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Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives

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MEDICARE HOME HEALTH CARE

Prospective Payment System Could Reverse Recent Declines in Spending

GAO/HEHS-00-176

Contents

Abbreviations

BBA	Balanced Budget Act of 1997
FFS	fee-for-service
HCFA	Health Care Financing Administration
HHA	home health agency
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
IPS	interim payment system
MedPAC	Medicare Payment Advisory Commission
MSA	metropolitan statistical area
PPS	prospective payment system
SAF	Standard Analytical File

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United States General Accounting Office
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Health, Education, and
Human Services Division

B-286001

September 8, 2000

The Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

Until 1997, home health care was one of Medicare's fastest growing benefits, with expenditures rising at an average annual rate of 30 percent between 1988 and 1997. Both the number of beneficiaries and the amount of services they received increased, changing what had been a short-term, posthospitalization benefit to one that encompassed long-term care and vastly different service patterns across beneficiaries, agencies, and geographic areas. In addition to concerns about Medicare expenditures, this wide variation in use raised issues about the appropriateness of services being provided and the lack of standards for care. To control home health spending, in 1997 the Congress mandated that the Health Care Financing Administration (HCFA), the agency responsible for administering the Medicare program, implement several payment and other policy changes to the home health benefit.[1] These changes were to culminate in the implementation of a prospective payment system (PPS) for home health services in October 1999.

Delayed until October 2000, the PPS will incorporate payment rates based on 1998 home health spending and utilization data—the latest available information—adjusted downward to reflect projected utilization in 2001.[2] However, home health spending and use have changed substantially in recent years. Medicare home health spending dropped from a peak in 1997 of $18.3 billion to $9.5 billion in 1999. Concerned about the decline in service use and its implications for Medicare payment policy, you asked us to (1) examine the declines in service use underlying the changes in spending; (2) determine the extent of the changes in use across

[1]The Balanced Budget Act of 1997 (BBA) (P.L. 105-33, title IV, chapter I, 111 Stat. 251, 466) mandated these changes.

[2]The Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 (P.L. 105-277) delayed the PPS implementation by 1 year to October 1, 2000.

beneficiaries, home health agencies (HHA), and locations; and (3) identify any implications these new patterns of home health use have for the impact of the PPS. To do this work, we analyzed HCFA home health claims and provider data from 1994, 1996, and 1999. We did our work in accordance with generally accepted government auditing standards between April and July 2000. (For a detailed discussion of our scope and methodology, see app. I.)

Results in Brief

The 48-percent reduction in Medicare home health care spending following the BBA was due to sharp declines in both the numbers of users and services used. The number of Medicare beneficiaries receiving home health services fell by 22 percent, from more than 100 users per 1,000 fee-for-service (FFS) beneficiaries in 1996 to 80 users per 1,000 beneficiaries in 1999.[3] During the same period, the average number of home health visits received by each user went down 44 percent, to 41 visits in 1999. The decline was not uniform across service types. Unskilled home health aide visits (including help with personal care and simple dressing changes) dropped more than skilled service visits (which include skilled nursing, therapies, and medical social services). While changes in payment policies undoubtedly played a big role in curtailing service use, other factors may have also contributed to the decline, such as increased efforts to combat Medicare fraud and abuse.

Changes in home health use varied across agencies and types of users as well. In nearly all instances, declines were greatest for the types of agencies that had provided and the patients who had used the most services in 1996. For example, the number of patients receiving more than 150 visits fell 67 percent between 1996 and 1999, compared with a 22-percent drop across all users. Similarly, proprietary agencies, which provided the highest number of visits per user in 1996, reduced their service provision by 47 percent between 1996 and 1999, compared with a 37-percent reduction for not-for-profit and government agencies. There was a similar pattern in the drop in usage across states. States that had the highest levels of service use in 1996 had larger declines than states where beneficiaries historically received fewer services. While the more than threefold difference in utilization continued between the highest- and lowest-use states in 1999,

[3]Medicare payment policies discussed in this report do not apply to HHAs providing services to beneficiaries enrolled in managed care plans. These beneficiaries and their service use have not been included in this report's analyses.

there were fewer states at the extremes. Declines in rural areas were larger than in urban areas. Although variation in use across states and agencies narrowed over this time, states with high use in 1996 continued to have rates nearly double the average visits per user of the rest of the country in 1999, and high-visit agencies still provided half again as many visits as the national average.

The recent changes in home health utilization occurred at least in part in response to changes in Medicare's payment policies mandated by the BBA. Because the new PPS payment rates are based on the historically high utilization in 1998, even after adjusting for projected declines in utilization, they likely will be generous compared with current use patterns. For this reason, home health agency responses to the PPS could result in overpayments relative to services provided while simultaneously raising Medicare spending. Under the PPS, Medicare will make a single payment for each 60-day episode of home health care. Some agencies may respond to the high payments by increasing services provided to beneficiaries. Others may maintain their reduced service levels, resulting in overpayments relative to the services delivered within the episode. At the same time, the PPS will give agencies an incentive to increase the episodes of care they provide. This, in turn, could cause total Medicare home health spending to rise.

In an earlier report, we outlined actions that HCFA should take to protect beneficiaries, HHAs, and the Medicare program from possible negative effects of the PPS.[4] We recommended, and HCFA agreed, that the PPS will need to be evaluated and refined periodically and that utilization monitoring and medical review of claims will be critical to ensuring that HHAs do not stint on care or provide unnecessary services. We also recommended that the PPS should be modified to incorporate a risk-sharing arrangement, which would limit aggregate HHA Medicare gains or losses, but HCFA believed that such modification was not necessary. However, we believe that the substantial changes in home health utilization that have occurred since the BBA lend additional support for a risk-sharing approach. Therefore, in this report we suggest that the Congress consider instructing HCFA to adopt risk sharing under the home health care PPS. HCFA agreed that risk sharing is one option to address concerns raised

[4]*Medicare Home Health Care: Prospective Payment System Will Need Refinement as Data Become Available* (GAO-HEHS-00-9, Apr. 7, 2000).

about the PPS but said it prefers other methods. We continue to support implementing a risk-sharing arrangement along with the PPS.

Background

Medicare's home health care benefit enables certain beneficiaries with post-acute-care needs (such as recovery from joint replacement) and chronic conditions (such as congestive heart failure) to receive care in their homes rather than in other settings. To qualify for home health care, a beneficiary must be confined to his or her residence ("homebound");[5] require intermittent skilled nursing, physical therapy, or speech therapy; be under the care of a physician; and have the services furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions are met, Medicare will pay for part-time or intermittent[6] skilled nursing; physical, occupational, and speech therapy; medical social services; and home health aide visits.[7] The benefit allows for an unlimited number of visits, provided the coverage criteria are met. Beneficiaries are not liable for any coinsurance or deductible.

Changes in the Benefit Have Led to Growth in Home Health Utilization

Between 1990 and 1997, Medicare home health payments grew annually at a rate of more than three times that of spending growth for the entire Medicare program. This increase was due primarily to a steady rise in the proportion of beneficiaries receiving home health care and in the number of visits per person served. The number of home health users per 1,000 beneficiaries increased from 57 to 109, and the average number of visits per user doubled from 36 to 73 during this period. An increase in payments per visit accounted for only a small share of the overall growth.

[5]A beneficiary is considered homebound when he or she has a condition that results in a normal inability to leave home except with considerable and taxing effort, and absences from home are infrequent or of relatively short duration or are attributable to receiving medical treatment (section 204.1, HCFA's *Home Health Agency Manual*, June 12, 2000).

[6]"Part-time or intermittent" means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished fewer than 8 hours each day and for 28 or fewer hours each week. Subject to review on a case-by-case basis, a beneficiary may receive up to 35 hours of home care per week, or up to and including 8 hours per day (full-time), 7 days per week, for temporary periods up to 21 days or longer in exceptional circumstances (section 206.7, *Home Health Agency Manual*).

[7]Home health aide services include (1) personal care services, such as assistance with eating, bathing, and toileting; (2) simple surgical dressing changes; (3) assistance with certain medications; (4) activities to support skilled therapy services; and (5) routine care of prosthetic and orthotic devices (section 206.2, *Home Health Agency Manual*).

Originally, Medicare imposed annual limits on the number of home health care visits covered for each beneficiary. The limitation on visits was removed by the Omnibus Reconciliation Act of 1980,[8] but utilization did not increase appreciably because of HCFA's stringent interpretation of the coverage and eligibility criteria. A court case challenged HCFA's interpretation, and the decision resulted in broadened coverage guidelines for home health care, allowing more beneficiaries to qualify for more visits.[9] The benefit then was transformed from one focused on patients needing short-term care after a hospitalization to one that also serves patients with chronic conditions needing longer-term care.

At the same time that much of this growth occurred, program controls were essentially nonexistent. Few claims were subject to medical review, and virtually all were paid. In 1986 and 1987, over 60 percent of home health claims were reviewed, but by 1995, claims reviewed had declined to about 1 percent. As a result, utilization after 1987 is increasingly likely to reflect a degree of inappropriate service use. Our prior investigations found a pattern of payments for "questionable or improper" services.[10] More recently, the Department of Health and Human Services (HHS) Inspector General also documented that some of the care provided lacked supporting documentation required to determine medical necessity.[11]

[8]P.L. 96-499, sec. 930, 94 Stat. 2599, 2631.

[9]*Duggan v. Bowen*, 691 F. Supp. 1487 (D.D.C. 1988).

[10]*Medicare: Home Health Utilization Expands While Program Controls Deteriorate* (GAO/HEHS-96-16, Mar. 27, 1996). More recent work has continued to find billing abuses and improper claims: *Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings* (GAO-HEHS-97-108, June 13, 1997) and *Medicare: Improper Activities by Mid-Delta Home Health*, (GAO/OSI-98-6, Mar. 12, 1998).

