# MONITORING MECHANISMS USED BY SELECTED HOME HEALTH AGENCIES TO PREVENT MEDICARE/MEDICAID FRAUD AND ABUSE IN TEXAS

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A THESIS

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We hereby recommend that the thesis prepared under our supervision by Eleanor Jean Lee Williams entitled Monitoring Mechanisms Used by Selected Home Health Agencies to Prevent Medicare/Medicaid Fraud and Abuse in Texas

be accepted as fulfilling this part of the requirements for the Degree of Master of Science.

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## DEDICATION

This thesis is dedicated to my husband for his untiring patience and devotion.

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# CHAPTER I

## INTRODUCTION

In 1965 Congress added two significant amendments on health care services to the Social Security program begun in 1935. Title XVIII of Public Law 89-97 established Medicare, a federal program of hospital and medical insurance for people over 65 who are disabled. Title XIX of Public Law 89-97 established Medicaid, a federal-state program to help provide medical services for the needy and the medically indigent.

Home health services are provided by Title XVIII and Title XIX. Under these Titles, home health agencies must meet the standards of regulatory agencies to maintain certification.

It has taken several years to convince legislators of the need for regulations to monitor the quality and cost of home health care. In 1975, Florence Moore, Executive Director of the National Council for Homemaker--Home Health Aide Services, made the following recommendations on behalf of the National Council in her testimony on Home Health Services to the Subcommittee on Health of the Committee on Ways and Means, House of Representatives:

1. That Federal funds be made available immediately to the states to assist them in strengthening their units responsible for the certification (monitoring) process under Medicare and Medicaid. Each state should be required to submit to and have approved by the Federal government its plan for the use of these funds for monitoring the quality of home health services. In addition, Federal training programs should be established and conducted for the personnel undertaking this certification process as the Federal government is doing now for similar personnel certifying nursing homes;

2. That quality assurance procedures, utilization review, medical review, professional standards review organizations (PSRO) activities and fiscal accountability not be limited to institutions but also concern themselves with home health services;

3. That the Federal government utilize the quality assurance programs, namely standards, of the national voluntary, non-profit sector to complement the public role in monitoring home health care. There is a precedent for this in the use the Federal government makes of the Joint Commission on the Accreditation of Hospitals. This principle should be extended to the standard-setting and monitoring programs of national voluntary organizations, such as that of the National Council for Homemaker--Home Health Aide Services for agencies which provide any aspect of homemaker-home health aide service. It will require the voluntary and the public sector working together to assure quality service in this rapidly expanding field. The National Council's new national approval program has already approved close to 100 agencies providing homemaker--home health aide services. A like number are in process. We urge that approval by this national organization serve in lieu of state certification of homemaker-home health aide agencies for Medicaid if the regulations proposed in the Federal Register on August 21, 1975 are adopted;

4. That the Department of Health, Education and Welfare coordinate its units which have jurisdiction over any aspect of homemaker--home health aide services so that a common approach to a definition, to standards and to monitoring systems emerge. At least

the following units of the Department of Health, Education and Welfare are involved:

Office of Human Development
Public Health Service
Social and Rehabilitation Service
Social Security Administration[1]

In 1976 the National Council of Homemaker--Home Health Aide again addresses the issue of quality assurance. This time the Department of Health, Education and Welfare asked the question: "Are present health care and administrative standards for home health services delivery appropriate, enforceable and measurable in terms of outcome of care?"[2] At this time most programs refer to process and structure instead of quality. It was recommended that research methodology be used to improve standards and monitoring for Medicare/Medicaid.

Another question was proposed, "What mechanisms are there to prevent fraud and abuse in home health care?"[3] The reply was:

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[1]National Council for Homemaker--Home Health Aide Services, Testimony on Home Health Services to the Subcommittee on Health of the Committee on Ways and Means, House of Representatives, September 19, 1975, pp. 4 & 5.

[2]National Council for Homemaker--Home Health Aide Services, Statement on Home Health Services to the Department of Health, Education and Welfare, September 20 & 21, 1976, pp. 16 & 17.

[3]Ibid.

> The best mechanism to prevent fraud and abuse is to establish basic national standards for home health care and see that they are closely monitored. Every agency providing home health services should have its standards of operations reviewed by an objective outside body. Such reviews should be done on a regular basis. If questions arise about the service between regular reviews, a special inquiry would need to be undertaken. Once this standards and monitoring system is in place, other mechanisms to prevent fraud and abuse would be needed much less frequently. However, there should be at the Federal level, available through regions, if not states, a mechanism for review of apparent fraud and abuse situations which arise despite the standards and the monitoring procedures. These units should be available as a resource to the quality assurance programs.[1]

Cost effectiveness and quality assurance were among the five areas of concern during the Department of Health, Education and Welfare public hearings. These hearings were held during the fall of 1976 in five states.

By 1977 Congress and HEW were giving attention to fraud and abuse in the Medicare and Medicaid programs. Standards and monitoring are the recommended approaches.

## Problem

The problem of this study was to determine if similar monitoring mechanisms to prevent Medicare/Medicaid fraud and abuse are utilized by home health agencies in the State of Texas.

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[1] Ibid.

## Research Questions

The research questions for this study were:

1. What monitoring mechanisms are utilized in the State of Texas to prevent Medicare/Medicaid fraud and abuse in home health services provided by Visiting Nurse Associations?

2. What monitoring mechanisms are utilized in the State of Texas to prevent Medicare/Medicaid fraud and abuse in home health services provided by County Health Departments?

3. What monitoring mechanisms are utilized in the State of Texas to prevent Medicare/Medicaid fraud and abuse in home health services provided by Other Sponsoring Agencies?

## Need for Study

A need existed to determine what monitoring mechanisms were used by home health agencies to prevent fraud and abuse in Medicare and Medicaid. Determination of monitoring mechanisms currently used by different types of home health agencies should be helpful in developing standardized and objective monitoring devices for each agency.

