GAO

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

Health, Education, and
Human Services Division

B-283578

October 19, 1999

The Honorable Fortney (Pete) Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Subject: Medicare Home Health: Effect on Spending of Limiting Payment for Non-Patient-Care Costs

Dear Mr. Stark:

Medicare spending for home health care grew from $3.7 billion in 1990 to $17.3 billion in 1998. Concerned about rising spending, the Congress required the Secretary of Health and Human Services to implement an interim payment system (IPS) to control outlays until a prospective payment system (PPS) could be put in place on October 1, 2000. PPS rates will be set so that Medicare expenditures will be equivalent to what would have been spent under the IPS if the IPS limits that will be in effect on September 30, 2000, were reduced by 15 percent.

Concerned about the substantial portion of home health agency (HHA) costs that were not directly related to patient care, you asked us to model the impact of constraining these costs through various limits. In this context, we (1) examined the variation in total and non-patient-care costs across agencies and (2) estimated the effect on Medicare payments if constraints were imposed on payments for non-patient-care costs. To obtain this information, we used data on 4,910, or approximately 75 percent, of the free-standing HHAs with information in the Health Care Financing Administration's (HCFA) fiscal year 1996 Health Care Provider Cost Report Information System data file (see encl. I).[1] We performed our work between August and October 1999 in accordance with generally accepted government auditing standards.

SUMMARY

Per-visit costs varied widely both by visit type and across free-standing agencies. Home health aide visits were the least expensive, and medical social service visits were the most expensive. Across agencies, costs per visit for the most expensive agencies were 4 to 10 times those of the least expensive agencies, depending on the type of visit. Non-patient-care

[1]HHAs may be either free-standing or facility-based. Most of the facility-based agencies are hospital-based. According to fiscal year 1996 data, there were 2,628 facility-based agencies and 6,465 free-standing agencies.

costs constituted a substantial portion of the cost for each home health visit, averaging around 44 percent for each visit type. Moreover, the portion of visit costs that were not directly related to patient care was higher for more expensive visits.

In addition, for the sample of free-standing HHAs we analyzed, Medicare payments would have been approximately 4 to 13 percent less if payments for non-patient-care costs had been held to various limits based on the cost experience of a subset of HHAs. For example, if Medicare payments for non-patient-care costs had been limited to the median costs of free-standing HHAs (the 50th percentile), total payments would have been reduced by 3.9 percent. If payments for non-patient-care costs had been limited to the cost level of the least expensive 20 percent of HHAs (the 20th percentile), total spending would have been 12.6 percent lower. The current per-visit cost limits already indirectly constrain Medicare payments for non-patient-care costs, although not as much as a limit applied directly to non-patient-care costs would. It is not known how the savings estimates would have differed if all HHAs, including the generally higher-cost hospital-based ones, had been included in the analysis.

BACKGROUND

Home health care is an important Medicare benefit that enables beneficiaries with post-acute care needs (such as recovery from joint replacement) and chronic conditions (such as congestive heart failure) to receive care at home rather than in other settings. The scope of home health care has changed markedly since Medicare began to cover it. Expansion of eligibility has allowed more beneficiaries to qualify for services and permitted more services to be provided to users, transforming the benefit from one that originally covered short-term care to one that covers long-term care as well. The standards for what constitutes necessary or appropriate home health care are not well defined, and service provision is inconsistent across agencies. Even the most basic unit of service, the visit, is not clearly defined. Costs per user vary widely, reflecting differences in patient needs, treatment patterns, agency type, and geographic location.

Costs per user also reflect the number, mix, and cost of individual home health visits. Costs for each visit type are composed of direct patient care expenses (predominantly labor costs for caregivers) and non-patient-care expenses (such as capital, plant operations and maintenance, transportation, and administration). Hospital-based HHAs generally have higher total per-visit and non-patient-care costs than free-standing agencies do.

