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MEDICARE HOME HEALTH AGENCIES

Role of Surety Bonds in Increasing Scrutiny and Reducing Overpayments



**Health, Education, and
Human Services Division**

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The Honorable William V. Roth, Jr.
Chairman
The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

Home health care—skilled nursing, therapy, and related services provided to homebound beneficiaries—has been one of Medicare’s fastest growing benefits in recent years. Between 1990 and 1997, spending increased from \$3.7 billion to \$17.8 billion, an average annual increase of 26 percent. This growth occurred because more beneficiaries used the services and more users received more home health care visits. Concurrent with the rise in spending was an increase in the number of home health agencies (HHA), which almost doubled from 1989 to 1997, reaching 10,600 in 1997. Changes in practice patterns and the need for home health care have contributed to the greater use of this benefit, but inappropriate use and billing practices have added to Medicare’s HHA spending as well. Concern about growth in spending, fraud and abuse, and inadequate oversight led the Congress and the administration to implement a number of initiatives to better control Medicare’s home health care costs.

Of particular importance, the Balanced Budget Act of 1997 (BBA) mandated major changes to the home health care benefit. To slow spending, Medicare’s payment method was altered and certain coverage criteria were clarified. The act also established new requirements for HHAs participating in Medicaid or in Medicare to shore up Medicare’s survey and certification process—the program’s approach to ensuring that only qualified providers bill for services. One of these new requirements is the posting of a surety bond of not less than \$50,000. Applying for such a surety bond would subject an HHA’s activities to review by a surety company to determine its worthiness to purchase the bond.

The Health Care Financing Administration (HCFA) issued the implementing regulation for BBA’s surety bond requirement on January 5, 1998. Under the regulation, HHAs are required to obtain a financial guarantee bond designed to allow HCFA to recover delinquent overpayments made for any reason rather than just those resulting from fraud and abuse. For larger agencies, it also set the bond amount at 15 percent of an HHA’s Medicare revenues, higher than the minimum \$50,000 required by the BBA. Concern arose

about the appropriateness of HCFA's specification of the surety bond requirement and its effect on home health care providers. Some HHAS reported difficulty in obtaining bonds and asserted that the burden of doing so was too onerous. In response, in June HCFA postponed the date when HHAS must obtain surety bonds until February 15, 1999, at the earliest.

You asked us to evaluate the surety bond requirement for HHAS participating in Medicare. Specifically, you requested that we (1) analyze the key features of surety bonds that affect their costs and effect; (2) examine the Florida Medicaid program's experience with a surety bond requirement for HHAS and its relevance to the Medicare surety bond requirement; (3) review the rationale for the surety bond requirements HCFA selected, the cost and availability of bonds, the benefits for Medicare, and the implications of substituting a government note for a surety bond as set forth in a Treasury Department regulation; and (4) draw implications from the implementation of the HHA surety bond requirement for implementing a similar surety bond provision for durable medical equipment (DME) suppliers, comprehensive outpatient rehabilitation facilities (CORF), and rehabilitation agencies. See appendix I for information on our scope and methodology.

Results in Brief

A surety bond is a three-party agreement in which a company, known as a surety, agrees to compensate the bondholder if the bond purchaser fails to keep a specified promise. The terms of the bond—the promise, the definition of default, and the penalty for default—determine the bond's cost and the amount of scrutiny the purchaser faces from the surety company. Types of bonds that have been seen as potentially appropriate for HHAS include financial guarantee bonds with a promise to fulfill financial obligations to the bondholder, antifraud bonds that compensate the bondholder for losses stemming from fraud or abuse, and compliance bonds based on a promise to conform to specified sets of terms or conditions. Purchasers pay a fee, usually a percentage of the bond's face value, and some must also provide collateral. Collateral is more likely to be required when the risk of default is higher or when the purchasing firm does not have sufficient assets to repay the surety in the event of a default. The surety checks certain characteristics of the purchasing firm before agreeing to issue a bond, such as its financial situation, business practices, and its principals' backgrounds. The relative emphasis that sureties place on these factors varies, however, depending on the purpose of the bond. When the terms of bonds increase the risk of default, more firms have

difficulty purchasing them. The likelihood that a firm will be unable to repay a surety increases fees charged and collateral requirements or the surety's unwillingness to sell it a bond.

Although often cited as an important precursor to Medicare's surety bond requirement, Florida Medicaid's experience offers few insights into the potential effect of Medicare's surety bonds because the state implemented its surety bond requirement selectively, for new and problem HHAs, in combination with several other program integrity measures. Bonds under Florida Medicaid involve a promise that the HHA will comply with all Florida Medicaid rules and regulations. After implementation, Florida officials reported that about one-quarter of its Medicaid-participating HHAs had left the program. However, this exodus was not caused primarily by the surety bond requirement. Few of the terminating agencies would have had to obtain a bond since they were not new to the program. Despite the reduction in the number of Medicaid-participating HHAs, Florida's governor stated that there was no decline in beneficiaries' access to home health care.

HCFA requires a surety bond guaranteeing HHAs' repayment of Medicare overpayments, and it has set the minimum level of the bond as the greater of \$50,000 or 15 percent of an agency's Medicare revenues out of concern that about 60 percent of HHAs had overpayments in 1996, amounting to about 6 percent of Medicare's HHA spending, and that, in their opinion, overpayments would increase in the future. Yet, HCFA's experience shows that most overpayments are returned, so that the net unrecovered overpayments were less than 1 percent of Medicare's home health care expenditures in 1996. Further, there was no evidence that larger agencies would be expected to have more unreturned overpayments to justify the requirement for a larger bond.

HCFA's implementing regulation requiring a bond guaranteeing the return of overpayments made for any reason rather than only those attributable to acts of fraud or dishonesty increases the risk of default. Consequently, sureties may require more HHAs to provide collateral to obtain a bond. The regulation may also benefit the Medicare program in terms of surety companies' scrutiny of HHAs and their incentives to repay overpayments in order to continue to qualify for a bond. Sureties' scrutiny, which focuses primarily on an agency's business practices and financial status, is probably most useful for screening new HHAs. Its value would probably diminish with an HHA's continued participation in Medicare. A Treasury Department regulation that allows the substitution of a government note

for any federally required surety bond may undermine the purpose of the bond because HHAS could avoid surety scrutiny.

The BBA also requires that DME suppliers, CORFS, and rehabilitation agencies obtain a surety bond valued at a minimum of \$50,000. HCFA has stated its intent to implement this requirement in the same way it does for HHAS. Medicare will benefit from greater scrutiny of these organizations and their stronger incentives to avoid overpayments. Many of these providers receive very limited Medicare revenue. Some may cease to participate because of the cost of obtaining a bond. The effect on beneficiaries' access to care may not be significant, however, because DME suppliers currently number more than 68,000 and alternative sources of therapy exist for beneficiaries who use CORFS and rehabilitation agencies.