[11]HHS Office of Inspector General, *Review of Medicare Home Health Services in California, Illinois, New York and Texas*, A-04-99-01194 (Washington, D.C.: HHS, Nov. 1999).

Growth Encompassed a Wide Range in Service Use

Historically, most home health users received few visits, and a small proportion of longer-term users received the majority of Medicare-funded visits. According to the Medicare Payment Advisory Commission (MedPAC), 51 percent of home health care recipients received fewer than 30 visits and accounted for 9 percent of all home health visits in 1996. By contrast, 15 percent of users had 150 visits or more, accounting for 59 percent of all Medicare home health visits that year. Approximately one-third of the beneficiaries in this latter group received over 300 visits.[12] In addition, short-term patients appeared to use a different mix of visits than did longer-term patients. MedPAC reported that in 1996 only 6 percent of all visits provided to short-term users—those who received nine or fewer visits—were for aide services; skilled nursing care comprised over 75 percent of their total visits. By contrast, about 56 percent of the visits for beneficiaries who had 100 visits or more were for home health aide services.

There also was marked variation in home health use across geographic areas. For example, Medicare home health users in Maryland received an average of 37 visits in 1997, with an average payment per user of $3,088. In that same year, users in Louisiana received an average of 161 visits each, with an average Medicare payment per user of $9,278. This wide variation in use persisted even after controlling for patient diagnosis. Patterns of care also differed across agency ownership and type.[13] For-profit HHAs tended to deliver more visits per beneficiary than other types of HHAs and to provide more aide visits. For example, in 1993, for-profit HHAs provided an average of 69 home health aide visits per beneficiary, compared with 43 and 48 visits from voluntary and government HHAs, respectively.[14] Such variation could be due to a variety of factors, including provider responses to financial incentives, differences in patient needs, regional practice patterns, and states' varying Medicaid coverage and eligibility policies.

Assessing whether the variation in service provision has been appropriate is difficult. Because no agreed-upon standards exist for what constitutes necessary or appropriate home health care, it is not clear when home

[12]MedPAC, *Report to the Congress: Context for a Changing Medicare Program* (Washington, D.C.: MedPAC, June 1998).

[13]Agencies may be not-for-profit, for-profit (or proprietary), or government-owned.

[14]GAO/HEHS-96-16, Mar. 27, 1996.

health care is warranted, how many services should be provided, or when services should be discontinued. Many home health users have chronic and multiple needs, so the care for a particular condition may overlap with care for another. Furthermore, even the most basic unit of service—the visit—is not specifically defined.

Home Health Anti-Fraud Measures Implemented

Beginning in 1995, several regulatory policies were initiated to reduce fraud and abuse within the home health industry, which could have affected home health use and spending. Operation Restore Trust, launched in 1995, employed a number of approaches to uncovering fraud, including the use of interdisciplinary teams to review individual HHAs that billed Medicare for unusually large numbers of services. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) also contained measures to control fraud and abuse by HHAs. For example, it stipulated that any physician who falsely certifies a patient as eligible for home health services is liable for a civil monetary penalty. HIPAA also provided more funding for claims review and other safeguard activities by Medicare's claims processing contractors. However, the proportion of claims reviewed did not increase substantially. In January 1998, HCFA announced plans to increase the number of claims reviewed to about 1.3 percent, far short of the peak levels in the mid-1980s. As part of the changes included in the BBA, coverage was eliminated for persons whose only skilled service need was venipuncture (the drawing of blood).

The BBA Changed the Medicare Payment Method to Control Spending

Before the BBA, HHAs were paid on the basis of their costs, up to preestablished per-visit limits. In 1996, these limits ranged from $46 for home health aide visits to $91 for skilled nursing visits, to a high of $130 for medical social services.[15] While payments varied by the type of visit, there was no definition of what actually constituted a home health visit, such as the time spent with the patient or the services provided. There were no incentives to control the volume of services delivered, and as a result, HHAs could enhance their revenues by providing more beneficiaries with more visits.

The BBA mandated substantial changes to Medicare's method of paying for home health services. Beginning October 1, 1997, HHAs were paid under an

[15]The per-visit limits are for urban, freestanding HHAs. The per-visit cost limits for rural agencies are higher than the urban limits.

interim payment system (IPS), which incorporated tighter per-visit cost limits than previously in place and subjected each agency to an annual Medicare revenue cap, which is the product of a per-beneficiary amount and the number of patients it served. The per-beneficiary amount is a blend of each agency's historical average payments for treating a Medicare beneficiary and a regional or national average amount.[16] To ensure that Medicare payments under the IPS cover its costs, an HHA needs to keep the average cost of its visits below the per-visit limits and keep its average cost per Medicare beneficiary below its per-beneficiary amount. For agencies with previously higher per-visit costs or that provided more visits per user, adjustments to the IPS may involve delivering visits more efficiently, changing the mix or reducing the number of visits provided to each user, increasing the proportion of lower-cost patients it treats, or some combination of these strategies.

[16]The IPS per-beneficiary payment limits were based on data for cost reporting periods ending in fiscal year 1994, reflecting 1993 costs and utilization, and are updated annually by the home health market basket index.

Beginning in October 2000, HHAs will be paid under the PPS. An agency will receive a single payment for each 60-day episode of care for a Medicare beneficiary, regardless of the services actually delivered during the period.[17] There is no limit on the number of episodes a beneficiary may receive. A base payment will be adjusted to reflect patient characteristics that have been shown to affect service use. Payments for patients expected to use the most services in an episode will be over 5 times the payment for patients expected to use the fewest services. Each episode payment also will be adjusted for differences in labor costs across geographic areas. HCFA will make outlier payments for certain extremely high cost episodes. The BBA required HCFA to set payment levels so that Medicare home health expenditures would be equivalent to what would have been spent under the IPS, with those limits reduced by 15 percent. This 15-percent reduction has been delayed until October 1, 2001, and the Secretary of Health and Human Services must report to the Congress within 6 months of implementation of the PPS on the need for the 15-percent or other reduction.[18]

In previous work on the home health PPS, we noted several concerns about HCFA's proposed, and now final, design.[19] Given the wide variation in service use, the 60-day unit of payment may not be suitable for all patients. Furthermore, the adjustments to the episode payment may not adequately account for differences in patient needs and, because the adjustments rely heavily on what services are provided to patients, they may be open to manipulation by agencies. Because of uncertainties about the effects of the PPS on beneficiaries, agencies, and the program, we recommended that a

[17]Payments would be adjusted if the episode of care is interrupted, such as when a beneficiary elects to transfer to another HHA, when a beneficiary is discharged because treatment goals are attained but then returns to the same HHA, or when the beneficiary experiences a significant change in condition. Episodes with extremely low service use (four or fewer visits) will receive a low-utilization payment adjustment based on per-visit costs.

[18]The Medicare, Medicaid and SCHIP Refinement Act of 1999 (P.L. 106-113, app. F, title I) delayed the 15-percent reduction in the payments required under the PPS until 12 months after implementation of the PPS. As a result, the rates for fiscal year 2001 will be set so that spending would be the same as spending under the IPS. The 15-percent reduction would be applied in fiscal year 2002.

[19]GAO-HEHS-00-9, Apr. 7, 2000.

risk-sharing arrangement, which limits the losses and gains a provider can experience over a period of time, be added to the PPS.[20] HCFA did not agree with this recommendation, indicating that risk sharing was not needed, given the adjustments included in the PPS, and that risk sharing would make the PPS difficult to implement. While we are sympathetic to HCFA's concerns and do not believe that the PPS should be delayed in order to implement risk sharing, we nevertheless remain convinced that the magnitude of potential excessive payments to some HHAs and large losses for others warrants this added complexity. We also recommended, and HCFA concurred, that the PPS be modified as appropriate as experience is gained under the PPS. To address concerns about the appropriateness of potential service reductions within episodes and whether each episode of care a beneficiary receives is medically necessary, we recommended that adequate resources be devoted to utilization monitoring and medical review. In agreeing with this recommendation, HCFA outlined the various activities it has planned to ensure that the data agencies submit are accurate, that its payments to agencies are appropriate, and that timely utilization data is readily available for possible PPS refinements.