## Definitions

The terms listed below have been defined as follows for the purpose of this study:

1. Monitoring mechanism--a routine procedure to observe and record measures utilized to prevent fraud and abuse in Medicare and Medicaid

2. Visiting Nurse Association (VNA)--a non-profit home health agency

3. Fraud--act of cheating

4. Abuse--ill usage

5. Medicare--a federal program of hospital and medical insurance including home health services for people over 65 years old, and some people under 65 who are disabled

6. Medicaid--a federal-state program including home health services to help provide medical services for the needy and medically indigent

7. Home Health Services--refers to a plan of care prescribed by a physician to be implemented in one's place of residence

8. Signed Document for Visit Verification--refers to a document signed by or for the client on date of service. Document shows the type of service rendered and the person who performed the service

9. Utilization Review--evaluation of case management by a group of professions inside and outside of the agency

10. Supervisor Review--a critique of employee performance by the employee's supervisor

11. Peer Review--a critique of professional by professional of the same discipline in home health care

12. Program Review--a study of the plan of operation (objectives) of a home health agency

13. Clinical Record--contains pertinent past and current medical, nursing, social and other therapeutic information, including the plan of treatment

14. Inservice Education--ongoing planned learning experiences for all disciplines of home health care

15. Parent Home Health Agency--"develops and maintains administrative controls of subunits and/or branch offices"[1]

16. Subdivision--a component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department which

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[1]Home Health Agency Survey Report, Form SSA 1572 (10-73), Department of Health, Education and Welfare, Social Security Administration.

independently meets the conditions of participation for home health agencies[1]

17. Subunit--a semi-autonomous organization which serves patients in a geographic area different from that of the parent agency. The subunit by virtue of the distance between it and the parent agency is judged incapable of sharing administration, supervision and services on a daily basis with the parent agency[2]

18. Branch Office--a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision, and services[3]

19. Other Sponsoring Agencies--refers to home health agencies selected at random which were not indicated on the Home Health Agency Listing of November 1, 1977, prepared by the Home Health Services Division, Texas Department of Health to be either VNA affiliated or Department of Health affiliated

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[1] Ibid.

[2] Ibid.

[3] Ibid.

## Limitations

The limitations of this study were:

1. Only 23 Texas home health agencies included on the Home Health Agency Listing of November 1, 1977, were utilized

2. The survey questionnaire utilized had not been standardized

## Assumption

The assumption for this study was that all questions of the survey questionnaire were answered truthfully.

# CHAPTER II

## REVIEW OF LITERATURE

Medicare is an insurance program which has two parts, A and B. Part A (hospital insurance) can help pay for medically necessary inpatient hospital care and, after a hospital stay, for inpatient care in a skilled nursing facility and for care in the home by a home health agency. Part B (medical insurance) can help pay for medically necessary doctors' services, outpatient services, outpatient physical therapy and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital part of Medicare. Medical insurance also can help pay necessary home health services when hospital insurance cannot pay for them.

Medicare is the same all over the United States. The Bureau of Health Insurance of the Social Security Administration of the United States Department of Health, Education and Welfare is responsible for Medicare.

Medicaid is an assistance program that varies from state to state. States design their own Medicaid programs within federal guidelines. It pays for at least these services:

1. Inpatient hospital care

2. Outpatient hospital services

3. Other laboratory and X-ray services

4. Skilled nursing facility services

5. Physicians services

6. Screening, diagnosis and treatment of children under twenty-one

7. Home health care services

8. Family planning services

In many states Medicaid pays for such additional services as dental care, prescribed drugs, eye glasses, clinic services, intermediate care facility services, and other diagnostic screening, preventive and rehabilitative services

Medicaid in Texas is the largest government-financed program for personal, physical health care in the state. Medicaid is administered by the State Department of Human Resources.

The Medical Services Administration of the Social and Rehabilitation Service of the United States Department of Health, Education and Welfare is responsible for federal aspects of Medicaid.

> The term "home health services" for purposes of both the hospital insurance and supplementary medical insurance programs, means the following items and services, provided (except as noted in item [7] below) on a visiting basis in a place of residence used as the individual's home [Social Security Act section 1861(m)];

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent home health aid services;

(5) medical supplies (other than drugs and biologicals) and the use of medical appliances, while under the established plan;

(6) medical services of interns and residents-in-training under approved teaching programs of a hospital with which the agency is affiliated; and

(7) any of the foregoing items and services which (a) are provided on an outpatient basis under arrangements made by the home health agency at a hospital or skilled nursing facility, or at a rehabilitation center meeting standards prescribed in regulations and (b) involve the use of equipment of such a nature that the items and services cannot readily be made available to the individual in his place of residence, or which are furnished at the facility while he is there to receive any item or service involving the use of such equipment (but excluding transportation of the individual).

Except as noted in item (7) above, and discussed under "outpatient services" (see paragraph 620.7), items and services must be furnished on a visiting basis in the place of "residence" (see paragraph 622.4) used as the individual's home. The law requires a physician to certify in all cases that the beneficiary is confined to his home. He does not have to be bedridden to be considered confined to his home, but he must have a functional limitation due to his illness or injury that restricts his ability to leave his place of residence. In fact, the condition of the patient should be such that leaving his home would require taxing effort and would be possible only with the aid of supportive devices, the use of special transportation, or the help of others, or if his condition is such that

> leaving his home is medically contraindicated [HHA Manual, HIM-11, #208.4].[1]
>
> Both Medicare and Medicaid insist on high standards, support development of needed facilities, encourage innovation in medical care delivery, require review of care and, in addition, Medicaid requires that medical services be available to all eligible people in a State.[2]

The program's ultimate goal is to make medical care of high quality available.

In order to participate as a home health agency in the health insurance program for the aged, an institution must be a "home health agency" within the meaning of section 1861(o) of the Social Security Act, which states:

> (o) The term "home health agency" means a public or private organization or a subdivision of such an agency or organization which:
>
> (1) Is primarily engaged in providing skilled nursing services and other therapeutic services;
>
> (2) Has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services which it provides, and provides for supervision of such services by a physician or registered nurse;

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[1] 1976 Social Security and Medicare Explained, (Chicago, Ill.: Commerce Clearing House, Inc.) 245, paragraph 620.

[2] Medicaid-Medicare, Which is Which?, Medical Services Administration Social and Rehabilitation Service, United States Department of Health, Education, and Welfare DHEW Publication No. (SRS) 75-24902 (July 1975).

(3) Maintains clinical records on all patients;

(4) In case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licenced pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; and

(5) Meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization.[1]

The following conditions must be met to establish qualification for participation as a Title XIX Home Health Agency in the Medicaid Home Health Care Program:

(1) Medicare Certification
The provider must be certified for participation as a home health agency under Title XVIII, Medicare.

(2) Medicaid Provider Agreement
The provider must enter into a written provider agreement with the Department of Public Welfare relating to the provision of services and making of payments. Program participation requirements are stated in the agreement.[2]

General conditions of coverage for both the hospital insurance (Medicare--Part A) and supplementary medical

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[1] Medicare--Home Health Agency Manual. United States Department of Health, Education and Welfare, Social Security Administration HIM 11(6-66) Reprint Date (9-75).