Prior to payment changes mandated in the Balanced Budget Act of 1997, agencies were paid on the basis of their costs up to preestablished per-visit limits equal to 112 percent of the national average cost per visit.[2] There was a separate limit for each type of visit (skilled nursing; physical, occupational, or speech therapy; medical social service; and home health aide), but the limits were applied in the aggregate to each agency's costs. That is, costs above the limit for one visit type would still be paid if costs were sufficiently below the limit

[2]The schedule of limits for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996, was based on per-visit limits calculated in 1993 (which were based on data from cost reporting periods ending on or after June 30, 1989, and before May 31, 1991, and were adjusted forward to 1993). The Omnibus Budget Reconciliation Act of 1993 mandated that there be no changes in the HHA limits for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996.

for other visit types so that, in total, agency costs were below the sum of their volume-adjusted per-visit limits.

The IPS was implemented on October 1, 1997. Under the IPS, agencies are paid their actual costs up to the lower of the per-visit limits applied in the aggregate or an agency-specific revenue cap that is based on a per-beneficiary amount and the number of beneficiaries served. The per-visit limits control the payments per visit, while the revenue cap constrains the visits provided to users. Under the PPS, the payment methodology will change again: payments will be established in advance of service delivery, and the payment for each user will vary to account for patient characteristics and other factors that affect the cost of home health care.

VARIATION IN NON-PATIENT-CARE COSTS

Average agency costs per visit varied considerably by the type of home health visit. Average visit costs varied even more for each type of visit across agencies. As a result of the wide range in visit costs across both visit types and agencies, the dollar amounts attributed to non-patient-care expenses were highly variable as well. Moreover, the share of per-visit costs attributable to non-patient-care expenses was larger for more expensive visits of all types.

In fiscal year 1996, the average free-standing agency per-visit costs ranged from $43 for a home health aide visit, the most frequent visit type, to $151 for a medical social service visit (see encl. II). Skilled nursing visits, the second most frequently supplied service, averaged $95. Non-patient-care costs accounted for a substantial proportion of these costs, averaging around 44 percent for each visit type. The dollar amount of the average agency's non-patient-care expenses varied from $19 for home health aide visits to $66 for medical social service visits.

For each of the visit types, the cost per visit varied substantially across agencies. For example, one-quarter of the HHAs had skilled nursing costs at or below $76, while the quarter of agencies with the most expensive skilled nursing visits had visit costs of $107 or higher (see table 1). Across the free-standing agencies in our sample, per-visit costs for the most expensive agencies were 4 to 10 times those of the least expensive agencies, depending on the visit type.

Table 1: Free-Standing HHA Costs per Visit, by Visit Type, Fiscal Year 1996

	Distribution of agency costs, by quartile[a]		
Visit type	25th percentile	50th percentile	75th percentile
Skilled nursing	$76	$91	$107
Physical therapy	86	105	131
Occupational therapy	84	105	134
Speech therapy	85	107	136
Medical social services	100	130	171
Home health aide	34	41	48

[a]The first quartile is the 25th percentile, the median is the 50th percentile, and the third quartile is the 75th percentile.

Source: GAO analysis of fiscal year 1996 HHA Medicare cost report data.

The share of the total costs attributed to non-patient-care expenses was higher for more costly visits. For example, non-patient-care costs for skilled nursing visits averaged 38 percent of total visit costs for the least expensive quarter of agencies, compared with 47 percent for the most expensive quarter. The range is even greater for home health aide visits, with the non-patient-care portion averaging 37 percent of total visit costs for the least expensive quarter of agencies and 49 percent for the most expensive quarter of agencies.

EFFECT ON MEDICARE PAYMENTS OF CAPPING NON-PATIENT-CARE COSTS

Caps on Medicare payments for non-patient-care costs, in addition to the existing per-visit limits, could have lowered Medicare payments to free-standing HHAs by nearly 4 percent to almost 13 percent, depending on the level of the caps. The per-visit limits, which are based on national average costs, indirectly restrict payment for non-patient-care costs, so non-patient-care payment caps would need to be set below the cost of the median HHA to substantially affect Medicare expenditures. Although non-patient-care costs are constrained, the application of the current per-visit cost limits still allows considerable variation in non-patient-care costs across agencies.

Aggregate Medicare spending for free-standing HHAs in fiscal year 1996 could have been 3.9 percent lower if non-patient-care costs had been limited to the median costs of free-standing HHAs, or the 50th percentile amount. At this cap, non-patient-care payments would have been no higher than $40 for a skilled nursing visit and $18 for a home health aide visit (see table 2).