Declines in Users and Visits May Reflect Overreaction to IPS

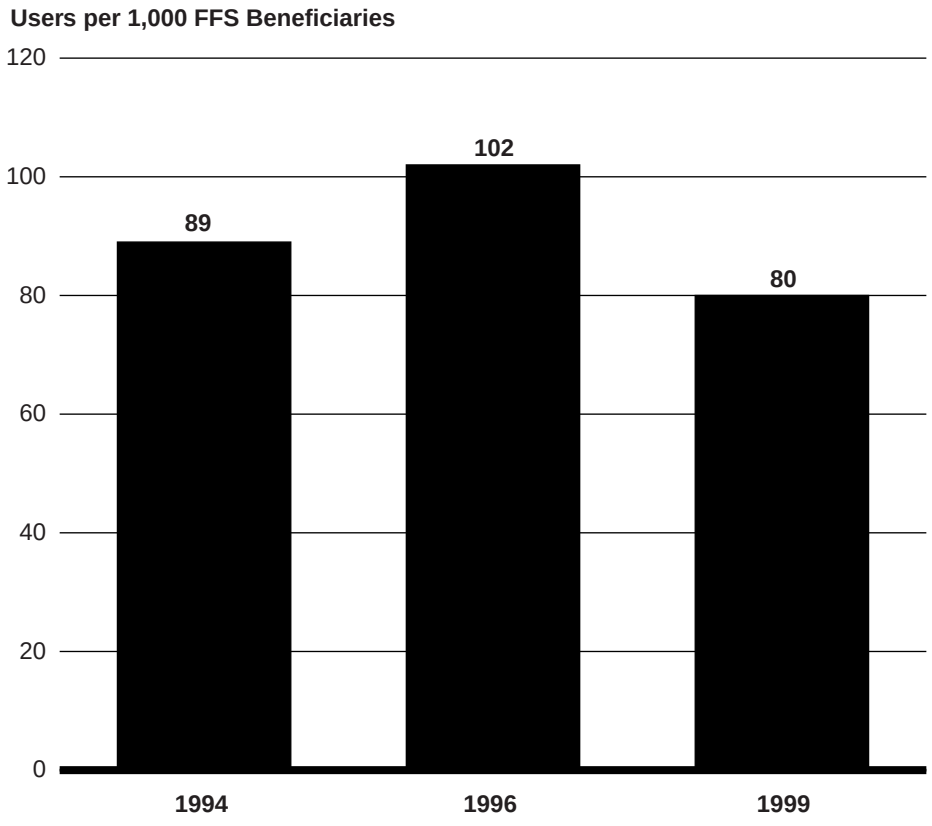
Since peaking in 1997, Medicare home health expenditures have declined rapidly so that by 1999 spending was about the same as it was in 1993. The drop in spending reflected a decrease in home health service use, both in the number of beneficiaries using home health care and the number of visits provided to each user. The patterns of decline have resulted in a benefit that involves a larger proportion of skilled services (skilled nursing and therapies) and considerably fewer home health aide services. The fall in visits per user is consistent with the objectives of the IPS but exceeds the reduction necessary for some agencies to stay within the limits of the IPS. The reduction in the number of home health users may be due in part to initiatives to combat fraud and abuse and to some agencies' overreaction to the IPS, which may have led them to avoid certain types of high-cost patients.

[20]For a more complete discussion of risk sharing, see our previous report, GAO-HEHS-00-9, Apr. 7, 2000.

Fewer Home Health Users Received Fewer and a Different Mix of Services in 1999

After having been a major driver in home health spending growth from the early 1980s through 1997, the number of FFS beneficiaries receiving home health visits has decreased. The percentage of FFS beneficiaries getting home health care fell 22 percent between 1996 and 1999. In 1996, more than 100 of every 1,000 FFS beneficiaries received home health care, compared with 80 in 1999 (see fig. 1). This decline, which followed a 15-percent increase in home health users between 1994 and 1996, brought the number of users in 1999 to below 1994 levels.

Figure 1: Home Health Users per 1,000 FFS Beneficiaries, 1994, 1996, and 1999



Source: GAO analysis of HCFA home health claims data.

The number of visits per home health user also dropped substantially over this period. In 1999, the average home health user received 41 visits, compared with 73 visits in 1996 (see table 1). The average number of visits

per user decreased for all visit types, although the amount of the decline varied significantly. The most notable drop was in home health aide use. In 1999, home health aide users received, on average, about half the number of home health aide visits that they received in 1996, 37 compared with 73 visits. Users of skilled nursing services in 1999 received almost one-third fewer skilled nursing visits than they did in 1996. Reductions in therapy visits were more modest than home health aide or overall average declines.

Table 1: Average Number of Home Health Visits per User by Visit Type, 1994, 1996, and 1999

	Average visits per visit-type user[a]			Percentage change	
	1994	1996	1999	1994-96	1996-99
All visits	65	73	41	12%	-44%
Skilled nursing	29	32	22	10%	-31%
Home health aide	64	73	37	14%	-49%
Physical therapy	13	14	11	8%	-21%
Speech therapy	12	11	8	-8%	-27%
Occupational therapy	8	8	7	0	-13%
Medical social services	3	3	2	0	-33%

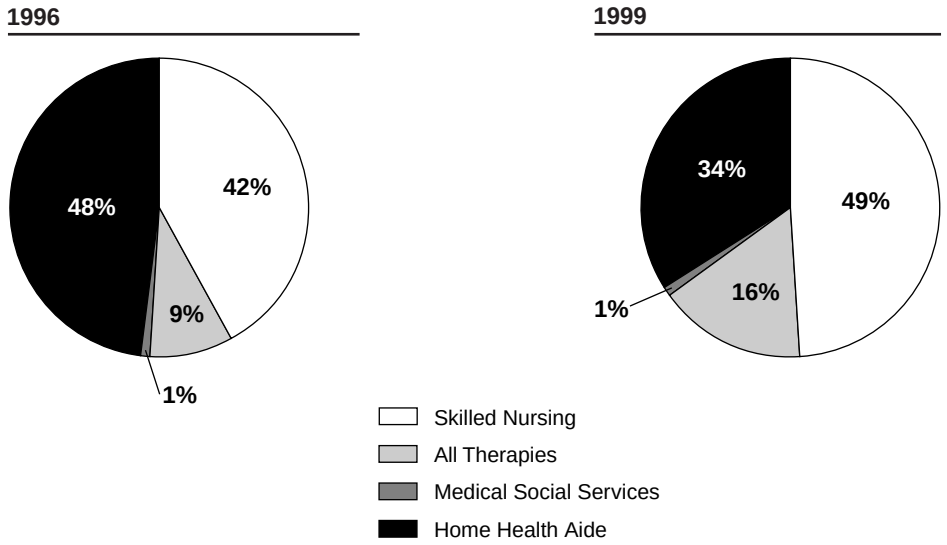
[a]Numbers in these columns reflect the number of visits of a particular type received by beneficiaries who used any of that visit type. Thus, the averages by visit type do not sum to the average of all visits.

Source: GAO analysis of HCFA's home health claims data for 1994, 1996, and 1999.

Because of the disproportionate reduction in aide visits and overall drop in use, post-acute-care services are becoming a more important component of the Medicare home health benefit. Compared with previous years, the average user in 1999 is more likely to receive therapy services, and less likely to receive home health aide services. Nearly one-half of all home health users received physical therapy visits in 1999, up more than 20 percent over 1996. By contrast, 38 percent of users received home health aide services in 1999, which is 22 percent below 1996 levels. Furthermore, aide visits in 1999 comprised a smaller share of all visits (34 percent), which is similar to the share of aide visits in 1987 (see fig. 2). Skilled nursing visits have become a larger share of all visits, comprising nearly half of total visits in 1999, and therapy services have increased their proportion of total visits as well. Combined, skilled services made up two-thirds of all visits in 1999, compared with half of all visits in prior years.

These shifts are consistent with care that reflects more short-term, post-acute use rather than care for longer-term chronic conditions.

Figure 2: Proportion of Home Health Visits by Visit Type, 1996 and 1999



Source: GAO analysis of HCFA's home health claims data for 1996 and 1999.

Decline in Utilization Reflects Payment Policy as Well as Other Changes

The reduction in the visits per user is consistent with agency incentives under the IPS to keep average per-user costs below the per-beneficiary amount, yet it appears that some HHAs may have overreacted to the IPS. Some agencies reduced the number of visits provided to beneficiaries. In addition, some agencies modified their admitting practices to lower the number of beneficiaries likely to need longer-term and more costly services. Our previous work found that HHAs said they had increased their efforts to identify the anticipated service needs of prospective patients; were more reluctant to accept longer-term, expensive patients; and stepped up their monitoring of patients' needs for timely discharge.[21] These results are consistent with a MedPAC-sponsored survey in which some HHAs reported that because of the IPS, they were no longer taking Medicare

[21] *Medicare Home Health Agencies: Closures Continue, With Little Evidence Beneficiary Access Is Impaired* (GAO/HEHS-99-120, May 26, 1999).

patients they previously would have admitted.[22] The types of patients HHAs were most likely to report they no longer admitted or discharged sooner included longer-term, chronic, and diabetic patients, all of whom are generally associated with longer-term utilization and heavy use of aide services.

Some agencies responded to the IPS by reducing per-beneficiary costs more than would have been necessary to remain under the per-beneficiary amounts. The per-beneficiary amounts, which were based on 1994 cost data and updated annually, essentially used service levels in that year as the standard. However, home health service use in 1999 dipped below 1994 levels. The average home health user received 41 visits in 1999, compared with 65 visits in 1994. Moreover, the IPS had no limitations on the number of beneficiaries that an agency could serve and be paid by Medicare. Yet, the proportion of FFS beneficiaries receiving home health services in 1999 was 10 percent lower than in 1994. Other policy initiatives, such as Operation Restore Trust, which increased scrutiny of claims, and stronger physician certification requirements, may have prompted HHAs to be more vigilant in their admissions and discharge processes. In our previous work on agency closures, we found that the caseload of agencies that had stopped serving Medicare beneficiaries included patients who were ineligible for Medicare home health care.[23] In a study of four states, HHS' Office of Inspector General found that improper or highly questionable home health services dropped from 40 percent of the total in 1995 to 19 percent of services in 1998.[24] In the MedPAC survey, 77 percent of agencies reported an increased reluctance on the part of physicians to refer Medicare patients for services. HHAs told us that a drop in physician referrals and the elimination of venipuncture as a qualifying service for home health care reduced agency caseloads.

[22]Abt Associates, *Survey of Home Health Agencies* (Cambridge, Mass.: Sept. 1999).

[23]Since the IPS went into effect, almost 3,000 HHAs have stopped participating in the Medicare program.

[24]Improper services included services not documented, services to beneficiaries not homebound, services without a valid physician order, and services not reasonable or necessary. HHS Office of Inspector General, *Review of Medicare Home Health Services in California, Illinois, New York and Texas*, A-04-99-01194 (Washington, D.C.: HHS, Nov. 1999).