[2] Blue Cross Medicaid Home Health Program Manual for Providers of Services, Texas Medical Assistance Program. September 1975.

insurance (Medicare--Part B) programs home health services are covered only if furnished to an individual who is under the care of a physician furnished on a visiting basis by a home health agency or by others under an arrangement with a home health agency, under a plan established and periodically reviewed by a physician. For example:

> An individual whose eligibility for post-hospital home health services is based on the need for one of the skilled services described below for the treatment of his medical condition and who meets the requirements of law given above is presumed to require skilled nursing care on an intermittent basis or physical therapy or speech therapy (speech pathology) for the number of home health visits designated below. The number of home health visits designated is predicated on the assumption that the length of the visits will be the usual and customary time. Where an individual's medical condition necessitates more than one of the types of skilled services specified below, and each type requires the same kind of unit, e.g., both require nursing visits, the individual is eligible for the presumed number of visits for the skilled service that presumes the largest number of home health visits. However, where each type of skilled service needed requires different kinds of visits, e.g., skilled nursing and speech therapy (speech pathology) visits, the individual is eligible for the presumed number of visits for each type of skilled services. The number of visits designated may be allocated in any combination so long as the visits do not exceed the total number of visits shown or the total time frame specified. [Reg. #405.133(d)].

| Skilled Services | Presumed number of covered home health visits |
|---|---|
| 1. Skilled observation for any unstabilized condition characterized by significant fluctuations in vital signs | Nine skilled nursing visits in a 3-week period |

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|---|---|
| or marked edema or elevated blood sugar levels | |
| 2. Application of dressings involving prescription medications and aseptic techniques because of the presence of open wounds, extensive decubitus ulcers, or other widespread skin disorders | Ten skilled nursing visits in a 2 week period |
| 3. A. Instruction in colostomy, ileostomy or gastrostomy care | Five skilled nursing visits in a 2 week period |
| B. Instruction in the routine care of an indwelling catheter | Three skilled nursing visits in a 2-week period |
| C. Instruction in tube feeding technique | Six skilled nursing visits in a 1-week period |
| D. Instruction in a newly diagnosed diabetic in a diabetic regimen, i.e., training in diet, the administration of insulin injections, urine tests, skin care, etc. | Eight skilled nursing visits in a 3-week period |
| E. Instruction of a recent hip fracture patient, or family members, in an exercise program and/or in the use of crutches, a walker, or a cane | Four skilled nursing or physical therapy visits in a 2-week period |
| F. Instruction of a recent post-orthoroplasty of hip patient or a recent above or below knee amputation patient in the use of a prosthetic device | Four skilled nursing or four physical therapy visits in a 2-week period |
| G. Instruction of a patient who requires respiratory therapy in the use of special equipment such as . . . oxygen units | Three skilled nursing visits in a 2-week period |

| | |
|---|---|
| H. Instruction in postural drainage procedures and pulmonary exercises | Three skilled nursing or three physical therapy visits in a 2-week period |
| I. Administration of anticarcinogenic chemotherapeutic agents | Four skilled nursing visits in a 2-week period |
| 4. Skilled physical therapy services and/or speech therapy (speech pathology) services to restore functions impaired by a recent[1] cerebrovascular accident resulting in hemiplegia and/or aphasia | Five physical therapy and/or five speech therapy (speech pathology) visits in a 2-week period |

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[1]Recent means the medical condition was either the reason for the qualifying hospital or skilled nursing facility stay or occurred during the qualifying stay.[1]

Who is eligible for Medicaid? Recipients of money payment under the state and federally aided public assistance programs and others who would be eligible for financial assistance except that they do not meet certain state conditions--durational residence requirements for example--are automatically eligible. A state may also include the "medically needy"--people who otherwise would qualify for public assistance under one of the four categories and whose

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[1]1976 Social Security, p. 243, paragraph 620.

income is considered high enough to meet daily living expenses but not high enough to meet medical bills.[1]

The Texas Medical Assistance program helps pay the costs of medical care for many people who are eligible for public assistance programs, such as the aged (65 or older), the blind, the disabled, members of families with dependent children and some other children.

> Unlike Medicare, which is a federal program for people over 65 of all income levels, the Texas Medical Assistance program is a state-authorized program for needy people, which is administered by the State Department of Human Resources. Although it is largely federally-funded, the Texas Medical Assistance program itself is the responsibility of the State, operating within federal guidelines. Included in the Texas Medical Assistance program is Medicaid, a part of the federal-state partnership in health care for needy persons, which supplements the National Medicare program.[2]

> Medicaid includes only limited home health care. It is for eligible recipients who are 65 years of age or older. The state program pays the deductible and co-insurance portions for Medicare home health care.[3]

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[1] Questions and Answers--Medical Assistance--Medicaid, United States Department of Health, Education and Welfare, Social and Rehabilitation Service, Medical Services Administration (June 1968).

[2] When People Need Help, Financial and Medical Assistance Programs of the State Department of Public Welfare, State Department of Public Welfare (July 1970) p. 18.

[3] Ibid., p. 22.

> Hospital Insurance (Medicare A) can pay for home health care if six conditions are met. All six conditions must be met. The six conditions are: (1) you were in a hospital for at least 3 days in a row (the day of discharge does not count as one of the 3 days); (2) the home health care is for further treatment of a medical condition which was treated during a covered hospital stay or skilled nursing facility stay; (3) you need part-time skilled nursing care or physical or speech therapy; (4) you are confined to your home (a facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home); (5) a doctor prescribes home health care and sets up a home health plan for you within 14 days of your most recent discharge from a hospital or participating skilled nursing facility; and (6) the home health agency providing services is participating in Medicare.[1]

Hospital insurance (Medicare A) pays the full cost of up to one hundred home health visits after the start of a benefit period. Bills are submitted by the home health agency for covered services.

> You do not have to have a 3-day stay in a hospital for medical insurance to cover home health care. But, medical insurance (Medicare B) can pay for home health care only if four conditions are met. All four conditions must be met. The four conditions are: (1) you need part-time skilled nursing care or physical or speech therapy; (2) a doctor prescribes home health care and sets up a plan for home health care; (3) you are confined to your home; and (4) the home health agency providing services is participating in Medicare.[2]

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[1] Home Health Care under Medicare, United States Department of Health, Education and Welfare, Social Security Administration, Department of Health, Education and Welfare Publication No. (SSA) (July 1975).