Background

The Medicare home health care benefit covers skilled nursing, therapy, and related services provided in beneficiaries' homes. To qualify, a beneficiary must be confined to his or her residence (that is, must be "homebound"); require intermittent skilled nursing, physical therapy, or speech therapy; be under the care of a physician; and be furnished services under a plan of care prescribed and periodically reviewed by a physician. If these coverage criteria are met, Medicare will pay for part-time or intermittent skilled nursing; physical, occupational, and speech therapy; medical social service; and home health aide visits. Only HHAS that have been certified are allowed to bill Medicare. Beneficiaries do not pay any coinsurance or deductibles for these services, and there are no limits on the number of home health care visits they receive as long as they meet the coverage criteria.

HCFA, the agency within the Department of Health and Human Services responsible for administering Medicare, uses five regional contractors (which are insurance companies), called regional home health intermediaries (RHHI), to process and pay claims submitted by HHAS and to review or audit their annual cost reports. HHAS are paid their actual costs for delivering services up to statutorily defined limits. During each fiscal year, HHAS receive interim payments based on the projected per visit cost and, in some instances, the projected volume of services for Medicare beneficiaries. At the end of the year, each HHA submits a report on its costs and the services it has provided and the RHHI determines how much Medicare reimbursement the HHA has earned for the year. If the interim payments that the agency received exceed this amount, the HHA must return the overpayment to Medicare. Otherwise, Medicare makes a

supplementary payment of the difference between the earned reimbursement and the interim payments. HHAs are expected to minimize overpayments and underpayments by notifying RHHIS of changes in projected costs or volume during the year so that their interim payments can be adjusted. Final cost report settlements generally do not occur until 2 years after an HHA's fiscal year ends.

The home health care benefit has been one of the fastest growing components of the Medicare program, increasing from 3.2 percent of total Medicare spending in 1990 to 9 percent in 1997. Medicare's home health care expenditures rose from \$3.7 billion in 1990 to \$17.8 billion in 1997. The rapid growth in home health care was primarily driven by legislative and policy changes in coverage.¹ These changes essentially transformed the home health care benefit from one focused on patients needing short-term posthospital care to one that also serves chronic, long-term care patients. The growth in spending has slowed markedly in recent years. Several factors probably contributed to the deceleration, including HCFA's recent antifraud measures.

While spending grew, HCFA's oversight of HHAs declined. The proportion of home health care claims that HCFA reviewed dropped sharply, from about 12 percent in 1989 to 2 percent in 1995, while the volume of claims about tripled. Yet the need for such review to ensure that Medicare pays only for services that meet its coverage rules has not diminished. In a study of a sample of high-dollar claims that were paid without review, we found that a large proportion of the services did not meet Medicare's coverage criteria.² Operation Restore Trust (ORT), a joint effort by federal and several state agencies to uncover program integrity violations, also found high rates of noncompliance with Medicare's coverage criteria among the problematic HHAs they investigated. In addition, RHHIS audited cost reports for only about 8 percent of HHAs each year from 1992 through 1996.

Until recently, the number of Medicare-certified HHAs increased along with the rise in home health care spending—from 5,700 in 1989 to 10,600 at the end of 1997.³ Last year, we reported that HHAs were granted Medicare certification without adequate assurance that they provided quality care or

¹Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

²Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

³During fiscal year 1998, 1,155 agencies quit participating in Medicare.

met Medicare's conditions of participation.⁴ Moreover, once certified, there was little likelihood that a provider would be terminated from the program.

Beginning in mid-1997, HHAs that request Medicare certification or change ownership have had to go through an enrollment process designed to screen out some problem providers. The process requires HHAs to identify their principals—that is, anyone with a 5-percent or greater ownership interest—and to indicate whether any of them have ever been excluded from participating in Medicare. HCFA also has proposed requiring all HHAs to reenroll every 3 years, which would entail an independent audit of providers' records and practices.

In the BBA, the Congress strengthened HCFA's ability to keep potentially problematic providers out of the Medicare program by codifying a \$50,000 surety bond requirement and establishing other participation requirements.⁵ The law also required HHAs participating in Medicaid to obtain a \$50,000 surety bond. The law expanded the enrollment process by requiring HHA owners to furnish HCFA with their Social Security numbers and information regarding the subcontractors of which they have direct or indirect ownership of 5 percent or more. The BBA also provides that an HHA may be excluded if its owner transfers ownership or a controlling interest in the HHA to an immediate family member (or household member) in anticipation of, or following, a conviction, assessment, or exclusion against the owner.

Subsequently, HCFA implemented additional changes to further strengthen requirements for HHAs entering the Medicare program and to prevent fraud and abuse.⁶ For example, the surety bond regulation imposes a capitalization requirement for home health care providers enrolling on or after January 1, 1998. New HHAs are required to have enough operating capital for their first 3 months in business, of which no more than half can

⁴Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies (GAO/HEHS-98-29, Dec. 16, 1997, and GAO/T-HEHS-97-180, July 28, 1997).

⁵HCFA has always had implicit authority to institute a surety bond requirement for HHAs under its statutory authority to protect the Medicare program and has had explicit authority to do so since the enactment of the Omnibus Budget Reconciliation Act of 1980.

⁶From September 15, 1997, until January 13, 1998, the administration placed a moratorium on admitting new HHAs into Medicare, except in underserved areas, while HCFA developed regulations to implement the program integrity provisions of the BBA—including the surety bond requirement—and to design other procedures to target home health care fraud and abuse.

be borrowed funds.⁷ In another regulation, HCFA requires that an HHA serve at least ten private-pay patients before seeking Medicare certification. This contrasts with the previous requirement that only a single patient had to have been served.

The BBA mandated surety bonds for Medicare suppliers of DME, CORFS, and rehabilitation agencies as well. Like HHAs, Medicare spending for these providers has grown rapidly in the past few years. Further, there is general concern that providers are given inadequate oversight and that their bills are insufficiently reviewed.

DME suppliers sell or rent covered DME (such as wheelchairs), prosthetics, orthotics, and supplies to Medicare beneficiaries for use in their home. In 1996, there were more than 68,000 Medicare-participating DME suppliers. From 1992 to 1996, spending for DME increased from \$3.7 billion to \$5.7 billion, an average annual increase of 11 percent. Medicare bases its payment of DME suppliers on a fee schedule. Consequently, how much Medicare should pay for each item is known when it is delivered. Overpayments that should be returned to Medicare arise almost entirely from claims submitted and paid inappropriately.