Beneficiaries, Providers, and Areas With Highest Service Use Experienced Largest Declines

The historically wide variation in home health service use across beneficiaries, types of providers, and geographic areas has narrowed substantially because of disproportionate declines in utilization among the highest users in these categories. The number of longer-term beneficiaries receiving 150 or more home health visits per year dropped by two-thirds, compared with a 22-percent reduction in all users. High-visit HHAs accounted for a disproportionate share of the overall utilization decline after 1996, as well as a greater share of the increase before 1996. Among HHAs that historically delivered the most services, the average number of visits per user decreased more than for all agencies. And the states with the highest utilization experienced greater declines after 1996 compared with the rest of the country, although wide variation in use persists. While rural areas experienced greater reductions compared to urban areas in the proportion of beneficiaries using services, rural users continue to receive more visits.

Larger Declines Among High-Use Patients Shift Benefit Toward Short-Term Use

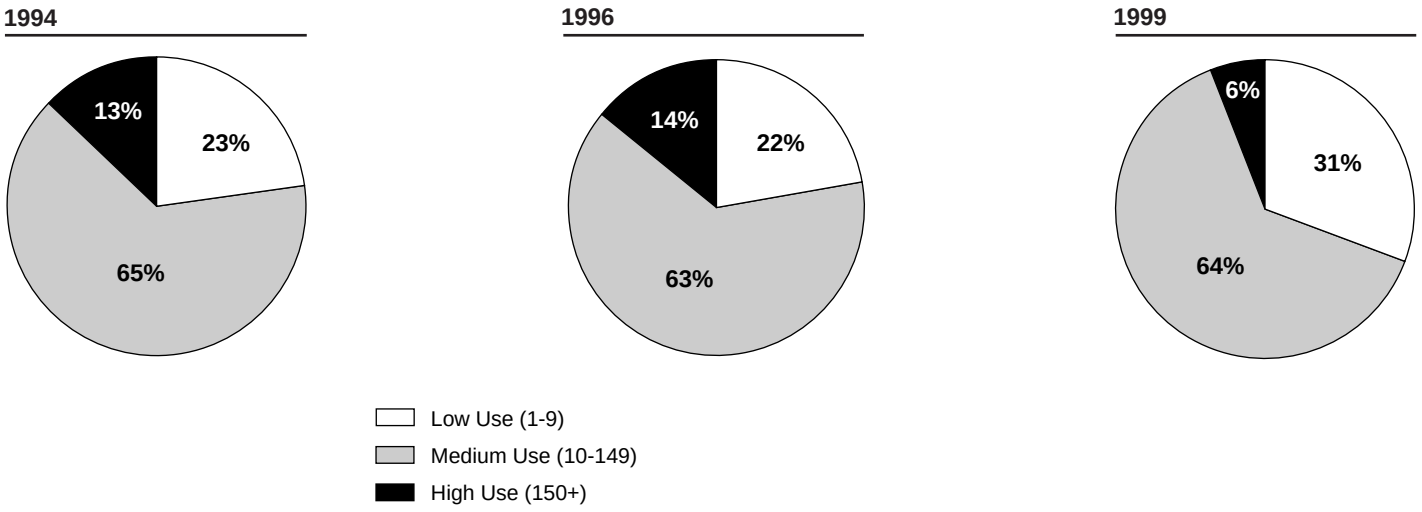
Long-term home health users, those receiving 150 or more home health visits per year, declined dramatically between 1996 and 1999, both in absolute numbers and as a proportion of all home health users. After substantial increases, the number of high-use beneficiaries per 1,000 FFS enrollees dropped 67 percent from 1996 to 1999, three times the decline among all users (see table 2). As a result, high-use beneficiaries as a proportion of total users fell by half over this period (see fig. 3). Conversely, the number of beneficiaries receiving fewer than 10 visits increased, and their share of all home health users rose from 22 to 31 percent.

Table 2: Medicare Home Health Users, by Utilization Level, 1994, 1996, and 1999

Utilization level (visits/year)	Home health users per 1,000 FFS enrollees			Percentage change	
	1994	1996	1999	1994-96	1996-99
Low (1-9)	20	23	24	15%	4%
Medium (10-149)	58	65	51	12%	-22%
High (150+)	11	15	5	36%	-67%
Total	**89**	**102**	**80**	**15%**	**-22%**

Source: GAO analysis of HCFA home health claims data.

Figure 3: Proportion of Home Health Beneficiaries, by Utilization Level, 1994, 1996, and 1999



Source: GAO analysis of HCFA home health claims data.

High-Visit HHAs Experienced Steeper Declines in Utilization

The difference in utilization across HHAs has declined since 1996, but substantial variation continues. High-visit HHAs, the 20 percent of HHAs with the highest average number of visits per user in 1996, experienced greater early increases, followed by larger declines than other agencies. In 1996, these HHAs provided an average of 151 visits per user, a 30-percent increase over 1994 levels, but this fell by over half to 67 visits in 1999 (see table 3). By contrast, historically low-visit HHAs continued to reduce service provision between 1996 and 1999 by 15 percent. Given their steeper rate of decline, high-visit HHAs accounted for a disproportionate share of the total drop in visits, even after controlling for the mix of HHAs participating in the Medicare program.[25] Among HHAs serving Medicare beneficiaries in 1994, 1996, and 1999, over one-third of the recent reduction in visits was attributable to high-visit HHAs.

[25]Between 1996 and 1999, there was considerable fluctuation in the number of HHAs serving Medicare beneficiaries. Almost 1,400 HHAs began serving beneficiaries and almost 1,900 stopped, for a net reduction of over 500 HHAs. In addition, previous GAO analysis found that the number of HHAs under for-profit ownership, as opposed to not-for-profit or government ownership, changed from 1996 to 1999 (see GAO/HEHS-99-120, May 26, 1999). To control for the changing mix of agencies, for this analysis we examined only HHAs that were open in 1994, 1996, and 1999.

Table 3: Average Visits per User, by Level of Agency Service Provision, 1994, 1996, and 1999

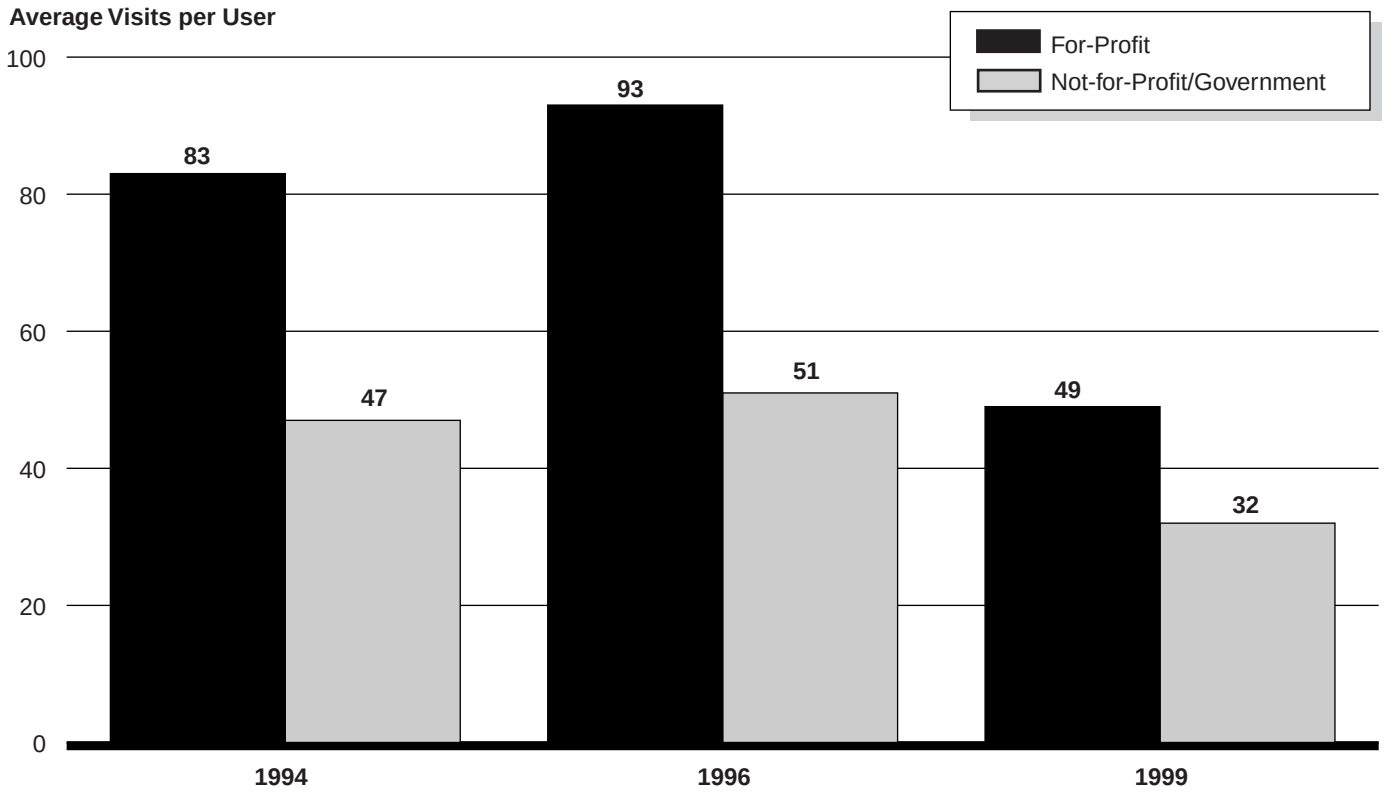
HHA utilization level in 1996	Average visits per patient			Percentage change	
	1994	1996	1999	1994-96	1996-99
Low	28	27	23	-4%	-15%
Medium	54	60	35	11%	-42%
High	116	151	67	30%	-56%

Note: Only HHAs open all 3 years (1994, 1996, and 1999) were included in this analysis. The 20 percent of HHAs with the highest visits per user in 1996 were categorized in the high group, with the lowest 20 percent defined as low, and the middle 60 percent defined as medium.

Source: GAO analysis of HCFA home health claims data.

We found similar patterns of changes in utilization across agency ownership categories (see fig. 4). Between 1994 and 1996, for-profit HHAs increased their service provision more than other agencies, and then reduced visits by almost half between 1996 and 1999.

Figure 4: Average Visits per User, by HHA Ownership, 1994, 1996, and 1999



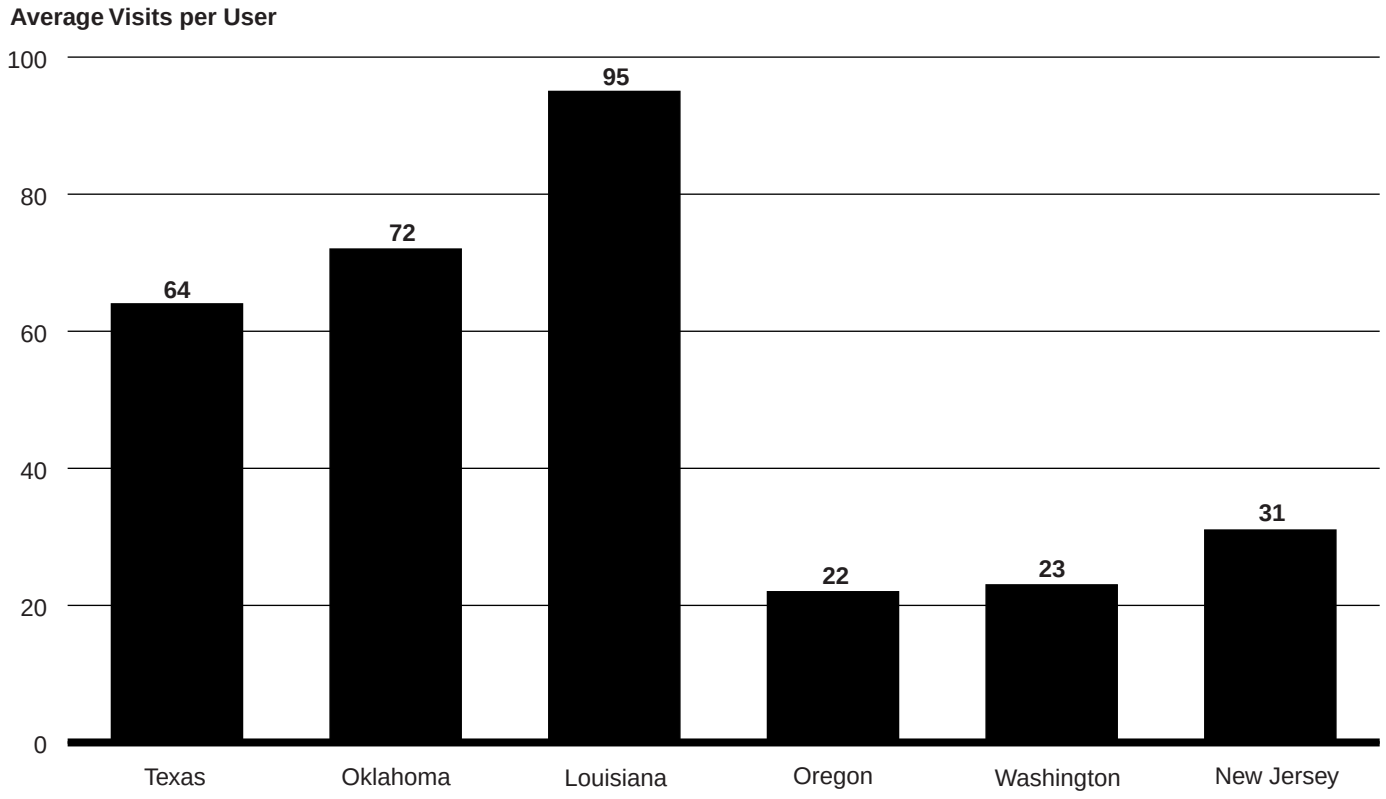
Source: GAO analysis of HCFA home health claims data.

Despite Larger Declines in High-Use States, Wide Variation Among States Persists

The wide range of utilization among HHAs is likewise seen across states, as are the substantial changes in use over time. The difference in visits per user between the highest- and lowest-utilization states has increased since 1994 (see app. II). In 1999, there was over a fourfold difference in average visits per user between the lowest-utilization state (Oregon) and the highest (Louisiana) (see fig. 5), and over a threefold difference among states in the number of home health users per 1,000 FFS Medicare beneficiaries (see app. III). Although the range in utilization remains large across states, there were fewer states with extremely high use levels in 1999 than there were in 1996. From 1994 to 1996, utilization in the eight states with the highest usage rates in 1996 grew at double the rate of other states.[26] By 1999, visits per user in these states had fallen by 47 percent from 1996 levels, compared with a 39-percent decrease for the rest of the country. These same eight states also had a greater reduction in the number of users per 1,000 FFS Medicare beneficiaries (33 percent, compared with a 19-percent reduction for the rest of the United States).

[26]The eight states are Louisiana, Oklahoma, Texas, Mississippi, Alabama, Tennessee, Utah, and Georgia.

Figure 5: Average Visits per User, Highest- and Lowest-Utilization States, 1999



Source: GAO analysis of HCFA home health claims data.

Fewer Rural Home Health Users, but Visits per Patient Remained Higher Than for Urban Users

In 1999, 75 out of 1,000 Medicare beneficiaries in rural areas received home health services, compared with 82 beneficiaries per 1,000 who lived in urban areas.[27] The number of home health users in rural areas declined more than in urban areas between 1996 and 1999, although the number of visits rural users received remained higher (see table 4). Rural beneficiaries on average received 15 percent more visits than their urban counterparts, primarily because of more home health aide visits.

[27]Urban and rural counts reflect beneficiary residence. Urban areas are defined as those within a metropolitan statistical area (MSA), and rural areas are those outside an MSA.

Table 4: Home Health Service Utilization Changes in Rural and Urban Areas, 1994, 1996, and 1999

Beneficiary residence	Users per 1,000 Medicare FFS enrollees			Average visits per user		
	1994	1996	1999	1994	1996	1999
Urban	88	101	82	62	70	40
Rural	92	105	75	74	83	46

Source: GAO analysis of HCFA home health claims data.

HHA Response to PPS May Cause Some Providers to be Overpaid and Increase Program Spending

In the past, home health service provision has fluctuated in response to changes in Medicare's payment and coverage policies. The PPS incorporates new incentives, and agencies are likely to respond by modifying how they care for Medicare beneficiaries in both the services provided within an episode of care and the number of episodes provided to each patient. HHA behavior could result in substantial overpayments relative to the level of services actually delivered and huge increases in Medicare home health spending. Adequate controls are necessary to mitigate these risks.

Previous Spending Patterns Suggest HHAs Are Likely to Respond to PPS Incentives

HHAs appear to have responded to previous Medicare payment incentives by changing their patterns of service delivery (see table 5).[28] In 1985, legislation more than doubled HCFA's funding for home health claims review after which Medicare outlays grew only 1 percent annually through 1988. Restrictions on coverage were relaxed as a result of the *Duggan v. Bowen* lawsuit decision in 1989, followed by spending growth at an annual rate of 30 percent. Utilization peaked in 1997 when BBA changes were implemented. Under the IPS, agencies have faced strong financial incentives to control the average number of visits and the average cost of care delivered to their patients. Once again, Medicare policies appear to have affected the delivery of services, as spending decreased 32 percent between 1998 and 1999.

[28]Because per-visit payments under prior law were relatively constant over time, growth in payment rates composed only a small share of Medicare spending growth for home health services. The changes in spending over time are, therefore, mostly attributable to changes in utilization.

Table 5: History of Medicare Home Health Care Spending Growth, 1985-99

Period	Annual spending rate	Significant change shaping service use
1985–88	1%	Tightened interpretation of coverage criteria; increased emphasis on medical review of home health claims.
1989–97	30%	Loosening of coverage criteria allowed more beneficiaries to receive more services.
1998–99	-32%	IPS limited per visit payments and limited aggregate agency payments; heightened scrutiny of claims; changed qualifying criteria for "skilled" services.

Sources: HCFA, *A Profile of Medicare Home Health Chart Book* (Baltimore, Md.: Nov. 1999), and GAO analysis of Medicare home health spending data from HCFA's Office of the Actuary.

The PPS, to be implemented October 1, 2000, will incorporate further major policy changes for Medicare that could have a profound effect on home health service use. Instead of per-visit limits and controls on the average costs of treating Medicare patients, HHAs will receive one payment for each 60-day episode of care, regardless of the actual services provided. Agencies will be rewarded financially for keeping their per-episode costs below the payment rate and thus will have a strong incentive to reduce the number of visits provided during an episode and to shift to a less costly mix of visits. Historical responses to policy changes suggest that agencies are likely to respond to the incentive to reduce services provided within an episode and to increase the number of episodes they deliver.

PPS Payment Rates May Allow Some Agencies to Increase Visits and May Be Excessive for Others

The PPS will use payment rates based on 1998 home health spending and utilization data. Although by 1998 home health care utilization had already started falling from its peak in 1997, the PPS rates will still be based on an average experience that is higher than current usage. Thus, the episode payments could present an ample cushion for many agencies. Not only could the episode amounts allow for more visits during a 60-day period than the average agency is now providing, but because there is no limit on the number of episodes an HHA may provide to a patient, agencies may revert to treating beneficiaries for longer periods.