[2] Ibid., p. 3.

Medical insurance (Medicare B) will pay full cost of up to one hundred home health visits each calendar year providing you have met the $100 deductible as of January 1977. The home health agency submits the claim to Medicare. The agency will bill you for any part of the deductible not met and for uncovered services.

Medicaid can pay what medicare does not pay for people who are eligible for both programs. It can pay the deductible Medicare cost per year and the remaining reasonable charges.

The Texas Medical Assistance program (Medicaid) makes payments to the provider of services. No payment is made to the patient under any circumstances.

In the February 4, 1977 issue of Leaves from the Vine the following report of a home health care hearing was given:

> The Senate Government Operations Federal Spending Practices Subcommittee held two days of hearings in Florida to look into home health care services. The hearings--in Tampa on April 12 and in Miami on May 5--together with its investigation led the subcommittee to conclude that widespread abuses were present throughout the system of supposedly non-profit agencies delivering home care services.
>
> Most abuses, according to the subcommittee report, seemed to involve excessive administrative salaries and other inflated costs billed to the government. In some cases profits were disguised as pension fund contributions, luxury automobiles were purchased for administrative personnel, parties were paid for with government money, and doctors referred patients from

their hospital practices to home care agencies in which the doctors had a financial interest.

Investigators reported a pervasive attitude among persons administering these agencies that overcharges and outright fraud were acceptable and commonplace activities. The committee found that the private operations often reported costs which were double those incurred by public agencies providing the same services.

Medicare and Medicaid Reform Legislation: A major proposal to curb the documented abuses of the Medicare and Medicaid programs was introduced by Senator Herman E. Talmadge (D-Ga.) on March 25. A year in the drafting, Talmadge's bill (S 3205) was co-sponsored by several other key members of the Senate Finance Committee. (For provisions, see NLN Public Affairs Report, Vol. 2, No. 2, July 1976) Hearings were held on Talmadge's bill in late July.

The first section of the mini-Talmadge bill would require HEW to establish an Office of Central Fraud and Abuse Control specifically to watch over the Medicare and Medicaid programs. The office would be required to help federal and state enforcement officials in the development of fraud cases.[1]

In the July 13, 1975 edition of the American Austin Statesman, the Department of Public Welfare was cited for violating home health care rules.[2] According to the Statesman, services were rendered to poor people in hospitals and nursing homes because the Texas Department of Public Welfare had failed to provide federally-required home health

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[1] "Home Health Care Hearing," Leaves from the Vine, February 4, 1977.

[2] Dave Mayes, "DPW Cited for Violating Home Health Care Rules," American Austin Statesman, July 13, 1975.

services under Medicaid. According to the Statesman, the medical care that is offered homebound Medicaid recipients is so limited until institutionalization becomes a necessity.

Medicare is expected to remain the major source for financing health care for the elderly. If national health insurance is commenced, Medicare will remain relatively unchanged. Some changes may occur in cost control, promote utilization and administration of health care services. Currently, monitoring of home health agencies is a state responsibility.

The 95th Congress approved the Medicare and Medicaid Anti-Fraud and Abuse Amendments on October 25, 1977.

> In the light of shortcomings believed to exist in the utilization review process, the 1972 Amendments added provisions to the Social Security Act that provide a review mechanism through which practicing physicians will eventually assume full responsibility for reviewing the utilization of services under the Medicare and Medicaid programs. Under these provisions, since amended several times most notably by the "Medicare-Medicaid Anti-Fraud and Abuse Amendments" (Public Law 95-142) of 1977, the Secretary is required to establish independent "professional standards review organizations" (PSROs) throughout the country in various areas.[1]

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[1] 1978 Social Security and Medicare Explained--Pension Plan Guide, (Chicago, Ill.: Commerce Clearing House, Inc.) 343, paragraph 669.0.

The State of Texas requires all home health agencies that wish to participate in the Medicare/Medicaid reimbursement plan to meet certification guidelines. These guidelines include an annual on-site visit. Prior to each site visit a preliminary questionnaire called the Home Health Agency Survey Report is sent to the agency. The Home Health Agency Survey Report addresses the following conditions:

1. Condition--Compliance with Federal, State and Local Laws
2. Condition--Organization, Services and Administration
3. Condition--Group of Professional Personnel
4. Condition--Acceptance of Patients, Plan of Treatment, and Medical Supervision
5. Condition--Skilled Nursing Service
6. Condition--Therapy Services
7. Condition--Medical Services
8. Condition--Home Health Aide Services
9. Condition--Clinical Records
10. Condition--Evaluation

The site visits are conducted by a surveyor from the Department of Health, Education and Welfare. If every facet of the Survey Report is accepted, the home health

agency is certified and its name is placed on the Home Health Agency Listing prepared by the Home Health Services Division, Texas Department of Health. This certification allows the home health agency to receive Medicare/Medicaid reimbursement.

This chapter has presented the provisions of Medicare/Medicaid, and the implementation of home health services by certified agencies. Selected literature on fraud and abuse of Medicare/Medicaid in home health services was also discussed.

# CHAPTER III

# METHODOLOGY

## Population

The Home Health Agency Listing of November 1, 1977, prepared by the Home Health Services Division, Texas Department of Health, includes all home health agencies which have been certified by Medicare and Medicaid in the State of Texas. A total of 52 home health agencies appear on this list. Of the 52 home health agencies listed, 7 were associated with Health Departments (units), 8 were associated with Visiting Nurse Associations (VNA), and 37 were arbitrarily classified as associated with Other Sponsoring Agencies; for example, private, not for profit, or profit agencies which were not directly affiliated with a health department or the VNA.

The sample was composed of the total number of Health Department Units (7), the total number of Visiting Nurse Associations (8), and 8 agencies randomly selected from the list of 37 Other Sponsoring Agencies. The random selection was made by cutting the list of names apart and placing the names in a pile on the table. From this pile eight home health agencies classified under Other Sponsoring

Agencies were selected by an objective person. Therefore, the total number of home health agencies in the sample was twenty-three.

