United States General Accounting Office

GAO

Report to Congressional Requesters

August 1990

MEDICARE

Options to Provide Home Dialysis Aides

GAO/HRD-90-153

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-239594

August 31, 1990

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable Pete Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

You asked us to review the transition of Home Intensive Care, Inc.'s (HIC's) end stage renal disease (ESRD) patients to different sources of dialysis. You also asked that we determine the circumstances under which it might be appropriate to authorize Medicare payments for an aide under the ESRD program when patients dialyze at home. On May 9, 1990, Chairman Stark also asked us to review increased indirect costs, such as for transportation and day care, incurred by HIC patients after the firm ceased furnishing paid aides for home dialysis.

The Health Care Financing Administration (HCFA) found alternate dialysis sources for all 1,553 former HIC home dialysis patients that received paid aides, although as of August 23, 1990, 16 patients had not been placed with a permanent alternate source.

Because Medicare does not authorize payment for aides to assist patients in dialyzing at home, amending the program to cover this benefit would, under most circumstances, increase Medicare costs. If a home dialysis aide benefit is authorized, the eligibility criteria should be designed to minimize the extent to which Medicare dollars are substituted for care currently received from or paid by other sources. For example, many home dialysis patients receive care from family members. The option with the least likelihood of increasing Medicare costs that we identified is restricting eligibility for paid dialysis aides to those beneficiaries who would otherwise qualify for Medicare payment for ambulance transportation to a dialysis facility.

While some former HIC patients probably incur new indirect costs related to obtaining dialysis, these costs are no different than those incurred by patients with other diseases, and those patients are not reimbursed. In addition, the former HIC patients are now responsible for about half as much coinsurance per treatment as they were when using HIC.

Background

Medicare covers dialysis services for patients suffering from an irreversible kidney impairment that requires regular dialysis treatments or a kidney transplant to maintain life. There are two general modes of dialysis treatment, hemodialysis and peritoneal dialysis, both of which can be performed at home. In hemodialysis, blood is taken from the patient's body and passed through a dialysis machine, which filters out body waste before returning the blood to the patient.

In peritoneal dialysis, the blood is filtered within the patient's abdominal cavity without leaving the patient's body. Hemodialysis is the most common mode of dialysis treatment and patients usually require three 4- to 6-hour treatments a week. Home hemodialysis patients need assistance, usually furnished by a relative or friend, to perform dialysis.

If a patient dialyzes in a facility, the facility receives a fixed payment for each treatment provided. As of July 1990, the nationwide average rate for independent dialysis facilities was $125 per treatment.[1] Medicare pays the facility 80 percent of the fixed rate, and the patient is responsible for the remaining 20 percent.

Medicare patients who choose to receive their dialysis treatments at home may obtain their supplies and equipment from dialysis facilities or suppliers. If the patient obtains supplies and equipment from a dialysis facility, called Method I, the facility receives the same payment for each home dialysis treatment as it does for an in-facility treatment and the patient is subject to the same coinsurance. The payment covers all necessary dialysis supplies, equipment, and related support services. If the patient obtains supplies and equipment directly from a supplier, called Method II, the Medicare claims processing agent determines the payment amount based on the program's reasonable charge criteria.[2] Medicare pays 80 percent of the reasonable charge, and the patient is responsible for the remaining 20 percent.

In October 1989, we reported that Medicare payments under Method II were much higher than Method I payments.[3] To reduce this disparity the

[1]Payment rates vary by geographic area because rates are adjusted to reflect differences in labor costs among areas.

[2]The reasonable charge for a service or item is the lowest of (1) the actual charge, (2) the customary charge by a particular supplier, or (3) the prevailing charge. The prevailing charge is defined as the 75th percentile of customary charges for similar services in the local area.

[3]Medicare: Payments for Home Dialysis Much Higher Under Reasonable Charge Method (GAO/HRD-90-37, Oct. 24, 1989).

