal care to the patient with a break from this responsibility. HCFA has not provided guidance on whether or to what extent respite care is a covered service under the Medicare home health benefit. For a number of the cases where we visited the patient at home, family members indicated that aide services were needed to provide them a respite. In many of these cases, an argument could be made for providing respite care. We believe HCFA needs to state if respite care is a justifiable reason for covering aide services and, if so, under what circumstances.

HCFA has also not published any official guidance on the extent to which a Medicare patient's family is responsible for providing personal care services. For a number of the patients we visited at home, there were family members who appeared to be able to provide personal care to the patient but were unwilling to do so. While HCFA has told the Blue Cross Association that aide services should not be authorized where there is a caring person--who presumably would not be a nonwilling family member--we believe HCFA needs to define family responsibility for personal care services so that HHAs and intermediaries will know if aide services are covered where family members are able but appear unwilling or are reluctant to furnish personal care.

CONCLUSIONS

The use of aides represents a significant portion of the Medicare home health program and should come under closer scrutiny. While HCFA has endorsed the concept that the program should not pay for aide services where family and friends are willing and able to do so, additional action needs to be taken.

Most HHAs visited said they do consider the availability of family and friends, but our visits with beneficiaries and live-in partners in their homes suggest otherwise. Further, there is little evidence in case files on the availability of family and friends much less and assessment of their capability to provide for the personal care needs of the beneficiary. To provide assurance that proper consideration is given to the beneficiaries' self-help capability and the capability of family, friends, hired help, etc., HCFA should develop an aides' needs assessment guide and require HHAs to use it.

Making a judgment or decision not to pay for aide services is relatively easy where family members or friends are willing and able to assist with patient care. Such decisions are difficult, however, in situations where the issue of respite care is and can be raised. To paraphrase a family member--"I am willing, able, and do provide supportive care, but I need some help." It is difficult to make an objective judgment when confronted with these situations. To assist HHAs and intermediaries to make such judgments, HCFA must decide if respite care is permitted under the program, and if so, under what circumstances. At the same time, HCFA should also address those situations where family members are able to provide aide services but are or appear unwilling or reluctant to help.

RECOMMENDATIONS

We recommend that the Secretary of HHS direct the Administrator of HCFA to

- develop a standard aide needs assessment guide which specifically assesses the availability and capability of family and friends to provide personal care services and require HHAs to use it;
- where HHAs provide aides services, require them to submit with their bills a copy of the aide needs assessment;
- address the issue of respite care, that is, is it authorized under the program and, if so, under what circumstances; and
- establish a policy for the use of aides in situations where family members are able but appear unwilling or reluctant to help the beneficiary with patient care.

INTERMEDIARIES AND HOME HEALTHAGENCIES REVIEWEDHCFA's Office of Direct Reimbursement

Orange County Health Department, Goshen, New York (HHS Region II--New York)

Home Health Services of Greater Philadelphia, Inc.
Philadelphia, Pennsylvania (HHS Region III--Philadelphia)

Washington County Health Department, Abingdon, Virginia (HHS Region III--Philadelphia)

Upjohn Healthcare Services, Inc., Shreveport, Louisiana (HHS Region VI--Dallas)

Upjohn Healthcare Services, Inc., Los Angeles, California (HHS Region II--San Francisco)

HHS Region IV (Atlanta)Blue Cross of Florida, Inc.

VNA of Pensacola, Inc., Pensacola, Florida

Northwest Florida Home Health Agency, Pensacola, Florida

Sun Coast Home Care, Inc., Sarasota, Florida

Blue Cross of Georgia/Columbus, Inc.

A.B.C. Home Health Service, Inc., Brunswick, Georgia

Visiting Nurse Association of Ware County, Inc., Waycross, Georgia

Blue Cross and Blue Shield of Mississippi, Inc.