The adjustments HHAs may make to adapt to the episode-based PPS will depend on their current service patterns. Agencies that have continued to incur expenses above the national average will be pressured to lower their

episode costs, which is likely to require decreasing the number of visits provided or shortening their duration. Agencies with below-average costs, probably reflecting fewer average visits for a given episode, will be rewarded financially under the PPS. Some of these agencies may increase service provision. Others, however, may choose to maintain their relatively low expenses (and probably low visit levels) or reduce services even further, thereby increasing profits. In such cases, the PPS likely will pay too much relative to the services delivered in each episode.

We noted in our April 2000 report that the adjusters to the basic payment rate to reflect patients' needs are more sensitive to differences in the amount of therapy services provided than to differences in patients' clinical indicators.[29] We remain concerned that the financial benefit of providing more therapy services to receive higher payments may interfere with the goal of the PPS to provide payments that support efficiently delivered care that meets patients' needs.

Incentive to Provide More Episodes May Result in Increased Program Spending

Agencies can enhance their revenues by serving more longer-term users and extending the length of time they serve patients in order to be paid for additional episodes. For some patients, the scheduling of visits could determine whether an agency is paid for one episode or two. In addition, the design of the PPS allows agencies to receive a full episode payment for a small number of visits. While the episode payment is based on an average of 27 visits, agencies can receive an episode payment if they provide as few as 5 visits.[30] As 16 percent of episodes in 1998 consisted of one to four visits, adding only a few visits would allow the agency to receive the full episode payment.

The budgetary implications of growth in the number of episodes are considerable. HCFA has projected 5.3 million full episodes for 2001, almost 13 percent fewer than in 1998. Because the industry has historically responded to changes in payment policy in ways that enhanced agency revenues, this projection may not adequately anticipate potential service growth in response to the PPS' strong incentives. If the number of episodes

[29]GAO/HEHS-00-9, Apr. 7, 2000.

[30]Under the PPS, HHAs can receive a full episode payment for a patient receiving 5 or more visits within a 60-day period.

in 2001 exceeds HCFA's projection by as little as 5 percent, program expenditures could be roughly half a billion dollars more than projected.

Program Controls May Be Inadequate to Counter PPS Incentives

HCFA has included three mechanisms under the PPS to counter the incentives to stint on services and generate additional episodes. First, HCFA will curtail gross overpayments for very low-service episodes by paying on a per-visit basis (through the low-utilization payment adjustment) when fewer than five services are provided in a 60-day period. Second, adjustments to the payment for an episode can be made if a significant change in patient condition occurs. The episode payment can be raised on a prorated basis if a patient's condition deteriorates or if therapy service provision increases after the beginning of an episode; the payment can be decreased on a prorated basis if the home health agency reports significant improvement in a patient's condition during the course of care that changed the required services. The third mechanism is a requirement for medical review of a portion of claims to detect underservice and unnecessary episodes. For fiscal year 2001, HCFA has targeted just over 2 percent of home health claims for review, even though provider incentives will be different than under previous payment methods. HCFA has characterized its planned utilization monitoring and medical review activities as similar to reviews conducted before the implementation of the PPS, when the payment incentives were different.

It is unclear whether these controls, in combination with HCFA's planned activities and continued anti-fraud-and-abuse activities, will be sufficient to counter incentives to provide fewer services within an episode and to generate additional episodes, especially given agencies' historical ability to quickly respond to such incentives. Furthermore, the lack of standard definitions of appropriate home health care will confound efforts to identify instances of excessive use or inadequate care.

Conclusions

The fluctuations in Medicare home health use suggest that agencies will continue to respond to their payment and policy environments by changing the volume and mix of the services they provide to Medicare beneficiaries. Indeed, the PPS is based on the premise that appropriate financial incentives cause HHAs to deliver services more efficiently. Previously, we expressed concern that the wide, unexplained variation in service use and inadequate patient-level payment adjusters could result in substantial underpayments to some agencies and for some types of patients and overpayments for others under a PPS based on national average costs.

After examining HHA responses to the IPS and the basis for Medicare's PPS, we continue to believe that additional protections for beneficiaries, agencies, and the program need to be incorporated into the payment mechanism through a risk-sharing arrangement that limits the aggregate losses or gains for each agency. Risk sharing would insulate agencies from extreme financial losses, protect beneficiaries from impaired access or inadequate care, and shield Medicare from burgeoning expenditures. HCFA disagreed with our recommendation that it implement a risk-sharing mechanism in conjunction with the PPS. HCFA argued that doing so would complicate the administration of the payment system and that the mechanism was not needed because certain features of the PPS, such as the case mix adjustment mechanism and the potential for unlimited episodes, would adequately protect beneficiaries and the program. We acknowledge HCFA's concerns that a risk-sharing arrangement adds administrative complexity to the PPS, but believe that the uncertainties about appropriate payment levels, as well as the lack of consensus regarding what constitutes adequate treatment, require this payment system modification. Further, we continue to have reservations about the adequacy of some of the features of the PPS that HCFA believes will offer protections from any unintended consequences of the new payment system. A risk-sharing arrangement would minimize excessive payments to some agencies and extreme losses for others, and it would moderate incentives to underserve beneficiaries and inappropriately change treatment patterns. Given the number of agencies and beneficiaries affected, and the potential effect on Medicare expenditures, we believe the added complexity engendered by risk sharing is warranted.

As service use changes in response to the PPS, we and HCFA agree that it will be important to refine the payment system. The rates will need to be evaluated to ensure that HHAs are not overpaid relative to the services provided. The Secretary of Health and Human Services' report, due by April 1, 2001, that will evaluate the need for a 15-percent payment reduction will be an important first step in assessing the adequacy of current payment rates. Ongoing refinements of the payment system—including reconsideration of the episode length, the average payment rate, and the patient-level payment adjusters—will continue to be needed, to account for changes in HHA service delivery and beneficiary needs.

Even as the system is improved, however, payment mechanisms alone may not be adequate to ensure appropriate service use. As we previously recommended and as was agreed to by HCFA, sufficient resources must be devoted to ensuring that any service reduction within episodes is

appropriate and that each episode of care a beneficiary receives is medically necessary.

Matter for Congressional Consideration

Given the uncertainties for beneficiaries, HHAs, and the Medicare program associated with the home health agency PPS, we believe that the Congress should consider requiring HCFA to implement a risk-sharing arrangement under the PPS to moderate excessive HHA gains or losses as soon as practicable. We believe that a risk-sharing arrangement would offer protection to Medicare beneficiaries, home health agencies, and the Medicare program from any unintended consequences of the home health PPS.

Agency Comments

In commenting on a draft of this report, HCFA found our analysis useful in understanding trends in home health utilization and payment trends under the IPS. HCFA concurred that many home health agencies may have over-reacted to the IPS by curtailing service provision after 1997 more than was necessary. HCFA also agreed that refinements to the PPS will be an ongoing activity based on HHA behavior and reiterated its commitment to monitor provider responses under the new system to ensure beneficiary access to needed services. While HCFA agrees with us that risk sharing in conjunction with the PPS is one option to moderate inappropriate behavior, it continues to have reservations about implementing such a provision. HCFA also provided technical comments, which we incorporated in the final report as appropriate.

HCFA raised concerns about a risk-sharing provision. First, it believes that a risk-sharing arrangement that limits HHA profits or losses through a comparison of Medicare payments with Medicare costs undermines the incentives of the PPS. HCFA said that this would encourage HHAs to increase their costs—potentially in ways unrelated to patient care—thus rewarding provider inefficiency. HCFA also said that costs are not the best measure of whether patients' service needs are being met. Further, it is concerned that relying on costs in the payment system perpetuates the need for an elaborate cost settlement reconciliation system. Because of these concerns, HCFA prefers a visit-based measure of utilization to correct inappropriate behavior. HCFA is also concerned that HHAs need time to adapt to the new payment system and therefore that it would be premature to immediately implement risk sharing before HHA responses to the PPS can be evaluated and before PPS adjustments, if any, are made on

the basis of observed behavior. Further, HCFA believes that HHAs compete for patients on the basis of service delivery and that competition among HHAs will be a primary driver of agency behavior and performance under the PPS.

We agree with HCFA that a visit-based approach to moderating inappropriate behavior would improve the current PPS, but we continue to believe that a risk-sharing arrangement based on a comparison of Medicare payments and costs is preferable. First, it offers HHAs more flexibility than a visit-based approach with respect to the services they provide under the PPS, because HHAs could balance visit costs, mix, and volume in meeting beneficiary care needs and keeping their costs in line with Medicare payments. Second, because cost-based risk sharing depends on HHA cost data, using this information in conjunction with the PPS could improve cost reporting data, which will be critical to evaluating the PPS. We acknowledge that a risk-sharing arrangement based on agency costs lessens the incentive for an HHA to cut its costs, but we believe that it could be designed in a way that would offset any incentive to maintain high costs. For example, if risk sharing always required HHAs to incur some portion of their losses, agencies would continue to have an incentive to lower their costs. Further, HCFA does not acknowledge the protection afforded by a risk-sharing approach against Medicare overpayments for episodes or Medicare expenditure growth due to increased numbers of episodes, which we believe are important justifications for this payment modification. Finally, we believe that risk sharing is an important tool in moderating the incentive HHAs can have under the PPS to stint on services and to protect Medicare patients from underservice.

We believe that risk sharing should be implemented as soon as practicable because our analyses of recent and historical utilization and spending data indicate that agencies respond dramatically and quickly, but not necessarily appropriately, to changes in Medicare payment policies. In its comments, HCFA noted the rapid growth in utilization between 1990 and 1997, and agencies' overreaction to the IPS between 1997 and 1999. Similarly, we believe that agencies may immediately respond to the incentives of the PPS in ways that may jeopardize beneficiary access to services or quality of care and increase program expenditures.