The home health agencies by category served the following counties of the State of Texas: (1) Visiting Nurse Associations--Brazoria, Bell, Bowie, Cass, Coryell, Dallas, El Paso, Fort Bend, Hamilton, Harris, Kaufman, Lampasas, Marvin, Milan, Miller, Mills, Montgomery, and San aba; (2) Health Department Units--Blanco, Caldwell, Cameron, Comal, Denton, Guadalupe, Hays, Hidalgo, Potter, Randall, Taylor, and Travis; and (3) Other Sponsoring Agencies--Dallas, Cameron, Hidalgo, Willary, Chambers, Hardin, Jefferson, Orange, Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, Presidio, Delta, Fannin, Lamar, Red River, Brazos, Grimes, Houston, Leon, Madison, Robertson, Wallace, Camp, Franklin, Hopkins, Morris, Titus, Andrews, Borden, Crane, Dawson, Ector, Gaines, Glasscock, Howard, Loving, Martin, Midland, Pecos, Reeves, Terrell, Upton, Ward, and Winkler.

## Instrument and Data Collection Procedures

The data were collected on a researcher-constructed questionnaire. The questions on this survey were stimulated by a review of the requirements for evaluation which

were indicated on the Home Health Agency Survey Report. These requirements were discussed in Chapter II of this study. In addition, sections of business texts that dealt with evaluation of business and business procedures were reviewed. The questions were written following this review and then discussed with selected employees of one home health agency. After the discussion, the questions were revised. See Appendix 1 for a copy of this questionnaire.

The research proposal and questionnaire were submitted on March 27, 1979 to the Human Research Committee. Approval was granted on April 19, 1979.

Following approval, a letter of introduction was sent to the selected home health agencies by the Director of Health Sciences. It provided information advising the agencies that it was a bona fide survey by the Texas Woman's University graduate student. See Appendix 2 for a copy of this letter.

The questionnaire included directions and a cover letter stating the purpose and nature of the study. A statement of confidentiality was made. The participating agencies were informed that they may receive a copy of this study if they so indicated on the questionnaire. Agencies were coded for control purposes only. This

provided a means of knowing which home health agencies had returned their questionnaires. It allowed the researcher to determine which home health agency did not respond to the initial questionnaire. Thus, the researcher could send out another questionnaire. The agencies were provided with a stamped, self-addressed envelope to return the questionnaire within three weeks. Any agency that failed to respond to the initial questionnaire was sent a second questionnaire, a cover letter (see Appendix 4) and a stamped, self-addressed envelope. Return was requested within one week.

## Analysis of Data

Following the return of the questionnaires from home health agency administrators, the data was tabulated, analyzed, and the results were recorded in raw numbers and percentages. Appropriate charts and graphs of the data were prepared.

## Summary

This chapter discussed the population, and the procedures of obtaining the sample for this study. It also addressed the assessment instrument, the data collection procedure and the analysis of data.

# CHAPTER IV

## ANALYSIS OF FINDINGS

The questionnaire, Monitoring Mechanisms Used by Home Health Agencies to Prevent Medicare and Medicaid Fraud and Abuse, was sent to 23 Texas home health agencies. The questionnaire was sent to home health agencies which were classified into the following 3 categories: Visiting Nurse Associations (8), Health Department Units (7) and Other Sponsoring Agencies (8). The agencies associated with Health Departments and Other Sponsoring Agencies had a 100% return. Two questionnaires were returned from the Visiting Nurse Associations (VNA). One VNA was no longer in operations; the second had a change of address. A questionnaire was then sent to the new address. Of the remaining home health agencies associated with Visiting Nurse Associations (7), there was a 100% return (see Table 1).

The starting operation date of the selected home health agencies in this study ranged from December 1908 to May 1977 (see Table 2). Within the category of Visiting Nurse Associations the starting dates extended through eight decades. One each was started in the 1900s and 1930s. After a lapse of almost two decades, two more Visiting Nurse Associations were started. Only one VNA

TABLE 1

NUMBER OF QUESTIONNAIRES MAILED AND RETURNED BY TYPE OF HOME HEALTH AGENCY

| | Visiting Nurse Associations | Health Departments | Other Sponsoring Agencies |
|---|---|---|---|
| Number of Questionnaires Sent | 8 | 7 | 8 |
| Number of Questionnaires Returned | 7 | 7 | 8 |
| % of Return | 88% (100%)* | 100% | 100% |

*One VNA no longer in operation , (N = 22),

was started in 1966 which was a popular beginning date for other classified home health agencies in this study. Two Visiting Nurse Associations were begun in the 1970s.

It was noted that home health agencies in the categories of Health Department and Other Sponsoring Agencies were developed only during the decades of the 1960s and 1970s. Three home health agencies associated with Health Departments were started in 1966, two in 1975, and two in 1976. While each category had home health agencies starting in the 1960s and 1970s, the most recent to be started (1977) was in the category of Other Sponsoring Agencies.

TABLE 2

STARTING DATE BY TYPE OF HOME HEALTH AGENCY

| Visiting Nurse Associations | Health Departments | Other Sponsoring Agencies |
|---|---|---|
| December 1908 | ? 1966 | July 1966 |
| March 1935 | June 1966 | July 1969 |
| October 1952 | July 1966 | April 1970 |
| December 1957 | May 1975 | January 1974 |
| July 1966 | June 1975 | October 1974 |
| June 1971 | October 1976 | May 1975 |
| November 1972 | October 1976 | June 1975 |
| | | May 1977 |

All of the home health agencies regardless of the category were certified providers for Medicare/Medicaid more than two years. Refer to Table 3.

Question 3 of the questionnaire stated:

> In addition to the Home Health Agency Survey Report that is provided by the Department of Health, Education and Welfare--Social Security Administration, what type of monitoring mechanisms do you utilize to prevent Medicare and Medicaid fraud and abuse?

Three out of seven (43%) of the home health agencies associated with the Visiting Nurse Associations had instituted monitoring mechanisms. The remaining four (57%) do not anticipate instituting other monitoring mechanisms for Medicare/Medicaid fraud and abuse(see Table 4).

TABLE 3

MEDICARE/MEDICAID CERTIFICATION BY LENGTH OF TIME AND TYPE OF HOME HEALTH AGENCY

| | Visiting Nurse Associations | Health Departments | Other Sponsoring Agencies |
|---|---|---|---|
| A. Medicare | | | |
| less than 1 year | 0 | 0 | 0 |
| more than 1 year but less than 2 years | 0 | 0 | 0 |
| more than 2 years | 7 | 7 | 8 |
| B. Medicaid | | | |
| less and 1 year | 0 | 0 | 0 |
| more than 1 year but less than 2 years | 0 | 0 | 0 |
| more than 2 years | 7 | 7 | 8 |

Six (86%) out of the seven home health agencies associated with Health Departments answered the question. Five have developed monitoring mechanisms and one has no plans to develop alternative monitoring mechanisms.