Omnibus Budget Reconciliation Act (OBRA) of 1989 limited the amount payable under Method II to the amount payable under Method I. The payment limit, effective February 1, 1990, for hemodialysis is $1,600 per month.

Before the establishment of this payment limit for Method II, HIC was one of the nation's largest suppliers of home dialysis equipment and supplies. HIC furnished a paid aide to assist many of its home patients during dialysis. Although Medicare did not authorize additional payment for aides for home patients, HIC recovered the costs of these aides through the payment it received under Method II, which was about twice as high as the Method I rate. Shortly after OBRA 1989 was enacted, limiting payments for Method II, HIC informed its patients that after February 1, 1990, it would no longer provide a home aide to assist with dialysis treatment. As a result, alternative dialysis services had to be found for many of HIC's home dialysis patients.

Medicare is administered by HCFA within the Department of Health and Human Services (HHS). HCFA develops program policy and contracts with and monitors the performance of insurance companies that process and pay claims for services.

Objectives, Scope, and Methodology

As requested, our objectives were to:

- determine whether all HIC patients who had been provided with home aides had been transferred to alternate sources of dialysis services,
- identify circumstances where it might be appropriate to adjust Medicare payments to provide for home dialysis aides, and
- examine indirect costs of patients who formerly were furnished paid aides by Method II suppliers.

To address the first objective, we reviewed HHS, HCFA, and HIC documentation, including individual patient information and placement data. We also discussed the transition of HIC patients with officials in HCFA's Bureau of Policy Development, which was responsible for the placement of the patients; HCFA regional offices; and HHS's Office of General Counsel.

To evaluate the circumstances where it might be appropriate to adjust Medicare payments for home dialysis aides, we reviewed GAO reports and other studies related to issues surrounding the criteria used to determine eligibility for coverage of assistance to patients in meeting

health needs. These include reports on ESRD, home health care under Medicare, and skilled nursing facility care under Medicare and Medicaid. We also discussed the issues with HHS and HCFA officials, as well as representatives of the National Renal Administrators Association, Renal Physicians Association, Institute of Medicine, and Urban Institute. We based our analysis on our knowledge of Medicare in general and the ESRD program in particular.

We also reviewed Medicare law and regulations as they relate to indirect costs, such as personal transportation, incurred by patients when they obtain covered services. Because of the limited time available, we did not attempt to assess the extent of such costs that former HIC patients now incur.

As requested by your offices, we did not obtain written comments from HHS on this report; however, we did discuss the contents with HCFA officials and their comments have been incorporated where appropriate. Our work was conducted between January and July 1990 in accordance with generally accepted government auditing standards.

Status of HIC Patients

HIC ceased providing aides to its home patients in February 1990, when OBRA 1989 limited payments to suppliers of dialysis equipment and supplies to the amount that facilities receive for dialysis treatment. As a result, alternate dialysis sources had to be found for many of HIC's home dialysis patients.

HCFA notified all HIC patients of the change in the law and ensured that they understood that HIC would no longer provide an aide at patients' homes. HCFA worked with its regional offices, renal networks,[4] and HIC to locate dialysis sources for all 1,553 patients who had been provided aides, HCFA had contacted and placed all of these patients with an alternate dialysis source by February 15, 1990. As of that date, 1,154 patients received dialysis in a facility, and the remaining 399 patients received dialysis at home. However, as of that date, HCFA had been unable to find a permanent alternate dialysis source for 61 of these HIC patients. Under experimental authority authorized by section 1881 of the Social Security Act, HCFA paid for a paid aide to assist with home dialysis for 33 of these patients or transportation to a facility for the other 28.

[4]Renal networks are the 17 organizations established by law to assure effective and efficient administration of ESRD benefits and ensure protection for patients.

When the experimental funding was due to end on May 1, 1990, there were still 20 patients receiving special services. HHS has extended the experimental funding through December 1990. As of August 23, 1990, there were still 16 patients receiving special services.