We agree with HCFA that agency competition for patients and medical review and monitoring efforts may deter HHAs from underserving beneficiaries. However, we remain concerned that these features may be insufficient to counter the financial incentives to stint on services within an

episode and to provide unnecessary episodes. Further, relying on competition to enforce appropriate agency behavior may place unrealistic expectations on a vulnerable population to have information about agencies' provision of services and assumes that beneficiaries have choices in selecting a provider, which is not necessarily true for all beneficiaries, particularly those located in rural areas. Given the potential limitations of competition and medical review in guarding against potential underservice, risk sharing could provide HCFA with an additional tool to protect Medicare's beneficiaries.

HCFA's comments are included as appendix IV.

We are sending copies of this report to the Honorable Nancy-Ann Min DeParle, Administrator of HCFA, and interested congressional committees. We will also make copies available to others upon request.

If you have any questions about this report, please call me or Laura Dummit, Associate Director, at (202) 512-7119. Major contributors included Carol Carter, Jean Chung, James E. Mathews, Kara Sokol, and Wayne Turowski.

Sincerely yours,

William J. Scanlon
Director, Health Financing and
Public Health Issues

Scope and Methodology

We conducted our analyses using Medicare provider, claims, and beneficiary files for calendar years 1994, 1996, and 1999. We chose 1994 as our starting point because its patterns of utilization and spending were used to set the interim payment system (IPS) payment limits. We analyzed 1996 data because the 1997 home health claims data include both pre-IPS and IPS claims. We did not analyze 1998 data, since HCFA had well-documented problems constructing this claims file. We thus selected 1999 claims data to reflect utilization patterns under the IPS.

Agency ownership and location were extracted from HCFA's end-of-year Provider of Services files for 1994, 1996, and 1999. We included in our analysis only those providers that were listed as active in each year.

We used 100 percent of Medicare claims from HCFA's home health Standard Analytical Files (SAF), final action claims, for 1994, 1996, and 1999 to analyze patterns and trends in home health utilization. These files were edited in three ways. First, the claims file for each year was compared with the Medicare corresponding Denominator File to exclude claims for beneficiaries who had enrolled in a Medicare managed care plan at any point in the year. Second, the HHAs included in the claims data were compared with the Provider of Service files for each year, and only claims from agencies participating in Medicare were included in our analyses. Last, we excluded aberrant values for service counts.

We used a 1999 claims file that was generated in May 2000, although HCFA's SAFs are usually not complete until June of the year following the claims year. After analyzing the distribution of claims by month, we concluded that the file was roughly 95 percent complete. Subsequent comparisons with HCFA's projections indicated that our estimate of the number of beneficiaries receiving home health services in 1999 was 4 percent lower than HCFA's final total. As a result, numbers presented in this report are likely to slightly understate actual utilization in 1999 and may slightly overstate the declines reported between 1996 and 1999.

In 1999, HCFA implemented a policy change that affected how home health agencies reported the units of service when submitting claims for payment to Medicare. Until July 1, 1999, units represented the number of visits; starting October 1, units represented the number of 15-minute increments making up the visit; and between July 1 and September 30, both counting methods were used on the claims. We incorporated these policy changes in our calculation of units from the claims files and verified our calculations by analyzing the monthly distribution of visits during 1999.

For our analysis of changes in the number of Medicare beneficiaries using home health services, we controlled for changes in Medicare enrollment by using home health users per 1,000 Medicare fee-for-service (FFS) beneficiaries. Our analysis only reflects Medicare FFS enrollees because HCFA data on service use exclude those enrolled in managed care plans and because the payment methods of interest in our analysis only apply to those receiving home health care under FFS. In analyzing geographic characteristics, we used the beneficiary's residence, reflecting HCFA's decision to pay agencies on the basis of where the patient resides, not where the agency is located. Because beneficiaries may receive care from multiple agencies, which could be of different types, we counted each unique beneficiary/agency combination as a separate home health user when analyzing service use by agency characteristics. As a result, the user counts included in our analyses of HHA characteristics are roughly 10 percent higher than those included in the beneficiary-level data.

To examine the response of users, agencies, and areas of high utilization to policy changes, we categorized beneficiaries, HHAs, and states as low-use, medium-use, and high-use according to the average number of visits per user in 1996. The low- and high-use cutoff points for beneficiaries and agencies were set such that roughly 20 percent of the observations in 1996 fell into each category, with the remaining group defined as medium-use. High-use states were defined as those with utilization 20 percent or more above the national mean.

To control for agencies opening and closing between 1994 and 1999, we created a cohort of agencies open in all 3 years and examined them separately. Their utilization trends were similar to those included in this report.

Our analysis of HCFA's proposed PPS was based on the *Federal Register* final rule[1] and briefings with HCFA officials.

[1]"Medicare Program: Prospective Payment System for Home Health Agencies," final rule, *Federal Register*, Vol. 65, No. 128 (July 3, 2000).

Medicare Home Health Users, by State of Residence, Calendar Years 1994, 1996, and 1999

State	Medicare home health users per 1,000 FFS enrollees			Percentage change		
	1994	1996	1999	1994-96	1996-99	1994-99
Alabama	113	123	77	9.1	-37.9	-32.2
Alaska	50	67	48	34.6	-29.0	-4.4
Arizona	64	75	54	17.1	-28.3	-16.0
Arkansas	93	103	70	10.8	-32.6	-25.3
California	93	107	86	15.0	-20.2	-8.3
Colorado	86	95	75	11.4	-21.4	-12.5
Connecticut	102	119	106	16.4	-10.9	3.6
Delaware	82	90	70	10.7	-22.3	-14.0
District of Columbia	71	86	72	20.1	-15.6	1.4
Florida	112	121	92	7.7	-24.1	-18.2
Georgia	104	108	72	4.2	-33.1	-30.2
Hawaii	38	42	34	10.9	-18.7	-9.9
Idaho	78	95	64	22.3	-32.7	-17.7
Illinois	87	100	78	15.8	-22.2	-9.9
Indiana	73	85	60	16.8	-29.6	-17.7
Iowa	63	76	56	19.4	-26.3	-11.9
Kansas	66	83	54	25.5	-34.1	-17.2
Kentucky	87	105	81	20.5	-22.8	-7.0
Louisiana	131	151	109	15.2	-28.1	-17.1
Maine	94	111	94	18.4	-15.3	0.3
Maryland	75	85	75	13.2	-11.9	-0.3
Massachusetts	121	142	115	17.0	-18.5	-4.7
Michigan	84	96	86	13.7	-10.0	2.4
Minnesota	45	55	41	22.3	-25.5	-8.8
Mississippi	135	152	103	12.3	-32.2	-23.9
Missouri	100	113	84	12.7	-25.8	-16.4
Montana	68	81	63	20.6	-22.9	-7.0
Nebraska	61	74	60	21.0	-19.5	-2.6
Nevada	71	81	63	15.6	-22.3	-10.2
New Hampshire	98	111	89	13.2	-19.9	-9.3
New Jersey	74	89	84	20.9	-5.3	14.5
New Mexico	78	93	71	18.5	-23.1	-8.9
New York	72	85	81	18.8	-4.7	13.2

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	Medicare home health users per 1,000 FFS enrollees			Percentage change		
State	**1994**	**1996**	**1999**	**1994-96**	**1996-99**	**1994-99**
North Carolina	82	96	78	17.4	-19.0	-4.9
North Dakota	66	76	63	15.9	-17.5	-4.3
Ohio	76	90	71	19.1	-20.7	-5.6
Oklahoma	104	129	88	23.9	-31.3	-14.9
Oregon	75	79	65	5.4	-17.5	-13.0
Pennsylvania	98	113	101	16.0	-11.2	3.1
Rhode Island	104	125	109	20.7	-12.9	5.2
South Carolina	82	97	75	17.9	-22.7	-8.8
South Dakota	55	71	54	30.1	-24.6	-1.9
Tennessee	127	131	86	2.9	-34.4	-32.5
Texas	102	125	84	23.4	-32.7	-17.0
Utah	88	96	71	9.7	-25.8	-18.6
Vermont	130	138	114	6.2	-17.6	-12.5
Virginia	76	90	76	18.2	-16.0	-0.7
Washington	70	77	63	10.1	-17.7	-9.4
West Virginia	72	88	64	20.8	-27.4	-12.2
Wisconsin	55	61	51	10.7	-17.0	-8.1
Wyoming	75	86	58	15.2	-33.4	-23.2
Nationwide	89	102	80	15.0	-22.0	-10.3

Source: GAO analysis of HCFA's home health claims data and beneficiary enrollment data for 1994, 1996, and 1999.