CORFS and rehabilitation agencies both provide rehabilitation services to outpatients. CORFS offer a broad array of services under physician supervision—such as skilled nursing, psychological services, drugs, and medical devices—and must have a physician on staff. Conversely, rehabilitation agencies provide physical therapy and speech pathology services, primarily in nursing facilities, to individuals who are referred by physicians. In 1996, there were 336 CORFS and 2,207 rehabilitation agencies. From 1990 to 1996, Medicare's spending for CORFS grew from \$19 million to \$122 million, an average annual increase of 36 percent. Spending for rehabilitation agencies increased from \$151 million to \$457 million, an average growth of 25 percent per year during the same period. Like HHAs, CORFS and rehabilitation agencies are paid on the basis of their costs. Therefore, the actual payment for a service is not known until the cost report is settled, after the end of the fiscal year. This increases the likelihood that overpayments will be made because of unallowable costs or cost-estimation problems during the year.

⁷The estimate of needed capital is based on the HHA's projection of the home health care visits it will provide during the first 3 months multiplied by the RHHI's estimate of cost per visit.

Surety Bond Specifications Determine Cost and Availability

A surety bond is a three-party agreement. It is a written promise made by the bond issuer, usually an insurance company, called a surety, to back up the promise of the purchasing firm to a third party named in the bond.⁸ For example, the surety may agree to compensate the third party if the bondholder fails to deliver a product on time or without significant defects. In issuing a bond, the surety signals its confidence that the bondholder will be able to fulfill the promised obligations. In purchasing a bond, the bondholder acknowledges its duty to indemnify—that is, compensate—the surety when a bond is redeemed.

Surety bonds entail many different types of guarantees, depending on what the third party requiring the bond wants to accomplish. Three types of surety bonds have been seen as potentially appropriate for HHAS—a financial guarantee bond, an antifraud bond, and a compliance bond. However, while labels are often applied to different types of bonds, the types have no strict definitions. The specific language in each bond describes the guarantee, what constitutes default, how a default is demonstrated, and what penalty or compensation ensues. The bond types can be described in general terms. A financial guarantee bond promises that the surety will pay the third party requiring the bond financial obligations not paid by the bondholder up to the face value of the bond. Antifraud bonds generally provide the third party protection in the event that it incurs losses from the bondholder's fraudulent or abusive actions. The third party delineates what constitutes fraud or abuse for purposes of bond default. A compliance bond generally guarantees that the bondholder will conform to the terms of the contract with the third party requiring the bond and that the surety will pay the third party if the bondholder does not meet the contract's terms. This bond also can be designed to guarantee that the bondholder complies with specific standards, such as having a required license or conforming to a set of regulations.

Just as surety bonds vary depending on what is being guaranteed, so do the criteria that sureties use in assessing or underwriting a prospective bond purchaser. There are, however, general underwriting rules. Sureties traditionally examine what they call a firm's "3 Cs"—character, capacity (or proven ability to perform), and capital. The emphasis that the surety places on each of these three elements varies with the guarantee incorporated into the bond. For a bond that guarantees that the surety will pay financial obligations, for example, sureties emphasize the financial

⁸Surety bonds required by federal agencies must be obtained from sureties on a list of about 300 sureties approved by the Treasury Department. These sureties go through a review process in which their solvency and other factors, such as their history and officers' and directors' experience, are checked.

resources of the bond purchaser and its principals. Sureties emphasize a bond purchaser's character or capacity in determining whether to provide a bond that guarantees that the surety will pay when the bonded firm acts dishonestly, although they are still interested in the purchaser's financial situation.

To underwrite or assess whether to provide a bond, sureties examine, at a minimum, information about the firm—such as an organizational plan, length of time in business, financial statements for the current year and the previous 2 years, resumes of key individuals, current sales and revenues, and a business plan. Sureties generally review the credit history of a firm and, if it is privately held, of its principals. This scrutiny is one of the benefits of requiring a surety bond.

The cost of obtaining a bond is the fee or premium charged plus having to provide collateral—cash or assets that can be turned into cash. The greater the surety's risk of having to compensate the third party without being able to recover that compensation from the bondholder, the higher the cost. The fee is usually 1 percent to 2 percent of the face value for most commercial bonds. Collateral, which ensures the compensation of the surety, is typically required when there is a greater risk of a loss because of the type of guarantee provided by the bond or the capacity of the firm to repay the surety. For example, sureties may require collateral of firms that do not have assets worth considerably more than the face value of the bond.

The collateral that sureties accept may be a deed of trust on real property, a Treasury bond, or an irrevocable letter of credit from a bank. The costs to the bondholder of providing collateral vary inversely with the costs to the surety for liquidating it. A property deed may be the least costly for the bondholder to provide, followed by a Treasury bond, and then an irrevocable letter of credit, which generally requires the payment of a fee to the financial institution. The latter two options require obligating cash from operating capital. These are the most secure options for the surety, however, since they can be liquidated with minimal costs.

For certain firms seeking a bond, a firm's principals may have to personally guarantee that they will repay the bond issuer for any losses. Such personal indemnity is generally required for smaller, privately held firms but not for most nonprofit firms or those that are publicly held. Surety industry representatives indicate that personal indemnity provides

a measure of the willingness of the principals who benefit from the firm to stand behind their company.

The ability to obtain a surety bond varies with the bond's terms and the characteristics of the firm. The surety industry maintains that the narrower the definition of what a bond guarantees, the easier it is for a firm to obtain the bond. For example, obtaining an antifraud bond would be easier if it required payment of the penalty only in cases involving criminal fraud rather than any type of abuse. Large, financially healthy firms that have been in business a long time generally have the least difficulty obtaining any surety bond. Smaller privately held firms, new or inexperienced businesses, firms that have filed for bankruptcy or have credit problems, and those with little credit have more difficulty obtaining a bond.⁹ Those that have defaulted on a prior bond are likely to face the most severe scrutiny. One surety industry representative indicated that firms that default on one bond are unlikely to be able to obtain another.

Anyone required by federal statute or regulation to furnish a surety bond may substitute a U.S. bond, Treasury note, or other federal public debt obligation of equal value.¹⁰ According to the surety industry, however, this option is taken only by large, well-financed entities.

Florida's Medicaid Surety Bond Requirement Has Few Implications for Medicare

The Florida Medicaid surety bond requirement has often been cited as an important precursor to Medicare's surety bond requirement. However, the effect of Florida Medicaid's program integrity measures has few implications for Medicare's imposition of a surety bond requirement. Florida instituted more stringent program integrity measures than Medicare at the same time it required the surety bond, such as a criminal background check. The state also targets the surety bond requirement to new and problem providers.

Florida introduced several new measures to combat fraud and abuse in its Medicaid program in December 1995. As a result of these measures, HHAS and other noninstitutional providers in Florida are now subject to closer scrutiny before they can participate in Medicaid, and home health care

⁹The Small Business Administration (SBA) has two surety bond guarantee programs that help construction contractors that are small businesses obtain a bond. SBA assumes a predetermined percentage of loss and reimburses the surety up to that amount if the contractor defaults. See appendix II for a description of the SBA programs. A representative of SBA told us that HHAS would not be able to participate in the surety bond guarantee programs unless the definition of eligible entities were changed by law.