Options Related to Coverage of Paid Aides for Home Dialysis

Because payments for aides for home dialysis patients is not authorized under Medicare, authorization of such a benefit would most likely increase Medicare costs. Also, having a paid aide for home dialysis can be an attractive alternative to facility dialysis for patients because it can be more convenient for the patient.[5] Therefore, we would expect that many patients would seek to qualify for the benefit if it is authorized. If paid aides are authorized, and Medicare cost increases are to be constrained, it will be necessary to establish criteria that limit the availability of paid aides to patients.

Many home hemodialysis patients currently receive care without a paid aide. Moreover, as discussed in our October 1989 report, at least one facility was able to provide paid aides to home patients while holding its costs below the amount received under Method I.

One criterion that could be applied if paid aides are authorized is that a family member is not available to furnish needed assistance. This would prevent the substitution of Medicare dollars for family support. When a family member is unavailable, criteria related to the patient's physical and health status could be used to determine eligibility for a paid aide. We identified several criteria that could be applied and, their advantages and disadvantages are discussed in the following sections. Data on the number of patients that would be eligible for paid aides under the options were not readily available.

HCFA paid about $70 per dialysis treatment for home aides of former HIC patients who received such assistance under Medicare's experimental authority. Assuming this payment rate, authorizing paid aides would cost Medicare about $8,750 per year for each patient that qualifies. Patients would be responsible for about $2,200 per year in coinsurance.

Homebound

HCFA could require that the beneficiary be homebound to qualify for a paid home dialysis aide. The apparent advantage is that HCFA has an

[5]The growth in HIC's patient population even though patient coinsurance responsibility was higher than if a facility has been used illustrates this.

established policy for homebound that is used as a qualifying condition for home health care.[6] However, we have identified serious problems in administering the homebound criteria for the home health care benefit.[7] Similar administrative problems would likely occur if the homebound definition were used for paid aides in the ESRD program. If so, Medicare could end up paying for aides for many patients who currently dialyze at a facility, and Medicare costs could increase significantly for those patients.

We have reported that the homebound criterion for home health care was difficult to administer because key terms were vague or undefined. Among the terms we identified as vague were those that state that to qualify as homebound an individual must normally be unable to leave the home without a considerable and taxing effort. Similarly, the criterion states that generally an individual can be considered homebound if he or she uses supportive devices or requires the assistance of another person to leave home. Individuals who currently get to a facility with the aid of supportive devices or with the assistance of another person could receive paid aide benefits if the homebound criterion was used. Moreover, because the homebound definition requires Medicare claims processing agents to make judgments based on these definitions, differences in coverage among geographic areas could result.

Bedridden

Another possible criterion for eligibility is that an individual be bedridden. Medicare does not have a definition for bedridden. If the term were to be defined as patients who are restricted to bed because of their physical condition and who cannot transfer themselves from a bed to a chair, it would probably be more restrictive than a homebound criterion and, thus, less costly to Medicare.

Under this option, patients who currently get to facilities with transportation assistance from relatives, friends, or voluntary programs could qualify for paid home dialysis aides. Also, a bedridden definition would probably be open to differing interpretations that could lead to problems

[6]A beneficiary is considered to be homebound if he or she has a condition (1) due to an illness or injury that restricts the ability to leave the residence except with the aid of supportive devices, such as crutches, canes, wheelchairs, and walkers, or the assistance of another person or (2) such that leaving the home is medically contraindicated.

[7]Medicare Home Health Services: A Difficult Program to Control (GAO/HRD-81-155, Sept. 25, 1981) and Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986).

similar to those for the homebound definition, including differences in coverage across areas.

Limitations in Activities of Daily Living

A patient's limitations in the activities of daily living (ADLs) could also be used for eligibility for paid aides. ADLs are used to measure people's needs for nursing home care and for provision of health and related services in the home. ADLs measure a patient's ability to perform six activities: bathing, dressing, getting around inside the house, getting in and out of bed, getting to the bathroom or using the toilet, and eating. Patients who have limitations in five or more ADLs are considered to be unable to function independently and severely disabled. Such dependence can be caused by chronic health problems, such as arthritis.