Table 2: Free-Standing HHA Estimated Non-Patient-Care Costs per Visit, by Visit Type, Fiscal Year 1996

	Distribution of non-patient-care costs, by decile[a]			
Visit type	20th percentile	30th percentile	40th percentile	50th percentile
Skilled nursing	$27	$32	$36	$40
Physical therapy	27	34	40	46
Occupational therapy	26	33	39	45
Speech therapy	27	33	39	45
Medical social services	34	42	49	57
Home health aide	11	14	16	18

[a]Deciles are percentiles at the 10th, 20th . . . 90th percentiles.

Source: GAO analysis of fiscal year 1996 HHA Medicare cost report data.

Aggregate savings could have reached 12.6 percent if the non-patient-care payment limits had been equal to the 20th percentile costs of free-standing HHAs (see table 3). At this cap, non-

patient-care payments would have been limited to $27 for a skilled nursing visit and $11 for a home health aide visit, as shown in table 2.

Table 3: Estimated Reductions in Medicare Spending for Free-Standing HHAs With Various Limits on Non-Patient-Care Expenses, by Percentile, Fiscal Year 1996

	Payment limit, set at percentile of non-patient-care costs			
	20th percentile	30th percentile	40th percentile	50th percentile
Percent reduction in Medicare spending	12.6	8.8	5.9	3.9

Source: GAO analysis of fiscal year 1996 HHA Medicare cost report data.

In 1996, the per-visit limits for each visit type except home health aide were near or below the median agency per-visit costs (see table 4). As a result, payments for non-patient-care costs were already being constrained. This is why the savings associated with a non-patient-care payment cap at the 50th percentile are not higher.

Table 4: Per-Visit Payment Limit and Proportion of Free-Standing HHAs With Costs at or Below the Payment Limit, by Visit Type, Fiscal Year 1996

Visit type	Per-visit payment limit	Percentage of HHAs with costs at or below the payment limit
Skilled nursing	$91	49
Physical therapy	92	33
Occupational therapy	92	34
Speech therapy	93	35
Medical social services	130	50
Home health aide	46	68

Source: GAO analysis of fiscal year 1996 HHA Medicare cost report data.

Per-visit limits on HHA payments do not constrain payments for non-patient-care costs, or limit the variation in these payments, as much as a cap directly applied to payment for such costs would. Under the per-visit limits, agencies could receive higher payments for non-patient-care costs if low direct patient care costs resulted in total visit costs that were below the per-visit limit. Furthermore, the per-visit limits are applied in the aggregate, so agencies with costs higher than the limits for one type of visit may still be paid their total costs if their costs for another visit type are sufficiently below the limit.

AGENCY COMMENTS

HCFA had an opportunity to comment on a draft of this letter. HCFA officials affirmed the need to implement a PPS that will ensure accurate payments that are based on patient needs and that will no longer vary from agency to agency on the basis of non-patient-care costs.

We are sending copies of this report to the Honorable Nancy-Ann Min DeParle, HCFA Administrator, and other interested parties, and we will make copies available to others on request. If you or your staff have any questions regarding this letter, please contact me at (202) 512-7119 or Carol Carter, Assistant Director, at (312) 220-7711. Other contributors to this analysis were Jean Chung, Christine DeMars, and Daniel Lee.

Sincerely yours,

Laura A. Dummit
Associate Director, Health Financing
and Public Health Issues

Enclosures - 2

ENCLOSURE I

SCOPE AND METHODOLOGY

We used fiscal year 1996 Medicare cost report data from the Health Care Financing Administration's (HCFA) Health Care Provider Cost Report Information System (HCRIS) data file to determine the variation in home health per-visit costs, identify actual home health agency (HHA) payments, and estimate payments that could result from limiting non-patient-care costs. We used fiscal year 1996 data because they were the most complete data available at the time of our analysis. To control for regional wage differences, we adjusted costs for wage differences across geographic areas according to the methodology prescribed in the regulations.[1] We excluded the 2,628 facility-based agencies from our sample because their non-patient-care costs are not separately reported in HCRIS.[2] We excluded 1,555 other providers that fell into the following categories:

- agencies with low or no Medicare utilization or no administrative costs;
- agencies we defined as outliers, or those with wage-adjusted average cost per visit greater than $800 or less than $10;
- agencies for which the individual cost component amounts did not add up to the reported total cost per visit amount; and
- agencies with cost report periods lasting less than 10 months or more than 13 months, since these agencies may have distorted costs.