¹⁰31 U.S.C. 9303.

coverage criteria have been tightened. One of Florida's new program participation requirements is that certain agencies purchase a 1-year surety bond.

The surety bond requirement applies to new HHAs, those in the program for less than a year when they reenroll, and problem agencies.¹¹ Each must obtain a 1-year, \$50,000 surety bond. Florida officials indicate that their primary reason for the surety bond requirement is that in underwriting a bond surety companies check the capacity and financial ability of providers to operate their business. They consider such review to be an effective and administratively efficient screening tool to keep unqualified providers from participating in the Medicaid program. Florida officials told us that the screening associated with obtaining a surety bond is so important that they no longer allow providers to substitute a \$50,000 letter of credit for the surety bond.¹²

The required surety bond is a guarantee that the bondholder's principals, agents, and employees will comply with Florida's Medicaid statutes, regulations, and bulletins and will perform all obligations faithfully and honestly. Since the surety bond requirement was implemented, no HHAs have had claims made against their bonds.

In addition to the surety bond requirement, Florida's Medicaid reforms included several policy changes. A new agreement was implemented for all noninstitutional providers. They are required to pay for a criminal background check for each principal (owners of 5 percent or more, officers, and directors) by the state Department of Law Enforcement. Providers also must allow state auditors immediate access to their premises and records. Other measures the Florida Medicaid program implemented in its campaign against fraud and abuse include new computerized claims edits and other types of claims review to identify inappropriate billings. In addition, new constraints on the coverage of home health care services were imposed, including prior approval requirements for extended periods of service.

More than one-fourth of HHAs that participated in Florida's Medicaid program when the program integrity measures were implemented are

¹¹Problem agencies are under investigation for fraudulent practices or have been found to have committed fraud. The state says they are not many because most were excluded from the Medicaid program.

¹²The director of Florida Medicaid, in commenting on a draft of the report, said that the letter of credit also is a more difficult instrument to administer than a surety bond because the institutions issuing the letters of credit often need the original documents returned at the end of their term.

reported to have left Medicaid. This estimate is based on an analysis of Medicaid provider numbers. Agencies with no provider number after the bond requirement effective date were counted as leaving the program. However, HHAs may stop using their provider numbers for reasons other than leaving the program or going out of business. Some, for example, use a new number obtained because they merged with another agency or were sold. We were able to locate seven of the nine largest HHAs that the state reported as having left the Medicaid program in 1996. All seven agencies were still providing Medicaid-covered home health care services.¹³ We did not assess what proportion of smaller agencies reported as leaving actually did so.

The departure of HHAs from Florida's Medicaid program cannot be attributed solely to the surety bond requirement. Bonds are required only for new or problem providers, so the requirement does not apply to most agencies that had been billing Medicaid. Most of the HHAs that left Medicaid would not have needed to obtain a bond.

Florida's governor maintains that the reduction in the number of Medicaid-participating HHAs has not affected patients' access to care. Closures, in fact, are not a good measure of access because it is possible for one agency to quickly absorb the staff and patients of a closing HHA. We did not identify any systematic evaluations of the effect of the closures, however.

HCFA Designed the Surety Bond Requirement to Recover Overpayments and Increase HHA Scrutiny

HCFA, concerned about increases in overpayments to HHAs, structured the bond as a financial guarantee that agencies' Medicare overpayments would be repaid, and it raised the required amount of the bond for larger agencies above the \$50,000 specified by the BBA.¹⁴ Larger HHAs participating in both Medicare and Medicaid were required to obtain two separate surety bonds: one bond for Medicare valued at 15 percent of Medicare revenues and one for Medicaid valued at 15 percent of those revenues.¹⁵ The specification of the bond requirements and the anticipated costs raised industry concern about their affordability and availability. Under HCFA's requirements, bonds, however, do increase the likelihood

¹³One HHA changed its corporate structure, which required a new provider number. Two were acquired by another firm. Three continued to provide Medicaid services as part of a large chain. One still provided services and claimed to have a Florida Medicaid provider number.

¹⁴HCFA also structured the surety bond to cover unpaid civil monetary penalties and assessments.

¹⁵HHAs with combined Medicare and Medicaid revenues of \$334,000 or less were required to have only one bond for both programs. This is because 15 percent of \$334,000 equals \$50,000, the minimum bond amount.

that they will be redeemed and, consequently, may increase the scrutiny of HHAs by surety companies and the proportion of agencies having to provide collateral. The requirements also provide an incentive for HHAs to repay any overpayments so they can continue to purchase bonds.

Unrecovered Overpayments Are Currently a Small Share of Medicare's HHA Payments

HCFA specified a financial guarantee bond in its regulation and raised the value of the bond above the legislated minimum for larger agencies because of its concern about the recovery of overpayments to HHAs. HCFA believes that this type of bond will reduce Medicare's risk of unrecovered overpayments. This risk, however, is currently small. Uncollected overpayments represented less than 1 percent of Medicare's 1996 spending for home health care services. Although overpayments are expected to rise in the near term, longer-term changes in Medicare policies will probably reduce their likelihood in the future. The higher bond amount for larger agencies may correspond to the level of payments they receive, but the data HCFA used to establish the higher bond requirement were unrelated to HHA size.

HHAs accounted for about one-fourth of all Medicare overpayments in 1996, and overpayments as a percentage of total HHA payments have been rising. In 1993, HHA overpayments were 4 percent of total program payments; by 1996, this had grown to 6 percent. HCFA estimates that about 60 percent of HHAs had overpayments in 1996. Most overpayments are recovered, however. HCFA data indicate that unrecovered overpayments in 1996 were less than 1 percent of Medicare's HHA payments, although even this lower percentage overstates the problem. HCFA counts as unrecovered overpayments some money that is not really overpayment.¹⁶ Further, some of the actual overpayments may be collected in the future.

HCFA and RHHI officials with whom we spoke expect to find that overpayments in 1998 were higher than in previous years because of the new limits on payments introduced by the BBA.¹⁷ They estimate that as many as 70 to 80 percent of HHAs may have overpayments for 1998. They also expect a larger proportion of overpayments to be uncollectible

¹⁶HCFA reported that \$116 million of uncollected overpayments in 1996, or more than half, were the result of 132 HHAs leaving the Medicare program and not filing a final cost report. HCFA categorizes all Medicare payments to an HHA that has not filed a cost report as overpayments, even though that HHA may have provided covered home health care services to beneficiaries. If the terminated agencies had gone through the year-end settlement process, at least a portion of the payments to some of them would likely have been appropriate.

¹⁷Medicare Home Health Benefit: Impact of Interim Payment System and Agency Closures on Access to Services (GAO/HEHS-98-238, Sept. 9, 1998).

because more HHAs will leave Medicare still owing overpayments. Overpayments are problematic when HHAs terminate because there is no readily available way to collect them. HCFA reported that from October 1997 through September 1998, 1,155 HHAs quit serving Medicare beneficiaries and terminated from the program. These HHAs represent a larger proportion of terminated Medicare-certified agencies than in previous years.

The recent spate of HHA closures and predicted increase in overpayments stem primarily from changes in Medicare's payment, participation, and coverage policies. Once these policies are fully implemented, RHHIS and agencies should be better able to estimate allowable costs, thus minimizing overpayments. HCFA also has a BBA mandate to implement a prospective payment system (PPS) for HHAs.¹⁸ Under PPS, HHAs will know the payment at the time of service because they will receive a fixed, predetermined amount per unit of service, further reducing the potential for overpayment. Once PPS is in place, overpayments should occur only when bills are submitted and paid for individuals who are not eligible for Medicare's benefits or for noncovered services.

HCFA's requirement that large agencies provide a bond equal to 15 percent of their Medicare revenues increases the cost of a bond considerably for some HHAs. HCFA officials argue that when large agencies fail to return overpayments, the potential loss to Medicare is greater than when smaller agencies do so. HCFA has not undertaken any analysis to determine the relationship between unrecovered overpayments and HHA size. In fact, larger agencies might be more likely to return them because they have more resources to manage the repayments and a greater incentive to remain in the Medicare program.

Fees Are the Primary Cost of Bonds for Large HHAs; Collateral Is the Largest Burden for Small HHAs

Some information on the cost of and access to surety bonds is available. Many HHAs shopped for and obtained bonds before the regulation was postponed to February 15, 1999, but many others did not. In addition, HCFA made a change to the required terms for the bonds on June 1, 1998, that affected surety companies' potential liability and their willingness to provide bonds to HHAs. The cost of obtaining a surety bond is the fee or premium charged plus any collateral that must be supplied.¹⁹ For large

¹⁸The PPS was originally supposed to be in place by fiscal year 2000, but the Congress delayed the effective date until fiscal year 2001 in the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999.

¹⁹Current law prohibits Medicare's reimbursement of HHA surety bond costs.

HHAs, the major cost of a surety bond is the fee, because they are required to have a bond equalling 15 percent of program revenues. They are less likely to have to provide collateral and the fee they pay may be a lower percentage of the bond's face value than the fee for smaller HHAs. Small HHAs are required to obtain the minimum \$50,000 bond but are more likely to have to put up collateral.

The range of fees for HHA bonds is comparable to other commercial surety bonds. The surety underwriting association reports that fees for HHA financial guarantee bonds generally range between 1 and 2 percent of their face value. Rates may be higher or lower depending on the HHA's financial situation. Some nonprofit and privately held for-profit HHAs that we interviewed had been quoted fees higher than those cited by the surety industry—up to 6 percent. Some of these quotes, however, were made before the changes in the regulation that reduced sureties' risk.²⁰

One surety that underwrote about 13 percent of the HHA surety bonds sold before the postponement of the requirement told us that its fees ranged from 0.5 to 3 percent of the face value of the bonds. It indicated that having a written business plan describing how the agency would respond to the new payment rates created by the BBA, audited financial statements, positive cash management history, and rigorous record keeping policies and practices reduced the HHAs' fees. This surety charged its lowest fees to nonprofit HHAs supported directly or indirectly by public or private foundations. Its highest fees were for providers new to the home health care business.

We found in looking at HCFA's 1996 data that between 6,000 and 7,000 HHAs would be required to obtain a bond of more than \$50,000 to participate in Medicare (see table 1). Assuming that sureties charge fees of 2 percent of a bond's face value, fees would begin at \$1,000, and about 2,400 HHAs would have to pay fees between \$3,000 and \$7,500 to obtain a bond. At that rate, fees could exceed \$60,000 for large agencies, although sureties might charge them a lower rate. Larger agencies choosing to participate in Medicaid would pay additional fees to obtain a second bond. HCFA

²⁰On June 1, 1998, HCFA published technical changes to the surety bond regulation. Previously, a surety issuing a bond covering a particular year was liable for any overpayments made to the HHA during that year, regardless of when those overpayments were discovered. With the change, HCFA limited a surety's liability to overpayments discovered in the year when the bond was in effect. However, for an HHA that terminates from the program, HCFA has a 2-year period in which to make a claim against the bond. HCFA also stated that the surety bond would be used as a last resort in recovering overpayments, gave sureties the right to appeal an overpayment finding if the HHA did not, and provided for reimbursing the surety for any money paid that was subsequently collected from the HHA.

specifically exempted smaller agencies from this requirement, but the majority of HHAs will have to obtain bonds for both programs.

Table 1: Distribution of HHAs by 1996 Medicare Payments, Surety Bond Values, and Estimated Premiums

Range of 1996 Medicare payments	Number of HHAs ^a	Surety bond face value	Estimated annual fee (at 2 percent)
Less than \$50,000	744	\$50,000	\$1,000
\$50,000 to \$100,000	452	\$50,000	\$1,000
\$100,001 to \$200,000	735	\$50,000	\$1,000
\$200,001 to \$334,000	767	\$50,000	\$1,000
\$334,001 to \$1,000,000	2,854	\$50,001 to \$150,000	\$1,000 to \$3,000
\$1,000,001 to \$2,499,999	2,406	\$150,000 to \$375,000	\$3,000 to \$7,500
\$2,500,000 to \$5,000,000	939	\$375,000 to \$750,000	\$7,500 to \$15,000
\$5,000,001 to \$10,000,000	415	\$750,000 to \$1,500,000	\$15,000 to \$30,000
\$10,000,001 to \$20,000,000	103	\$1,500,000 to \$3,000,000	\$30,000 to \$60,000
\$20,000,001 or more	29	\$3,000,000 +	\$60,000 +

^aAbout 1,400 government-operated HHAs that may not have been required to obtain a surety bond are included in these numbers.

^bSurety industry representatives indicated fees would generally range from 1 to 2 percent.

Source: GAO's analysis of HCFA data.

The surety bond fee is not the only cost of obtaining a bond. Having to provide collateral raises the cost to HHAs. Sureties report requiring collateral because HCFA's requirement that bonds be a financial guarantee increases the likelihood of claims. They want collateral from HHAs that pose greater risks of not being able to repay a surety if the bond is redeemed. Requirements for collateral vary among sureties, but generally they require collateral of privately held HHAs, particularly small and medium-sized agencies. The surety cited above required collateral of new HHAs unless they were financially strong and personal indemnity of the principals of all privately held firms.²¹

HCFA reported that about 40 percent of HHAs obtained Medicare surety bonds before the June 1998 delay in the implementation of the

²¹An initiative like the SBA program for construction contractors could offer some relief to certain small HHAs. The SBA program, however, reinsures bonds only for contractors that have been in business for at least 3 years.

requirement (see table 2).²² Provider-based HHAs (those that are part of a hospital or skilled nursing facility) of any size were more likely to secure a surety bond than other types of HHAs; freestanding HHAs not part of a chain were least likely. It is impossible, however, to determine the proportion of HHAs that could have secured bonds. Surety and home health care industry representatives told us that some providers postponed the purchase of surety bonds, waiting for actual implementation of the requirement. They also said that some owners did not provide the collateral and personal indemnity that would have made it possible for them to obtain a bond. The timing of the surety bond requirement may have affected HHA proprietors who were particularly reluctant to use their personal assets as collateral and to provide personal indemnity because of the uncertainty created by the substantial changes in Medicare's payment policy. It is not possible to determine whether they could have purchased bonds or ultimately will.

Table 2: Distribution of HHAs With Surety Bonds by June 1998

Type of HHA	Total HHAs	HHAs with surety bonds	
		Percentage	
Small HHAs			
Provider-based	502	305	60.8
Free-standing (chain)	265	107	40.4
Free-standing (nonchain)	2,199	575	26.1
Total	2,966	987	33.3
Medium HHAs			
Provider-based	638	445	69.7
Free-standing (chain)	323	137	42.4
Free-standing (nonchain)	1,699	390	23.0
Total	2,660	972	36.5
Large HHAs			
Provider-based	1,279	974	76.2
Free-standing (chain)	619	312	50.4
Free-standing (nonchain)	1,916	547	28.5
Total	3,814	1,833	48.1
All HHAs	9,440	3,792	40.2

Note: For this table, small HHAs have annual Medicare revenues of \$200,000 or less, medium HHAs have \$200,001 to \$1,000,000, and large HHAs have more than \$1,000,000.

Source: HCFA.

²²Although almost 4,000 bonds were submitted to HCFA, the number purchased may have been higher. A representative of the surety company that sold about 13 percent of the bonds told us that he believes that in some cases bonds were purchased but not forwarded to HCFA.

Financial Guarantee Bond Ensures Greater Scrutiny and Return of Overpayments Than Other Bond Types

A more narrowly defined antifraud bond, one triggered only by the failure to return overpayments received fraudulently, would probably be easier and less costly to obtain than a financial guarantee bond. Because the specified acts of fraud would not occur frequently, the risk of a claim against a bond would be low and sureties would provide bonds more readily. HHAS would be unlikely to have to pledge collateral if they could demonstrate good character and ties to the community, although personal indemnity from principals would possibly still be required of privately held HHAS.

HCFA's use of a financial guarantee bond for the return of overpayments regardless of their source will ensure more scrutiny and benefits to Medicare, however, than other types of bonds. In underwriting this type of bond, a surety will be likely to pay particular attention to financial statements, business practices, and overpayment history. This scrutiny will provide the Medicare program with several benefits. Proprietors who do not have relevant business experience will be deterred from incurring entering the program. Existing Medicare-certified HHAS will be examined as to business soundness. HHAS with overpayments that do not make an effort to repay them will be unlikely to obtain a subsequent surety bond and will be out of the Medicare business. And, generally, all providers will be deterred from incurring overpayments and will have incentive to repay any that are discovered.

Screening by a surety appears to be most useful for new agencies. The rapid increase in the number of HHAS entering the Medicare program with little scrutiny also makes requiring surety bonds a useful mechanism for screening HHAS already in the program. However, the value of this scrutiny would probably diminish with an HHA's continued participation in Medicare. Little may be gained from repetitive scrutiny of established, mature HHAS.

The option to substitute a Treasury note or other federal public debt obligation for a surety bond will allow well-financed firms to avoid scrutiny. Whether this option is problematic depends on the purpose of the surety bond. If its primary purpose is to guarantee payment, then this causes no concern. If, however, the primary purpose is to increase scrutiny, then the ability to substitute may undermine that objective.

Identifying the potential effect and cost of a compliance bond would be difficult because the terms of such a bond can vary widely. A bond like that required by Florida Medicaid, which requires compliance with all

program rules and regulations, could effectively create a monetary penalty for violating Medicare's conditions of participation. Now HHAs are required to comply but have the opportunity to address and correct deficiencies before losing their right to participate in the program. However, in underwriting a compliance bond, sureties might choose to avoid agencies that have been noted for violations in the past. Even if a bond were restricted to more serious deficiencies, sureties might be more reluctant to provide one. Sureties are less experienced in assessing compliance with Medicare rules and regulations than financial capacity, so it would be more difficult for them to predict which HHAs represent greater risk.

Representatives of the surety industry acknowledge that no surety bond can screen out all people who want to take unfair advantage of the Medicare program. Some individuals who want to delude the surety will still be able to obtain surety bonds. In addition, individuals who have no history of criminal action but who intend to defraud or abuse the program once in could obtain bonds. Further, the substitution of a Treasury note, U.S. bond, or other federal public debt obligation, as allowed by Treasury regulation, eliminates any review of an HHA's suitability or its history of performance.

Similar Surety Bond Requirements for DME Suppliers, CORFs, and Rehabilitation Agencies Will Benefit Medicare but May Affect Small-Provider Participation

HCFA intends to propose surety bond requirements for DME suppliers, CORFs, and rehabilitation agencies that will parallel those for HHAs—a financial guarantee bond with a face value equal to the greater of \$50,000 or 15 percent of Medicare payments.²³ As with HHAs, Medicare will benefit from sureties' review of these providers and the incentive created to return overpayments. There are numerous small DME providers, making it difficult for Medicare and other payers to monitor them. Historically, there has been general concern about DME suppliers' business and billing practices. ORT found that a substantial number of suppliers billed Medicare for DME either not furnished or not provided as billed. The scrutiny provided by sureties will offer a review of their business practices and financial qualifications. For CORFs and rehabilitation agencies, the likelihood of overpayments is higher than for HHAs. HCFA estimates that in 1996, uncollected overpayments equaled 10.7 percent of the \$122 million total Medicare spending for CORFs and 6.2 percent of the \$457 million for rehabilitation agencies—significantly greater than the less than 1 percent estimated for HHAs.

²³According to HCFA officials, physicians who supply DME incidentally to their providing professional services will be exempt from obtaining surety bonds.

These providers' access to and costs for surety bonds will also be comparable to those of HHAs. Larger firms or firms with more assets and other financial resources will probably have little difficulty obtaining a bond. Small firms and privately held ones with few resources will be more likely to have to provide collateral and personal indemnity to obtain one. Most of the smaller providers have limited revenues from Medicare; we estimate from HCFA data that between 74 and 97 percent would require a \$50,000 surety bond (see table 3). Firms that own buildings or equipment will probably not have to pledge additional collateral if they have sufficient equity.

Table 3: Distribution of Surety Bond Face Value Required

Surety bond required	DME suppliers		CORFs		Rehabilitation agencies	
	Number	Percent	Number	Percent	Number	Percent
\$50,000	66,106	97	247	74	1,890	86
15% of Medicare payments	2,205	3	89	26	317	14
Total	68,311	100	336	100	2,207	100

Source: GAO's analysis of HCFA data.

Since many DME suppliers receive very limited Medicare revenue, they may be more likely to cease participation in the program if they view the surety bond requirement as too costly. The average DME supplier receives about one-twentieth of the Medicare revenue that the average HHA does. The effect on beneficiaries' access may not be significant, however, given that DME suppliers currently number more than 68,000. While CORFs and rehabilitation agencies receive more Medicare revenue on average than DME suppliers, some may find the costs of obtaining a surety bond a barrier to Medicare participation. Access for beneficiaries may not be compromised significantly since other providers offer alternative sources of therapy.

Conclusions

The Congress mandated surety bonds for HHAs because of concern about the growth in the home health care benefit and the lack of adequate oversight. HCFA implemented the requirement to ensure that it could recover Medicare overpayments made to HHAs. In underwriting the bonds, sureties will evaluate HHAs entering or continuing in the program by examining financial stability and business practices, which may raise the standard for Medicare participation by sureties. This scrutiny can help

address the congressional concern. Specifying the terms of a bond as HCFA did will provide incentives for HHAs to return overpayments. Thus, the surety bond requirement can also achieve HCFA's objectives.

We believe that HCFA made a prudent choice in specifying the surety bond as a financial guarantee. A financial guarantee surety bond will raise the standard for HHAs entering the Medicare program and will help ensure that Medicare is protected against unrecovered overpayments. However, we believe that HCFA's decision to require that larger agencies obtain bonds equal to 15 percent of their Medicare revenues may be unnecessarily burdensome for several reasons. First, this standard imposes a greater burden on large HHAs without a demonstrated commensurately greater benefit. Second, the home health care industry's history of unrecovered overpayments does not warrant this requirement, even in the face of growing overpayments. Instead, we believe that a bond in the amount of \$50,000 balances the benefit to Medicare of increased scrutiny and recovery of overpayments with the burden on participating agencies.

Requiring a surety bond may effectively screen HHAs to determine whether they are reasonably organized entities, follow sound business practices, and have some financial stability. Such screening is most useful for new agencies. Given the considerable increase in recent years in the number of HHAs and the lack of scrutiny as these organizations entered the program, screening all existing HHAs is also useful. However, little may be gained from continued screening of established mature agencies. For such HHAs, the underwriting process is likely to be sensitive only to significant changes in financial stability.

We also believe that requiring HHAs to obtain separate surety bonds for Medicare and Medicaid may be excessive. Even though HCFA exempted small agencies from obtaining two bonds, the majority of HHAs are required to purchase two bonds. This entails two fees and, in many cases, pledging collateral for two bonds. However, the level of scrutiny by the surety will be similar regardless of whether one or two bonds are needed. Requiring one bond for the two programs diminishes the financial protection but not HHAs' incentives to repay overpayments. This is because an HHA that defaults on its bond to either Medicare or Medicaid is unlikely to obtain a bond in the future.

Allowing HHAs to substitute a Treasury note for the surety bond makes sense when the primary objective of the requirement is to increase HCFA's ability to recoup some unrecovered overpayments. However, this

substitution undermines the objectives of requiring Medicare providers to submit to outside scrutiny and giving them strong incentives to return all overpayments. If congressional intent is to screen HHAs, the option of substituting a Treasury note does not afford that scrutiny.

Recommendations to the Administrator of HCFA

We recommend that to implement BBA's surety bond requirement for HHAs, the HCFA Administrator revise the present regulation so that all HHAs obtain one financial guarantee surety bond in the amount of \$50,000 for the guaranteed return of overpayments for both Medicare and Medicaid.

Matters for Congressional Consideration

With respect to the surety bond requirements that we are recommending, the Congress may wish to consider

- exempting from a surety bond requirement HHAs that have demonstrated fiscal responsibility—for example, those that have maintained a bond for a specified period of time and have returned any overpayments—and
- eliminating the option for HHAs of substituting a Treasury note, U.S. bond, or other federal public debt obligation for a surety bond.

Agency and Industry Comments

In written comments on a draft of this report, HCFA agreed with our findings, conclusions, and recommendations. The agency also agreed that the Congress should consider eventually exempting from the surety bond requirement HHAs that have demonstrated fiscal responsibility and eliminating the option for HHAs to submit federal public debt obligations in lieu of a surety bond. HCFA provided technical comments that we incorporated into the final report.

We also obtained written comments from Florida Medicaid officials on the section of the report pertaining to the state's program integrity efforts. They concurred with our findings and conclusions, and their technical comment was incorporated into the final report.

Surety and home health care industry representatives reviewed a draft of this report. Their technical comments are included in the final report. The National Association of Surety Bond Producers and the Surety Association of America represented the surety industry. They expressed concern about the risk to the surety industry of writing \$50,000 financial guarantee bonds for HHAs and asserted that a fraud and abuse bond would be more appropriate because it would provide the desired level of scrutiny of HHAs and be available to more of them. They also thought that a \$50,000 bond

would be too high for some HHAS. They suggested basing the amount of bonds on a percentage of Medicare revenues with a dollar upper limit. The surety industry representatives also believed that limiting the time during which HHAS must have surety bonds after demonstrating fiscal responsibility is not appropriate for several reasons. First, they maintained that the screening process remains important over time because sureties monitor changes in management and business practices, as well as in financial status, that may indicate problems. Second, they believed that if the requirement is limited, the cost of issuing bonds will go up as the group of HHAS purchasing bonds gets smaller. They expressed general concern about the attractiveness of this line of business to the surety industry if our recommendations are adopted. We believe that a \$50,000 financial guarantee bond appropriately balances the costs to HHAS in obtaining a bond with protection for the Medicare program in the form of scrutiny and incentives to repay overpayments. We also believe that a financial guarantee bond will ensure more scrutiny and greater benefit to Medicare than other types of bonds. Further, after an HHA has demonstrated its commitment to repay or avoid overpayments, we believe that the value of the bond to the Medicare program diminishes substantially.

The home health industry representatives who reviewed the report were from the American Association of Services and Homes for the Aging, the American Federation of HHAS, the American Hospital Association, the Home Care Association of America, the Home Health Services and Staffing Association, the National Association of Home Care, and the Visiting Nurses Association of America. Most of these organizations supported limiting the requirement to one \$50,000 surety bond for both Medicare and Medicaid. They were concerned, however, that small HHAS might find the bond requirement burdensome and, given the payment changes implemented in 1998, might have to leave the Medicare program. The home health care industry representatives agreed that HHAS with “good track records” should be exempt from any surety bond requirement but thought that this exemption should be immediate. One representative thought that the Florida Medicaid program’s experience with surety bonds may be more relevant to Medicare’s experience than we do. It was also suggested that other mechanisms within the Medicare program could accomplish the screening function of a surety bond and that these options should be explored. The home health care industry representatives asserted that compliance bonds and antifraud bonds are more appropriate for the home health care industry than a financial guarantee bond. As noted earlier, we believe that a flat bond amount of \$50,000 balances the

concern of the industry with needed additional protections for the Medicare program. We believe that it is appropriate to require all HHAS to obtain a bond initially because this would ensure a level of scrutiny across all HHAS and because developing criteria to determine who should be exempt would be challenging. While other options could be pursued to screen HHAS, we believe that a financial guarantee bond will ensure more scrutiny and greater benefit to Medicare than other types of bonds.