ADL definitions are commonly used and could be applied to ESRD patients. The number of ESRD patients who would qualify for paid aides would depend on the level and number of limitations selected as the criterion. The ADL limitations of ESRD patients in general are currently not available.

Again, inconsistent interpretation by carriers and physicians of ADL limitation definitions and thus of patients' eligibility could be a problem. Assessing ADL limitations would also be an additional administrative burden on providers and Medicare.

Serious Medical Condition That Would Be Exacerbated by Travel

Another option for eligibility for home dialysis aides would be to require that the patient have a serious medical condition that would be exacerbated by travel to a dialysis facility. This would require detailed criteria on the types of medical conditions that would be exacerbated by travel. Such criteria could be difficult to determine and administer. Defining a serious condition in terms of particular illnesses would probably not be sufficient. Illnesses have different levels of severity and affect people differently. Another potential problem relates to combinations of illnesses. Illnesses that individually would not be considered serious could qualify as a serious medical condition if a patient has several of them.

It would also be difficult to monitor the patient's medical condition to determine if the condition has changed. If a patient's condition improves, he or she may no longer qualify. Patients would have to be monitored for continued eligibility.

Dialysis Patients Eligible for Medicare Ambulance Service

Restricting eligibility for paid aides to individuals who qualify for ambulance transportation to a dialysis facility is least likely to increase Medicare costs. An advantage of using this option is that only the relatively few very ill patients who cannot travel without medical assistance would qualify.[8]

HCFA requires that ambulance service be medically necessary and reasonable and that the patient's condition be such that the use of any other means of transportation would endanger his or her health. HCFA's analysis of 1987 sample claims found that 2,000 (1.7 percent) of dialysis patients were considered high ambulance users.[9] Among states, high users ranged from 1.1 to 11.3 percent of dialysis patients.

Home dialysis aides could cost less per treatment than ambulance service to a facility. Using HCFA's estimate of $200 per round-trip ambulance service and its payment of $70 per visit for a home aide under the experimental authority, the home aide would be less costly.

Additional Indirect Costs Probably Incurred by Patients

On May 9, 1990, Chairman Stark wrote to us that some former HIC patients were concerned about new costs they incurred for such things as transportation and day care. He asked that we look into this matter.

Because of the limited time available, we did not attempt to assess how many Method II patients who had been furnished paid aides were incurring new costs or the extent of such costs. Some of these patients probably do incur costs related to obtaining dialysis that they did not incur with paid aides. For example, a former HIC patient who switched to a facility for dialysis could incur the costs of driving his or her car to the facility or perhaps the cost for a van service to the facility. However, this is no different than a non-ESRD patient driving or riding to a physician's office or outpatient rehabilitation facility for treatment. Medicare does not reimburse the patient in either case.

Moreover, former HIC patients are now responsible for substantially lower coinsurance costs because of the reduction in the amount allowed

[8]As of June 6, 1990, 4 of 18 patients still receiving additional assistance probably would qualify for the Medicare ambulance benefit. If home aides were available, however, some patients currently dialyzing at facilities would possibly choose home dialysis care for its greater convenience and seek eligibility under the ambulance service option.

[9]HCFA based this estimate on a 5-percent sample of the 1987 part B Medicare data. HCFA defined a high ambulance user as one who had annual ambulance charges of $10,000 or more. Ambulance costs for all reasons, including trips for dialysis treatment and in-patient care, were totaled.

by Medicare.[10] The reduction in their coinsurance would be on the order of $25 per dialysis treatment. This copayment reduction should help offset any new indirect costs incurred.

We are sending copies of this report to other interested congressional committees; the Director, Office of Management and Budget; the Secretary of HHS; and other interested parties. Please call me on (202) 275-5451 if you or your staffs have any questions about this report. Other major contributors are listed in appendix I.

Janet L. Shikles
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[10]Beneficiaries are responsible for a 20-percent coinsurance payment. They may be able to purchase a Medicare supplement policy, commonly called Medigap, to help them pay coinsurance amounts.

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