There was a 50% response to this question in the category of Other Sponsoring Agencies. Three have developed monitoring mechanisms and one indicated no plans for additional monitoring mechanisms..

TABLE 4

MONITORING MECHANISMS INSTITUTED TO PREVENT MEDICARE/MEDICAID FRAUD AND ABUSE BY TYPE OF HOME HEALTH AGENCY

| | Visiting Nurse Associations | Health Departments | Other Sponsoring Agencies |
|---|---|---|---|
| Yes | 3 | 5 | 3 |
| No | 0 | 1 | 1 |
| No Answer | 4 | 1 | 4 |

Not all home health agencies that answered "yes" to question 3 listed the additional monitoring mechanisms being utilized. None of the home health agencies indicated a time table for instituting their proposed additional monitoring mechanisms as requested.

Each home health agency that answered "yes" was given an opportunity to specify the monitoring mechanisms used by their home health agency in addition to the Home Health Agency Survey Report. These have been listed according to the three categories used in this study:

Visiting Nurse Associations

1. Intermediary survey, intermediary audit, Medicare and Medicaid cost reports, internal record audits
2. Guidelines are carefully observed--record reviews
3. Utilize every method we hear about to effect good control
4. Several

Health Departments

1. Intermediary closely screens our agency for over utilization. In addition we follow guidelines established by Medicare as we admit and discharge our patients
2. Record review, active and closed--annual evaluation of services and program
3. The city auditors and Health Department administrator
4. We have a Board of Directors, made up of Professional[s], as well as civic leaders, who meet once a month. We report to them quarterly and submit an annual survey

Other Sponsoring Agencies

1. Monthly audit of patients' charts
2. At present we do not have a standardized method of preventing abuse and fraud. All we have to rely on is good communications between neighboring agencies (Home Health), DHR [Department of Human Resources] and other groups with Medicare/Medicaid contracts and #4 answers (of questionnaire)
3. Utilization review, chart audits, close monitoring to discharge patients as soon as possible, close monitoring of equipment usage

Twenty-one home health agencies in this study answered the remaining items, questions 4, 5, and 6, on the questionnaire. Refer to Table 5.

"Signed Document for Visit Verification" refers to a document signed by or for the client on date of service. The document shows the name of client, type of service rendered, and the person who performed the service. Of the sixteen reporting home health agencies who utilize a signed document for visit verification (Item A, Table 5), five or 31% were Visiting Nurse Associations, four or 25%

TABLE 5

ADDITIONAL MONITORING MECHANISMS UTILIZED TO PREVENT MEDICARE/MEDICAID FRAUD AND ABUSE BY TYPE OF HOME HEALTH AGENCY

| Monitoring Mechanisms | Visiting Nurse Associations N = 7 | | Health Departments N = 6 | | Other Sponsoring Agencies N = 8 | |
|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No |
| A. Signed Document for Visit Verification | 5 | 2 | 4 | 2 | 7 | 1 |
| B. Utilization Review | 6 | 1 | 6 | 0 | 8 | 0 |
| C. Supervisor Review | 7 | 0 | 6 | 0 | 8 | 0 |
| D. Peer Review | 6 | 1 | 2 | 3 | 7 | 1 |
| | | | No Response | 1 | | |
| E. Program Review | 6 | 1 | 4 | 1 | 7 | 1 |
| | | | No Response | 1 | | |
| F. Clinical Record Review | | | | | | |
| (1) Active | 7 | 0 | 6 | 0 | 8 | 0 |
| (2) Closed | 7 | 0 | 5 | 0 | 8 | 0 |
| | | | No Response | 1 | | |
| G. Inservice Education | 7 | 0 | 6 | 0 | 8 | 0 |
| H. Financial Audit | | | | | | |
| (1) Internal | 4 | 1 | 5 | 1 | 7 | 0 |
| | No Response | 2 | | | No Response | 1 |
| (2) External (outside firm) | 6 | 1 | 3 | 1 | 7 | 1 |
| | | | No Response | 2 | | |

were Health Departments and seven or 44% were in the category of Other Sponsoring Agencies.

"Utilization Review" is an evaluation of case management by a group of professionals inside and outside of the agency. Twenty of the twenty-one answering this portion of the questionnaire stated their agency used utilization review (Item B, Table 5) as a monitoring mechanism. Of this number six or 30% were Visiting Nurse Associations, six or 30% were Health Departments and eight or 40% were Other Sponsoring Agencies.

A critique of an employee's performance by the employee's supervisor is a "Supervisor Review" (Item C, Table 5). All home health agencies in the three categories used in this study utilized supervisor review.

"Peer Review" is a critique of a professional by professionals of the same discipline in home health care. Six or 86% of the Visiting Nurse Associations utilized peer review (Item D, Table 5). Two or 33% of the agencies associated with Health Departments utilized peer review. One home health agency classified with health departments did not respond to this part of question 4. Seven or 88% of the Other Sponsoring Agencies utilized peer review.

"Program Review" is a study of the plan of operation (objectives) for a home health agency. Six of the

seven (86%) Visiting Nurse Associations utilized program review (Item E, Table 5). Four home health agencies associated with Health Departments utilized program review. One home health agency in this category did not respond to this part of the questionnaire. Of the eight, seven or 88% of the home health agencies categorized as Other Sponsoring Agencies utilized program review.

This study required the participating home health agencies to indicate whether they instituted a review of the clinical record (active and closed) as a monitoring mechanism to prevent Medicare/Medicaid fraud and abuse. A "Clinical Record" contains pertinent past and current medical, nursing, social and other therapeutic information, including the plan of treatment. Home health agencies in all three categories utilized the review of active clinical records (Item $F_1$, Table 5). All of the home health agencies associated with the Visiting Nurse Associations and Other Sponsoring Agencies utilized the review of the closed clinical record (Item $F_2$, Table 5) as a monitoring mechanism. Five (83%) of the six home health agencies associated with Health Departments used the method of closed clinical record review. One agency in this category did not respond.

There was 100% response by all home health agencies in the three categories to inservice education (Item G, Table 5) being utilized in their agency. "Inservice Education" is the ongoing planned learning experiences for all disciplines of home health care.

The questionnaire asked each administrator participating in this portion of the study if internal and external financial audit was utilized in their agency as a monitoring mechanism for Medicare/Medicaid fraud and abuse. "Financial Audit" is an examination of accounts or records. An internal financial audit is done by an agency employee, whereas an external financial audit is done by a consulting firm whose expertise is in this field.

In the category of Other Sponsoring Agencies seven of the eight or 88% used both internal and external financial auditing. One home health agency in this category did not respond to the first half of this item on the questionnaire. Sixteen (89%) of the eighteen home health agencies that responded to this question indicated the use of an internal and external financial audit system. However, the Visiting Nurse Associations had fewer agencies utilizing an internal audit system (Item $H_1$, Table 5). Eighty-six percent of the home health agencies associated with

Visiting Nurse Associations utilized external financial audit (Item $H_2$, Table 5). The Health Departments had less (3) utilization of external audit systems and internal audit system was utilized more (5) by the home health agency. However, there was a lack of response by two Health Departments to this particular item on the questionnaire.

Each administrator was given an opportunity to list other monitoring mechanisms not mentioned on the questionnaire that were utilized by their agency. There was one response each from home health agencies associated with Visiting Nurse Associations and Health Departments. Two of eight home health agencies in the category of Other Sponsoring Agencies made a listing of monitoring mechanisms used by their agencies to prevent Medicare/Medicaid fraud and abuse. All listings are made according to the categories used in this study:

Visiting Nurse Associations

> Medicare Certification; Medicare/Medicaid Audit; Prof. [Professional] Relations Review, Community Survey Questionnaires, NLN [National League for Nurses] Accreditation Review; OSHA [Office of Safety and Health Administration] Review, United Way Program Evaluation.

Health Departments

> City . . .Auditors, Audit every 2-3 years. Auditors are not on Health Dept. [Department] Staff although we are a City Dept. [Department]

Other Sponsoring Agencies

1. Followup audit by Medicare and Medicaid Case Monitoring by State Department of Human Resources
2. Intermediary's Auditors (Medicare)
   State Auditors (Medicaid)
   Agency Auditors
   Outside Auditors

All identifying names were omitted to provide confidentiality.

Table 6 indicates by category of home health agency whether a specific staff member was assigned the task of monitoring Medicare/Medicaid fraud and abuse. Of the three categories in this study, 57% of the total number of Visiting Nurse Associations, 33% of the total number of Health Departments, and 33% of the responding number of Other Sponsoring Agencies indicated a staff member was assigned to this task. However, two did not respond to the question.

TABLE 6

STAFF ASSIGNED TO MONITOR MEDICARE/MEDICAID FRAUD AND ABUSE BY TYPE OF HOME HEALTH AGENCY

| | Visiting Nurse Associations | Health Departments | Other Sponsoring Agencies |
|---|---|---|---|
| Yes | 4 | 2 | 2 |
| No | 3 | 4 | 4 |
| No Response to Question #5 | 0 | 0 | 2 |
| Part-Time | 1 | 2 | 0 |
| Full-Time | 0 | 0 | 2 |

Of the four home health agencies associated with Visiting Nurse Associations that utilized staff to monitor Medicare/Medicaid fraud and abuse, three agencies had assigned full-time employees to this task. One Visiting Nurse Association utilized a part-time employee. Three home health agencies of this category indicated no specific employee was assigned to the task of monitoring Medicare/Medicaid fraud and abuse.

Thirty-three percent of the Health Departments have part-time employees for monitoring Medicare/Medicaid fraud and abuse. Sixty-six percent of these agencies associated with Health Departments indicated no employees specifically assigned this task.

Two home health agencies in the category of Other Sponsoring Agencies have full-time employees to monitor Medicare/Medicaid fraud and abuse. Sixty-six percent of the responding agencies had no one employed for this specific task.

All of the participating home health agencies did not take advantage of the opportunity to make comments. The comments which were made are listed according to the three categories in the study:

Visiting Nurse Associations

1. The staff is so concerned about unnecessary costs to the government that we are certain in some cases we should do more for the patient or give more

visits than we do. We have no denials from Medicare. When further care is indicated, patients are taken off Medicare, Medicaid and given free care under United Way auspices or charged personally

2. [Administrator] is responsible for the Quality Assurance Program--so indirectly monitoring of fraud and abuse is part of QA (Quality Assurance] program

Health Departments

1. It is extremely difficult to conceive of any HH [Home Health] Agency in Texas to consistently practice fraud and abuse because of the close monitoring by the intermediary and the survey conducted by the Texas Health Department yearly

2. The Program (Home Health) Coordinator is responsible for the monitoring. Since our agency is small . . . this is not a problem at this time

3. Supervisor of Home Health Services monitor services provided without specific charge to monitor abuse

4. We only employ a small staff . . . so some reviews such as peer are unavailable

5. We know our services have been of benefit to the many people we have served, but we feel that knowledge of our services is not adequately available

Other Sponsoring Agencies

1. Each employee is given the task of monitoring service and equipment

2. Administrative staff checks records, . . . , supplies, staff hours, mileage of nurses making visits. . . . We have never had a denial nor deficiency from HEW monitoring. I say this humbly. I feel any conscientious Director or Administrator should monitor their work plus outside peers. This can be done. Within the State Home Health Agencies, we have a Peer Review Committee. I must admit, it is a difficult job to approach another agency for this purpose. I feel if the State level and Federal level would use expertise of people who know the pitfalls and symptoms of abuse, they should not ignore such information and think it will go away. I've known of abuse of [in] Nursing Homes. I would like to see the authority to move early with the proliferation of Home Health Agencies and prevent and expose agencies that are guilty of Fraud and Abuse

All identifying statements were omitted to provide confidentiality.

# CHAPTER V

# SUMMARY, CONCLUSIONS, DISCUSSION AND RECOMMENDATIONS

## Summary

This study was done to determine if similar monitoring mechanisms to prevent Medicare/Medicaid fraud and abuse are utilized by home health agencies in the State of Texas. To obtain this data, home health agencies were divided into three categories: (1) Visiting Nurse Associations, (2) Health Departments, and (3) Other Sponsoring Agencies. Each agency administrator was sent an investigator-made questionnaire so that the following research questions could be answered:

1. What monitoring mechanisms are utilized in the State of Texas to prevent Medicare/Medicaid fraud and abuse in home health services provided by Visiting Nurse Associations?

2. What monitoring mechanisms are utilized in the State of Texas to prevent Medicare/Medicaid fraud and abuse in home health services provided by County Health Departments?

3. What monitoring mechanisms are utilized in the State of Texas to prevent Medicare/Medicaid fraud and abuse in home health services provided by Other Sponsoring Agencies?