Marion County Home Health Agency, Columbia, Mississippi

Southwest Mississippi Home Health Agency, Natchez, Mississippi

Professional Home Health Services, Inc., Biloxi, Mississippi

HHS Region V (Chicago)Health Care Service Corporation (Blue Cross of Chicago)

Fox Valley Home Health, Inc., Geneva, Illinois

In-Home Health Care Service of Suburban Chicago
North, Morton Grove, Illinois

Home-Med. North, Inc., Chicago, Illinois

Blue Cross and Blue Shield of Minnesota

In-Home Health Care Service of Minneapolis
North Inc., Minneapolis, Minnesota

Crow Wing County Public Health Nursing Service,
Brainerd, Minnesota

St. John's Hospital-Home Care Program,
St. Paul, Minnesota

Blue Cross Blue Shield United of Wisconsin

Kenosha Visiting Nurse Association, Kenosha, Wisconsin

Jefferson County Public Health Nursing Service,
Jefferson, Wisconsin

Columbia County Public Health Service,
Portage, Wisconsin

HHS Region VI (Dallas)Group Hospital Service, Inc. (Texas Blue Cross)

Gregg County Home Care, Inc., Longview, Texas

Cherokee Home Health Care Center,
Jacksonville, Texas

Dallas Visiting Nurse Association,
Dallas, Texas

Mutual of Omaha Insurance Company

Waco-McClennan County Home Health Care Service,
Waco, Texas

Visiting Nurse Association of Brazoria
County, Inc., Angleton, Texas

Louisiana Health Service & Indemnity Company
(Louisiana Blue Cross)

Professional Home Health Services of Allen,
Oakdale, Louisiana

Rapides General Hospital-Home Care Program,
Alexandria, Louisiana

HHS Region IX (San Francisco)

Blue Cross of Southern California

Southern California Community Health Association,
Los Angeles, California

Home Health Services, Culver City, California

Home Health Agency of San Luis Obispo County,
San Luis Obispo, California

Aetna Life and Casualty

Nevada Home Health Services, Inc., Elko, Nevada

Washoe County District Health Department VNAs,
Reno, Nevada

Blue Cross of Northern California

Home Health and Counseling Services, Walnut Creek,
California

O'Connor Hospital Home Care,
San Jose, California

Alta Bates Hospital Home Health Agency, Berkley,
California

HOME HEALTH MANUAL DEFINITIONOF HOMEBOUND (emphasis added)

"208.4 Patient Confined to His Home.--In order for a beneficiary to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the beneficiary is confined to his home * * *. An individual [HOWEVER] does not have to be bedridden to be considered as confined to his home. HOWEVER, the condition of these patients should be such that there exists a NORMAL INABILITY TO LEAVE HOME and, consequently, leaving their homes would require a CONSIDERABLE AND TAXING EFFORT. IF the patient does in fact leave the home, the patient MAY NEVERTHELESS be considered homebound IF the absences from the home are INFREQUENT or for PERIODS OF RELATIVELY SHORT DURATION. It is expected that in MOST instances absences from the home which occur will be for the purpose of receiving medical treatment. HOWEVER, OCCASIONAL ABSENCES from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, would not necessitate a finding that the individual is not homebound SO LONG AS the absences are undertaken on an INFREQUENT basis or are of RELATIVELY SHORT DURATION and DO NOT INDICATE that the patient has the CAPACITY to obtain the health care provided outside rather than in the home.

GENERALLY SPEAKING, a beneficiary will be considered to be homebound if he has a condition due to an illness or injury which restricts his ability to leave his place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if he has a condition which is such that leaving his home is medically contraindicated. Some examples of homebound patients which are also illustrative of the factors to be taken into account in determining whether a homebound condition exists would be: (1) a beneficiary paralyzed from a stroke who is confined to a wheelchair or who requires the aid of crutches in order to walk; (2) a beneficiary who is blind or senile and requires the assistance of another person in leaving his place of residence; (3) a beneficiary who has lost the use of his upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and, therefore, requires the assistance of another individual in leaving his place of residence; (4) a patient who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, his actions may be restricted by his physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.; and (5) a patient with arteriosclerotic heart disease of such severity that he must avoid

all stress and physical activity, and (6) a patient with a psychiatric problem if his illness is manifested in part by a refusal to leave his home environment or is of such a nature that it would not be considered safe for him to leave his home unattended, even if he has no physical limitations.

The aged person who does NOT OFTEN travel from his home because of FEEBLENESS and INSECURITY brought on by advanced age would not be considered confined to his home for purposes of receiving home health services UNLESS he meets one of the above conditions. A patient who requires speech therapy but does not require physical therapy or nursing services must also meet one of the above conditions in order to be considered as confined to his home. Thus, a person who has undergone a laryngectomy, yet is recovered to the point of being able to get about normally WITHOUT UNDUE EFFORT, would not be considered as confined to his home.

ALTHOUGH a patient must be confined to his home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required which cannot be made available there. If the services required by an individual involve the use of such equipment, the home health agency may make arrangements with a hospital, extended care facility, or a rehabilitation center to provide these services on an outpatient basis * * *. HOWEVER, even in these situations, for the services to be covered as home health services the patient must be considered as confined to his home; and to receive such outpatient services it may be expected that a homebound patient will generally require the use of supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility.

If for any reason a question is raised as to whether an individual is confined to his home, the agency will be requested to furnish the intermediary with the information necessary to establish that the beneficiary is homebound as defined above."

ACTIVITIES OF DAILY LIVING EXCERPT
FROM THE DUKE UNIVERSITY MULTIDIMENSIONAL
FUNCTIONAL ASSESSMENT QUESTIONNAIRE 1/

- Can you use the telephone...
- 2 without help, including looking up numbers and dialing,
 - 1 with some help (can answer phone or dial operator in an emergency, but need a special phone or help in getting the number or dialing),
 - 0 or are you completely unable to use the telephone?
 - Not answered
- Can you get to places out of walking distance...
- 2 without help (can travel alone on buses, taxis, or drive your own car),
 - 1 with some help (need someone to help you or go with you when traveling),
 - 0 or are you unable to travel unless emergency arrangements are made for a specialized vehicle like an ambulance?
 - Not answered
- Can you go shopping for groceries or clothes...
- 2 without help (taking care of all shopping needs yourself, assuming you had transportation),
 - 1 with some help (need someone to go with you on all shopping trips),
 - 0 or are you completely unable to do any shopping?
 - Not answered
- Can you prepare your own meals. . .
- 2 without help (plan and cook full meals yourself),
 - 1 with some help (can prepare some things but unable to cook full meals yourself),
 - 0 or are you completely unable to prepare any meals?
 - Not answered
- Can you do your housework. . .
- 2 without help (can scrub floors, etc.),
 - 1 with some help (can do light housework but need help with heavy work),
 - 0 or are you completely unable to do any housework?
 - Not answered

1/The numbers--2, 1, 0--associated with each response are used to develop an overall rating of an individual's capability to perform the activities of daily living.

- Can you take your own medicine. . .
- 2 without help (in the right doses at the right time),
 - 1 with some help (able to take medicine if someone prepares it for you and/or reminds you to take it),
 - 0 or are you completely unable to take your medicines?
 - Not answered
- Can you handle your own money. . .
- 2 without help (write checks, pay bills, etc.),
 - 1 with some help (manage day-to-day buying but need help with managing your checkbook and paying your bills),
 - 0 or are you completely unable to handle money?
 - Not answered
- Can you eat. . .
- 2 without help (able to feed yourself completely),
 - 1 with some help (need help with cutting, etc.),
 - 0 or are you completely unable to feed yourself?
 - Not answered
- Can you dress and undress yourself. . .
- 2 without help (able to pick out clothes, dress and undress yourself),
 - 1 with some help,
 - 0 or are you completely unable to dress and undress yourself?
 - Not answered
- Can you take care of your own appearance, for example combing your hair and (for men) shaving. . .
- 2 without help,
 - 1 with some help,
 - 0 or are you completely unable to maintain your appearance yourself?
 - Not answered
- Can you walk. . .
- 2 without help (except from a cane),
 - 1 with some help from a person or with the use of a walker, or crutches, etc.,
 - 0 or are you completely unable to walk?
 - Not answered
- Can you get in and out of bed. . .
- 2 without any help or aids,
 - 1 with some help (either from a person or with the aid of some device),
 - 0 or are you totally dependent on someone else to lift you?
 - Not answered

Can you take a bath or shower. . .

- 2 without help,
- 1 with some help (need help in getting in and out of the tub, or need special attachments on the tub),
- 0 or are you completely unable to bathe yourself?
- Not answered

Do you ever have trouble getting to the bathroom on time?

- 2 No
- 1 Have a catheter or colostomy
- 0 Yes
- Not answered

[IF "YES" ASK a.]

a. How often do you wet or soil yourself (either day or night)?

- 1 Once or twice a week
- 2 Three times a week or more
- Not answered

Is there someone who helps you with such things as shopping, housework, bathing, dressing, and getting around?

- 1 Yes
- 0 No
- Not answered

[IF "YES" ASK a. AND b.]

a. Who is your major helper?

Name _____ Relationship _____

b. Who else helps you?

Name _____ Relationship _____

(For a. and b. CODE 1. SPOUSE 2. SIBLING 3. OFFSPRING 4. GRANDCHILD 5. OTHER RELATIVE 6. FRIEND 7. OTHER)

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