Average Visits per Medicare Home Health User, by State of Residence, Calendar Years 1994, 1996, and 1999

	Visits per person served			Percentage change		
State	**1994**	**1996**	**1999**	**1994-96**	**1996-99**	**1994-99**
Alabama	112	121	63	8.0	-48.5	-44.4
Alaska	43	48	23	11.3	-51.5	-46.0
Arizona	55	60	29	8.0	-51.7	-47.8
Arkansas	75	79	45	5.6	-43.5	-40.4
California	47	53	31	11.5	-41.1	-34.4
Colorado	60	70	39	16.4	-44.9	-35.9
Connecticut	46	55	40	19.3	-27.7	-13.8
Delaware	46	50	31	9.2	-38.7	-33.0
District of Columbia	42	51	42	20.7	-16.3	1.0
Florida	75	79	43	4.8	-45.7	-43.1
Georgia	103	105	52	2.5	-50.6	-49.4
Hawaii	44	47	25	6.0	-45.9	-42.6
Idaho	55	64	30	17.6	-54.1	-46.0
Illinois	51	54	32	5.0	-40.2	-37.2
Indiana	72	77	37	6.6	-52.5	-49.4
Iowa	45	49	27	7.0	-44.8	-40.9
Kansas	56	63	32	12.5	-49.5	-43.2
Kentucky	65	71	48	9.3	-32.7	-26.4
Louisiana	126	162	95	28.6	-41.0	-24.1
Maine	59	65	39	10.3	-39.2	-32.9
Maryland	37	38	29	2.9	-24.2	-22.0
Massachusetts	75	85	46	13.4	-45.1	-37.8
Michigan	45	51	34	13.5	-34.3	-25.5
Minnesota	40	47	27	19.4	-43.0	-31.9
Mississippi	113	127	80	13.1	-37.6	-29.4
Missouri	50	55	32	10.1	-40.8	-34.8
Montana	50	53	31	5.8	-42.1	-38.7
Nebraska	42	45	28	7.5	-38.6	-34.0
Nevada	68	66	39	-2.6	-40.9	-42.4
New Hampshire	51	59	38	16.2	-34.9	-24.4
New Jersey	40	44	31	10.9	-29.8	-22.1
New Mexico	57	75	36	30.0	-51.3	-36.7
New York	44	51	36	15.6	-30.2	-19.4
North Carolina	57	56	37	-3.3	-34.3	-36.5
North Dakota	44	44	27	1.4	-39.0	-38.1

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	Visits per person served			Percentage change		
State	**1994**	**1996**	**1999**	**1994-96**	**1996-99**	**1994-99**
Ohio	51	53	32	4.4	-38.7	-36.0
Oklahoma	105	144	72	36.9	-50.0	-31.5
Oregon	39	37	22	-5.7	-41.1	-44.5
Pennsylvania	43	47	32	10.0	-32.2	-25.3
Rhode Island	43	52	34	20.2	-34.5	-21.3
South Carolina	67	66	41	-1.5	-38.6	-39.6
South Dakota	39	45	26	15.9	-43.0	-33.9
Tennessee	115	114	67	-1.4	-41.1	-41.9
Texas	98	132	64	35.2	-51.8	-34.8
Utah	96	113	55	17.8	-51.0	-42.3
Vermont	56	67	44	20.3	-34.7	-21.5
Virginia	49	56	39	15.2	-30.5	-20.0
Washington	39	35	23	-9.5	-34.4	-40.7
West Virginia	50	58	34	15.7	-40.9	-31.6
Wisconsin	41	44	29	7.2	-33.0	-28.2
Wyoming	73	75	37	2.3	-50.5	-49.4
Nationwide	65	73	41	12.7	-43.6	-36.5

Source: GAO analysis of HCFA's home health claims data and beneficiary enrollment data for 1994, 1996, and 1999.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

AUG 31 2000

Office of the Administrator
Washington, D.C. 20201

TO: Laura A. Dummit
Associate Director
General Accounting Office

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: GAO Draft Report: "Medicare Home Health Care: Prospective Payment System Could Reverse Recent Declines in Spending" (GAO/HEHS-00-176)

We have reviewed the above mentioned report and want to thank the General Accounting Office (GAO) for the chance to make these comments.

Home health care is an important benefit that enables Medicare beneficiaries to receive many services in their homes as covered under Medicare. HCFA is committed to protecting this critical benefit for those who qualify for it. The home health prospective payment system (PPS) will help strengthen this benefit for Medicare beneficiaries by appropriately paying home health agencies (HHAs) according to the health condition and care needs of each beneficiary.

Background

In the Balanced Budget Act of 1997 (BBA), Congress significantly reformed the payment system and other rules for HHAs. The BBA eliminated cost-based reimbursement that encouraged agencies to provide more visits and to increase costs up to set limits. As a first step toward giving HHAs incentives to refocus their efforts on providing care efficiently, this older system was replaced by the Congressionally-mandated interim payment system (IPS). This interim system is to operate until the PPS is effective.

Since the enactment of the BBA, there has been a significant decline in actual home health spending. The recent drop in home health spending came after a period of rapid growth. Between 1990 and 1997, home health expenditures grew at an average annual rate of 25 percent – three times the growth rate for the program overall. Since then, the Administration and Congress have worked together to protect Medicare's home health benefit while slowing the rapid rise in its costs. As required by the Balanced Budget Act, we have taken a number of steps to protect and strengthen the home health benefit, and we are seeing the successful results. In November, the Health and Human Services Inspector General (IG) issued a report showing that we had cut the home health improper payment rate by more than half – from 40 percent to 19 percent – since a similar study in 1997.

While some of the reduction in spending reflects elimination of overpayments, waste and fraud, it may be causing isolated access problems in some situations. GAO, MedPAC and the IG agree that there does not appear to be system-wide access problems, but some patients who have long-term conditions, like diabetes, have had increased difficulty in accessing home health services. To assure a smooth transition to the PPS, the President, as part of his Mid-Session review

budget, has proposed to dedicate $2 billion over 5 years ($3 billion over 10 years) to ensure adequate payment to HHAs during the transition to PPS.

Development of the PPS

The home health PPS is the product of over ten years of research on case mix and HHA payment issues. Even prior to the passage of the BBA, HCFA used numerous demonstration projects and worked with outside research organizations, such as Mathematica Policy Research, to help lay the groundwork for PPS. Although work on home health PPS has intensified since the passage of BBA, HCFA agrees with the GAO recommendations in the April 2000 report on home health that research should continue. That is why HCFA will closely monitor and refine the PPS based on experience and the findings of future research. This is critical for protecting beneficiaries, HHAs, and the Medicare Trust Fund. HCFA has taken, and will continue to take, actions to ensure that beneficiaries have access to the quality home health care guaranteed to them under Medicare.

HCFA is continuing to build on these earlier research activities. In fact, consistent with the GAO's recommendations earlier this year, HCFA had already developed plans to pursue on-going research and refinements to the home health PPS. This will include intensive monitoring of PPS claims, payments, cost report data, and quality/outcome data from the Outcome and Assessment and Information Set (OASIS) system. HCFA will also conduct additional research, both internally and with Abt Associates, on case mix. This aggressive monitoring effort, coupled with the research effort, will serve as the basis for future improvements that HCFA will make to the PPS. HCFA has also taken steps to ensure that beneficiaries are protected from the major risk inherent in all PPS systems --underutilization-- and to ensure that all HHAs are paid appropriately for the services provided. Our response to the GAO's April 2000 report details our extensive commitment to monitor the PPS and our strategy to detect and mitigate future concerns.

Response to the GAO Report

In your report, the GAO has done an excellent job compiling comparative statistics on home health utilization and payment trends. It is especially useful in understanding some of the trends in utilization behavior among HHAs during the IPS. These data indicate that HHAs do not respond quickly to program and payment changes. As the report notes, despite a strong history of high utilization, agencies responded to IPS in ways that indicated a failure to understand the level of expenditures possible under an aggregate per-beneficiary cap. Many agencies reduced utilization well below the levels indicated by the caps.

Additionally, the GAO expresses concern that HCFA must be alert to any issues that may arise regarding the PPS and must engage in an ongoing effort to improve the PPS. We agree. We have taken, and will continue to take, steps to ensure that there is as smooth a transition as possible to the PPS thereby helping to ensure beneficiary access to the home health benefit. In fact, to help protect beneficiaries by assuring that HHAs have the proper incentives to provide care, HCFA has already included several items in the PPS such as:

- *Case mix* system that provides higher payments for high care need patients;
- *Unlimited episodes* that aid agencies that care for beneficiaries with longer term needs;
- *Outlier payment system* for extraordinarily costly patients; and,

Page 3 -- Response to Laura Dummit

- *Significant Change in Condition (SCIC) feature* that permits an HHA to receive higher or lower payments when a beneficiary's condition changes substantially.

As with the April 2000 report, GAO argues that a risk sharing provision is needed to ensure against any unintended consequences of the PPS. We share the GAO's concerns, and we agree that risk sharing is one option to correct inappropriate behavior.

We prefer approaches that look at utilization measured in terms of visits, as opposed to utilization as measured by costs. Our view in this case is that the key to a properly functioning PPS is to assure that services are properly provided. We view costs as an inadequate measure of services, so, if adjustments for service delivery were necessary, we would want to adjust payments not by costs but by utilization in the PPS system. The reservations we have regarding reliance on cost reimbursement include the following:

- Cost-based risk sharing provides the incentives to increase costs in ways that are unrelated to service volume (e.g., rent, travel, training, salaries and consultation costs, etc.);
- Cost-based risk sharing would significantly dampen the financial incentives inherent in PPS and encourage inefficiency by providing a protection against poor business practices;
- The use of cost ceilings and floors would not be a good measure of whether a patient's service needs are met; costs vary greatly among agencies, therefore, higher costs does not necessarily mean a higher number of visits; and
- Cost report based risk sharing would require the continued elaborate cost settlement reconciliation system.

We would not recommend immediately moving to risk sharing. As noted, we believe that any industry takes time to react to new payment systems. Making changes in the PPS before we are able to observe the impact of this new PPS may cause a cycle in which the industry is confused as it attempts to respond to different signals. Further, we believe that the industry competes on service delivery and that competition among HHAs will be a primary driver of agency behavior and performance under PPS.

HCFA will use the early period of PPS implementation to look closely, through program data and medical review, at HHA behavior, and base further program refinements on observed behavior. We are aware of the inherent vulnerability of under-service within a PPS episode and have put safeguards in place to protect against this vulnerability. However, if we observe inappropriate behavior, we will work within our existing legal authority and with Congress to assure that the PPS provides high quality care and properly reimburses HHAs. Risk sharing is one option we would consider.

Again, we appreciate the effort that went into this report and will continue to monitor beneficiary access to ensure that they receive appropriate services. We look forward to working with GAO on this and other issues.

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