## Conclusions

In order to answer these questions a non-standardized questionnaire was sent to twenty-three home health agencies in Texas. The varied percentage rate of participating home health agencies indicated, by their answers, a lack of standardized monitoring mechanisms. Even though all Medicare/Medicaid certified home health agencies in the State of Texas utilized the Home Health Agency Survey Report that was provided by the Department of Health, Education and Welfare--Social Security Administration, all of the participating agencies utilized the following types of monitoring mechanisms to a varying degree: signed document for visit verification, utilization review, supervisor review, peer review, program review, clinical record review (active and closed), inservice education and financial audit (internal and external).

## Discussion

Selected literature recommended the establishment of standards and monitoring mechanisms for home health care

on the federal level extending to the regions and locally. The study indicated various methods used on all levels to monitor Medicare/Medicaid fraud and abuse. Indications by some home health agencies participating in this study were that standards and monitoring mechanisms needed standardizing in uniformity. The quick response to the quentionnaire sent by the researcher as well as the large (19 of 22) request for the findings in the study showed statewide concern for solving of this problem.

There are investigation teams sponsored by the Department of Health, Education and Welfare for Medicare providers. The State Department of Human Resources has investigators for Medicaid providers. The providers include all information of health care, not just home health care.

## Recommendations

The recommendations for this study are that:

1. The questionnaire be pretested to determine its validity and reliability

2. Definitions should be listed on the questionnaire to prevent misinterpretation of terms used and duplication of answers

3. A larger sample be selected if study is to be replicated

4. Other categories of home health agencies be established

# APPENDICES

# APPENDIX 1

# QUESTIONNAIRE

Directions:

Please answer the questions as they relate to the home health services provided by your home health agency. Please return this questionnaire within one week of the date received. Return in stamped self-addressed envelope.

If you wish a copy of this study, please indicate by placing a check here. ( )

Please fill in or check (✓) the appropriate blank or blanks.

1. Give the month and year your home health agency was started.

_____
(Month) (Year)

2. Give length of time agency has been a certified provider:

A. Medicare

_____ less than 1 year
_____ more than 1 year but less than 2 years
_____ more than 2 years

B. Medicaid

_____ less than 1 year
_____ more than 1 year but less than 2 years
_____ more than 2 years

3. In addition to Home Health Agency Survey Report that is provided by the Department of Health, Education and Welfare--Social Security Administration, what type of monitoring mechanisms do you utilize to prevent Medicare and Medicaid fraud and abuse?

If none, do you anticipate instituting monitoring mechanisms?

_____ Yes _____ No

If so, specify the mechanisms and the time table for instituting the mechanisms.

If you answered question No. 3 no, you do not need to answer the remaining items. Place this questionanire in the envelope provided and return it to me. Thank you for your participation in this survey.

If monitoring mechanisms are utilized, please continue answering this questionnaire.

4. Does your agency require:

A. Signed document for visit verification

_____ Yes _____ No

B. Utilization Review

_____ Yes _____ No

C. Supervisor Review

_____ Yes _____ No

D. Peer Review

_____ Yes _____ No

E. Program Review

_____ Yes _____ No

F. Clinical Record Review

(1) Active

_____ Yes _____ No

(2) Closed

_____ Yes _____ No

G. Inservice Education

_____ Yes _____ No

H. Financial Audit

(1) Internal

_____ Yes _____ No

(2) External (outside firm)

_____ Yes _____ No

I. Others _____

_____

_____

5. Is a member of your staff given the task of monitoring Medicare and Medicaid fraud and abuse?

_____ Yes _____ No

If yes:

_____ Part-time _____ Full-time

6. Comments: _____

_____

_____

_____

_____

# APPENDIX 2

TEXAS WOMAN'S UNIVERSITY
Box 23716, TWU Station
Denton, Texas 76204

School of Health Care Services

April 3, 1979

(Address)

Dear Home Health Agency Administrator:

Mrs. Eleanor Williams, a Master's Degree Student in Health Care Administration at the Texas Woman's University, Denton is conducting research dealing with monitoring mechanisms used by selected home health agencies to prevent Medicare and Medicaid fraud and abuse in Texas.

The home health agencies which have been chosen to be included in Mrs. Williams' study were selected from the Home Health Agency Listing prepared by the Home Health Service Division, Texas Department of Health. She would like for you to fill in a short questionnaire concerning the above topic. She will be contacting you by mail.

I will be grateful for any help you can give Mrs. Williams in this study.

Sincerely,

Barbara J. Cramer

Barbara J. Cramer, Ph.D.
Director: School of
Health Care Services

BJC:cs
cc: Mrs. Williams

# APPENDIX 3

April 20, 1979

(Address)

Dear Home Health Agency Administrator:

I am a candidate for a Master's Degree in Health Care Administration at the Texas Woman's University. In partial fulfillment of the requirements for a Master's Degree, I am writing a thesis on monitoring mechanisms utilized by selected home health agencies to prevent Medicare and Medicaid fraud and abuse in the State of Texas. Dr. Barbara J. Cramer, Director of the School of Health Care Services, from the Texas Woman's University wrote you earlier about my study. The value of this study is that the determination of monitoring mechanisms currently used by different types of home health agencies should be helpful in developing standardized and objective monitoring devices for each agency.

Agencies are coded for control purposes only; all information will be kept confidential.

Please answer the attached questionnaire and return within one week in the self-addressed stamped envelope which is enclosed. If you have any questions please call or write me. Please indicate on the questionnaire if you wish a copy of this study.

Thank you in advance for participation in this study.

Sincerely,

Eleanor Williams
Master's Degree Student
Health Care Administration Program
2926 Prince Hall Lane, #154
Dallas, Texas 75216
214-941-3101

# APPENDIX 4

May 11, 1979

(Address)

Dear Home Health Agency Administrator:

As I wrote you on April 20, I am a candidate for a Master's Degree in Health Care Administration at the Texas Woman's University. As I advised I am writing a thesis on monitoring mechanisms utilized by selected home health agencies to prevent Medicare and Medicaid fraud and abuse in the State of Texas. In this connection, I enclosed with my April 20 letter a questionnaire with the request that it be completed and returned to me.

I realize that there are many demands on your time. However, most of the questionnaires have been returned and if you could take just ten or fifteen minutes to complete the questionnaire, it would be of the greatest assistance to me in the completion of this study. If the questionnaire has been misplaced or there is any other problem, please let me know. I am enclosing another return envelope for your convenience.

Thank you again for your cooperation and assistance.

Sincerely,

Eleanor Williams
Master's Degree Student
Health Care Administration
Program
2926 Prince Hall Lane, #154
Dallas, Texas 75216

EW:mw

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