The surety industry and one home health care representative expressed concern about the timing of the surety bond requirement. Since the regulation was suspended, it is not clear when HHAS will have to obtain a surety bond or the amount of time it will need to cover. We agree that these details could affect future bond terms and the availability and cost of bonds.

As agreed with your offices, unless you release the report's contents earlier, we plan no further distribution for 30 days. We will then make copies available to other congressional committees and Members of the Congress with an interest in these matters, the Secretary of Health and Human Services, the Administrator of HCFA, and others upon request.

If you or your staff have any questions, please call me on (202) 512-6806 or William J. Scanlon, Director, Health Financing and Systems Issues, at (202) 512-7114. Major contributors to this report are Sally Kaplan and Shari Sitron.

A handwritten signature in black ink, appearing to read "Richard L. Hembra". The signature is fluid and cursive, with a large initial "R" and "H".

Richard L. Hembra
Assistant Comptroller General

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Abbreviations

BBA	Balanced Budget Act of 1997
CORF	comprehensive outpatient rehabilitation facility
DME	durable medical equipment
HCFA	Health Care Financing Administration
HHA	home health agency
ORT	Operation Restore Trust
PPS	prospective payment system
PSB	Preferred Surety Bond
RHHI	regional home health intermediary
SBA	Small Business Administration

Scope and Methodology

To examine the surety bond issue, we reviewed our earlier extensive work on home health care and studied the regulation implementing the surety bond requirement in the Balanced Budget Act of 1997 (BBA) and related revisions and program memoranda, Department of Health and Human Services Office of Inspector General reports, and congressional hearing testimony. We conducted interviews with Health Care Financing Administration (HCFA) staff to determine the history and decision making process that resulted in the surety bond regulation. We also interviewed staff from the Florida Medicaid program and from three regional home health intermediaries (RHHI) who have responsibility for claims processing and medical review and cost report review and audit for almost 80 percent of the Medicare home health agencies (HHA).

We interviewed officials with the Small Business Administration (SBA) and representatives of both the home health care and surety bond industries, including representatives of the trade associations for surety underwriters and surety producers, 4 sureties, 4 national home health care trade associations, 5 state home health care trade associations, and owners or operators of 44 HHAs from 13 states.

HCFA provided us with data on comprehensive outpatient rehabilitation facilities (CORF) and rehabilitation agencies. These data came from systems HCFA uses to manage the Medicare program. Florida Medicaid provided us with a list of HHAs that had been in the program for 18 months or longer and dropped out of the program in 1996, taken from data systems used to manage the program. We conducted our work from April 1998 to November 1998 in accordance with generally accepted government auditing standards.

SBA Surety Bond Guarantee Programs for Construction Firms

SBA can guarantee surety bonds for construction contracts worth up to \$1.25 million for small and emerging contractors who cannot obtain surety bonds through regular commercial channels. For surety bonds issued under two separate programs, SBA assumes a predetermined percentage of loss and reimburses the surety up to that amount if a contractor defaults. To be eligible for the SBA programs, a contractor must qualify as a small business (for example, have annual receipts for the previous 3 fiscal years of no more than \$5 million) and meet the surety's bonding qualification criteria. The information generally required by sureties includes an organization chart, current financial statements prepared by an accountant, financial statements for the previous 2 years, resumes of key people, a record of contract performance, the status of work in progress, and a business plan. The contractor pays the surety company's fee for the bond, which cannot exceed the level approved by the appropriate state regulatory body. Both the contractor and the surety pay SBA a fee for each bond: The contractor pays \$6 per \$1,000 of the contract amount and the surety pays 20 percent of the amount paid for the bond. These fees go into a fund used to pay claims on defaulted bonds.

In the Prior Approval program, SBA evaluates each bond application package to determine that the applicant is qualified and that the risk the agency will assume is reasonable before issuing a guarantee to the surety. SBA guarantees sureties 90 percent of losses on bonds up to \$100,000 and on bonds to socially and economically disadvantaged contractors and guarantees 80 percent of losses on all other bonds under this program. Generally, contractors bonded under the SBA Prior Approval program are less experienced than contractors bonded under the Preferred Surety Bond (PSB) program.

The PSB program is currently restricted to 14 sureties that are not permitted to participate in the Prior Approval program. The PSB program does not require SBA's individual approval of bond applications but guarantees that SBA will pay 70 percent of surety losses if the contractor defaults. This program is for more experienced contractors that demonstrate growth potential and that are expected to be able to obtain surety bonds without an SBA guarantee in about 3 years. The firms in this program are usually larger than those in the Prior Approval program.

A representative of SBA told us that HHAS would not be able to participate in its surety bond guarantee programs unless the definition of eligible entities were changed by law.

Related GAO Products

Medicare Home Health Benefit: Impact of Interim Payment System and Agency Closures on Access to Services ([GAO/HEHS-98-238](#), Sept. 9, 1998).

Medicare: Interim Payment System for Home Health Agencies ([GAO/T-HEHS-98-234](#), Aug. 6, 1998).

Medicare Home Health Benefit: Congressional and HCFA Actions Begin to Address Chronic Oversight Weaknesses ([GAO/T-HEHS-98-117](#), Mar. 19, 1998).

Medicare: Improper Activities by Med-Delta Home Health ([GAO/T-OSI-98-6](#), Mar. 19, 1998, and [GAO/OSI-98-5](#), Mar. 12, 1998).

Medicare Home Health: Success of Balanced Budget Act Cost Controls Depends on Effective and Timely Implementation ([GAO/T-HEHS-98-41](#), Oct. 29, 1997).

Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies ([GAO/HEHS-98-29](#), Dec. 16, 1997, and [GAO/T-HEHS-97-180](#), July 28, 1997).

Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings ([GAO/HEHS-97-108](#), June 13, 1997).

Medicare: Home Health Cost Growth and Administration's Proposal for Prospective Payment ([GAO/T-HEHS-97-92](#), Mar. 5, 1997).

Medicare Post Acute Care: Home Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment ([GAO/T-HEHS-97-90](#), Mar. 4, 1997).

Medicare: Home Health Utilization Expands While Program Controls Deteriorate ([GAO/HEHS-96-16](#), Mar. 27, 1996).

Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements ([GAO/HEHS-95-171](#), Aug. 8, 1995).

Medicare: Allegations Against ABC Home Health Care ([GAO/OSI-95-17](#), July 19, 1995).

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