After all exclusions, the total number of agencies remaining for our analysis was 4,910. Because some agencies do not provide all types of visits, however, the number of agencies included in each step of the analysis varied depending on the type of visit being analyzed.

The Medicare cost report presents costs for each visit type in five categories: direct costs associated with providing a visit, capital-related costs, plant operations and maintenance costs, transportation costs, and administrative and general costs. The non-patient-care costs were defined as the last four cost categories.

---

[1]58 Fed. Reg. 36,751 (July 8, 1993).

[2]Although our sample excluded facility-based HHAs, it is important to note that there are instances in which the Medicare program has discounted facility-based costs in developing reimbursement rates (for example, for skilled nursing facility payments) and has calculated separate rates for free-standing and hospital-based facilities (for example, for dialysis services).

ENCLOSURE I

Almost all (97 percent) of the non-patient-care costs in aggregate are in the administrative and general cost category.

ENCLOSURE II

TOTAL AND NON-PATIENT-CARE COSTS PER VISIT, BY VISIT TYPE AND PERCENTILE GROUPINGS

				Percentile of total costs							
	Number of agencies	Per-limit cost limit	Mean	0-5	6-10	11-25	26-50	51-75	76-90	91-95	96-100
Skilled nursing											
Average cost/visit	4,910	$91	$95	$50	$61	$71	$85	$99	$114	$133	$195
Average non-patient-care cost/visit			$42	$18	$22	$28	$38	$45	$53	$61	$93
Average % nonpatient care			44%	35%	36%	40%	45%	46%	46%	46%	48%
Physical therapy											
Average cost/visit	4,001	$92	$115	$54	$67	$79	$96	$117	$145	$180	$264
Average non-patient-care cost/visit			$49	$16	$19	$28	$39	$54	$72	$96	$150
Average % nonpatient care			43%	30%	29%	35%	41%	46%	50%	53%	57%
Occupational therapy											
Average cost/visit	3,875	$92	$116	$43	$63	$76	$94	$118	$150	$192	$291
Average non-patient-care cost/visit			$50	$16	$21	$26	$38	$54	$75	$98	$146
Average % nonpatient care			43%	37%	33%	35%	40%	46%	50%	51%	50%
Speech pathology											
Average cost/visit	3,637	$93	$120	$42	$63	$77	$96	$120	$154	$198	$323
Average non-patient-care cost/visit			$51	$16	$21	$28	$38	$54	$75	$99	$171
Average % nonpatient care			43%	37%	33%	36%	40%	45%	49%	50%	52%
Medical social services											
Average cost/visit	4,033	$130	$151	$46	$70	$89	$114	$147	$201	$280	$446
Average non-patient-care cost/visit			$66	$17	$24	$35	$50	$68	$97	$134	$222
Average % nonpatient care			44%	37%	34%	39%	44%	46%	48%	48%	50%
Home health aide											
Average cost/visit	4,897	$46	$43	$23	$28	$32	$38	$45	$52	$61	$93
Average non-patient-care cost/visit			$19	$8	$10	$13	$16	$21	$25	$30	$46
Average % nonpatient care			44%	34%	36%	39%	42%	46%	48%	50%	50%
Average % nonpatient care for all visit types			44%								

"These per-visit limits, set by HCFA, are for urban HHAs, which constitute approximately 75 percent of the agencies we analyzed. The per-visit cost limits for rural agencies are higher than the urban limits.

Source: GAO analysis of fiscal year 1996 HHA Medicare cost report data for free-standing agencies.

(101853)

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted, also. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000
or by using fax number (202) 512-6061, or TDD (202) 512-2537.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web Home Page at:

http://www.gao.gov

United States
General Accounting Office
Washington, D.C. 20548-0001

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested