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Human Resources
Division

RELEASED

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May 8, 1980

The Honorable Sam M. Gibbons
Chairman, Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

HSG
04102

Dear Mr. Chairman:

Subject: Evaluation of the Health Care Financing Administration's Proposed Home Health Care Reimbursement Limits (HRD-80-84)

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This letter is in response to the Subcommittee's concerns that the limits proposed on February 15, 1980, by the Health Care Financing Administration (HCFA) on home health care reimbursements are too high. Specifically, we were asked to review (1) the accuracy of the data base used to develop the limits, (2) the methodology used in developing the limits, (3) the accuracy of HCFA's estimated savings, and (4) alternative methods HCFA could use in improving existing limits and/or developing subsequent home health reimbursement limits.

We identified a number of problems with the data base and procedures HCFA used in computing the proposed home health care reimbursement limits. Under the methodgy used, relatively minor changes in (1) the number of home health agencies included in the data base or (2) the data themselves can result in substantial changes to the computed reimbursement limits. Also, small changes in the level at which the reimbursement limits are set can have a relatively large impact on the savings resulting from implementation of the limits. For example, lowering the limits by 10 cents would result in increasing the savings by over $200,000, using the methodology HCFA applied to estimate the savings that would be realized if the proposed limits were implemented.

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In reviewing the data base we identified a number of problems including:

--HCFA included home health agencies in its data base which should have been excluded and excluded agencies which should have been included. Adding to or deleting from the data base the improperly excluded or included agencies identified in our sample resulted in changes to the reimbursement limits ranging from increasing one limit by 9 cents per visit to decreasing another limit by 82 cents per visit.

--HCFA included in its data base information from unaudited, unsettled home health agency cost reports. On the average, allowable costs are reduced by about 3.5 percent during the audit and settlement process. Reducing the costs reported by freestanding home health agencies by 3.5 percent for unaudited cost reports resulted in changes to the proposed limits ranging from no change to a $1.96 per visit reduction.

--Costs reported under certain cost reporting methods permitted by HCFA had to be allocated in order to obtain the data needed to compute the proposed limits. HCFA's procedures for these allocations produced inaccurate results--primarily through miscounting the number of visits used to calculate per visit costs. We reallocated the data relating to three of the limits, and one limit increased by $1.42 per visit while the others decreased by $.72 and $1.35.

--A computer programing error resulted in the limits being set too high. The correctly computed limits ranged from 1 cent to 49 cents per visit lower.

We also noted some anomalies with the wage index data used to establish the reimbursement limits for individual agencies. These anomalies could result in the limits being set too high for some agencies and too low for others.

Details on these and several other problems we identified are included in enclosure I. Each problem is discussed independently of the other problems. Therefore, the separate impacts cannot be totaled to arrive at an overall impact.

Because of the problem with HCFA's data base, we were unable to determine the correct levels at which the proposed limits should be set using HCFA's methodology or to verify the accuracy of HCFA's estimated savings. Also, because the data base was incorrect we saw no useful purpose to applying to it other methodologies for determining reimbursement limits.

We reviewed pertinent documents and records used to develop the proposed cost limits, and interviewed HCFA officials. We also discussed the impact of the existing and proposed limits with officials from HCFA's Atlanta and Chicago Regional Offices, officials from 18 intermediaries--organizations which reimburse, under contract with HCFA, home health agencies--selected at random, and HCFA's Office of Direct Reimbursement, the Government's intermediary.

In addition we interviewed officials from the Department of Labor's Bureau of Labor Statistics to evaluate HCFA's use of Bureau data to create the wage index used in the proposed home health reimbursement limits.

As requested by your office, we did not obtain written comments from HCFA on this report. A similar letter has been sent to Senator Bob Packwood, who expressed similar concerns about the proposed health limits. Unless you publicly announce the report's contents earlier, no further distribution will be made until 30 days from the date of the report. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Gregory J. Ahart
Director

Enclosure

ENCLOSURE I

EVALUATION OF THE HEALTH CARE FINANCING ADMINISTRATION'S PROPOSED HOME HEALTH CARE COST LIMITS

MEDICARE REIMBURSEMENT

Medicare outlays for home health care--health and health-related services provided in the beneficiary's home--nationally increased from $287 million in fiscal year 1976 to $634 million in fiscal year 1979. The Health Care Financing Administration (HCFA) estimates fiscal year 1981 expenditures will be $964 million. Medicare essentially allows reimbursement for all costs claimed by home health agencies as long as the costs are related to patient care, reasonable, and not substantially out of line with comparable agencies. Although Medicare is required by law to pay home health agencies reasonable costs, the Department of Health, Education, and Welfare (HEW) 1/ has been granted authority to set reimbursement limits.

The Social Security Amendments of 1972 became law on October 30, 1972. Section 223 of the law gave HEW authority to set cost limits. Specifically the law allows establishing limits:

> "* * * on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery

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1/On May 4, 1980, a separate Department of Education was created. The part of HEW responsible for the activities discussed in this report became the Department of Health and Human Services. This Department is referred to as HEW throughout this report.

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of needed health services to individuals covered by [Medicare]." 1/

Under authority of section 223, HEW has established limits for hospitals, skilled nursing facilities, and home health agencies. The initial home health limits, which are currently in force, were published on June 1, 1979, and were applicable for services rendered after July 1, 1979. The limits establish reimbursement ceilings for each type of visit made by home health agencies. Two limits were set for each type of visit 2/--one for Standard Metropolitan Statistical Areas (SMSAs) and one for nonmetropolitan areas. The limits are applied in the aggregate; that is, costs exceeding the limit for one type of visit can be offset by costs below the limit for another type of visit.

The February 15, 1980, proposed revisions to the home health limits would make two major changes in the way the limits are set. First, seperate limits by type of service would be established for facility-based home health agencies (primarily associated with hospitals) and for freestanding home health agencies. This change was proposed because HEW said that one reason facility-based home health agencies have higher costs is because of required allocations of facility overhead costs to the agency. HEW did not believe facility-based agencies should be unduely penalized because of such required allocations. Second, limits would be established for each individual SMSA and for the nonmetropolitan areas

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1/Section 223 limits on reimbursable costs are set prospectively. Beneficiaries may be charged by providers for their costs in excess of these limits, but only if

--HEW provides notice to the public that the particular provider will charge beneficiaries an amount in excess of what has been determined necessary for the efficient delivery of services and

--the provider informs the beneficiary of the charges and that they are in excess of the costs determined to be necessary for the efficient delivery of services.

2/Home health agencies provide six basic types of visits--skilled nursing, physical therapy, speech therapy, occupational therapy, medical social services, and home health aide. The classification of a visit depends on the primary type of service provided.

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of each State. This change was proposed to enable adjustment of the limits for wage level differences among the various areas of the Nation. The limits for a particular SMSA or the rural areas in a particular State are computed by adjusting the base limits by the "wage index" 1/ for the area in question.

According to a HCFA official, under both the current and the proposed limits, home health agencies are notified of the limits applicable to them. An agency can request an exception for the limits applicable to it. Exceptions are granted if the agency can demonstrate that (1) it provides atypical services which are more costly or (2) its high costs resulted from extraordinary circumstances beyond its control. An agency can also request exemption from the limits if it is the only provider available in the community.

Under the proposed revision a home health agency could also request an exception if it is a new provider operating for less than 3 years or if it can demonstrate that the percentage of its costs represented by labor are more than 10 percent higher than the percentage used for the wage index adjustment (see p. 5). Also, the proposed revisions permit an increase in the limits if the actual rate of inflation is at least 0.25 percent greater than the rate for inflation used in deriving the limits. The proposed reimbursement limits also provide an add-on adjustment for agencies in Alaska and Hawaii to cover the increased costs of operating home health agencies in these States.

The home health reimbursement limits currently established and the February 1980 proposed revisions are listed in the following table.

1/The wage index is the ratio of the average wage level in the hospital industry in a particular area to the average wage level in the hospital industry nationwide.

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Type of service	Current limits		Proposed revisions to the current limits a/ for freestanding providers		for facility-based providers	
	SMSA	non-SMSA	SMSA	non-SMSA	SMSA	non-SMSA
Skilled nursing	$41.80	$38.05	$46.67	$44.27	$58.33	$46.83
Physical therapy	40.95	39.50	45.87	47.54	51.73	44.68
Speech therapy	44.95	41.20	47.63	46.14	51.53	b/
Occupational therapy	46.97	48.85	48.96	56.85	54.23	b/
Medical social services	52.62	43.88	52.52	42.78	59.35	b/
Home health aide	33.00	27.70	34.94	30.64	50.61	42.37

Note a/ To arrive at the actual limit for a particular home health agency, these base limits are adjusted by the wage index for the geographic area in which the agency is located.

b/ HEW said there was insufficient data available to establish limits for this type of visit. HEW is proposing to use the limit for non-SMSA free standing agencies as the limit.

The current home health care limits are used to limit overall reimbursements to an agency. The following examples illustrate how the limits are applied.

Home health agency	Type of visit	Number of visits	Per visit reimbursement limit	Reimbursement limit	Actual cost	Medicare payment
A	Skilled nursing	5,000	$41.80	$209,000	$220,000	
	Physical therapy	1,000	40.95	40,950	32,000	
	Home health aide	1,000	33.00	33,000	26,000	
	Total	7,000		$282,950	$278,000	$278,000
B	Skilled nursing	5,000	$41.80	$209,000	$212,000	
	Physical therapy	1,000	40.95	40,950	37,000	
	Home health aide	1,000	33.00	33,000	41,000	
	Total	7,000		$282,950	$290,000	$282,950

Under the proposed revisions (assuming the same per visit reimbursement limits apply), home health agency A would receive Medicare reimbursements totaling $267,000 and home health agency B would receive $279,000. The differences in reimbursement amounts between the current and proposed limits result because the proposed limits are applied for each type of visit while the current limits are applied only in the aggregate.

METHODOLOGY USED BY HCFA TO SET PROPOSED LIMITS AND ESTIMATE SAVINGS

HCFA divided total home health agency costs into two parts--a wage portion representing employee salaries, including the costs of services provided to agencies under contract, and a nonwage portion representing all other costs incurred by agencies. The two portions were based primarily on data from all home health agency cost reports submitted to HCFA through fiscal year 1976. The wage portion equals 69.78 percent of total costs, and the nonwage portion equals the other 30.22 percent of total costs.

HCFA also obtained data from the Bureau of Labor Statistics (BLS) on the average wage level for the hospital industry nationwide, by SMSA and by non-SMSA areas of each State. These data are derived by BLS from information on employment reported for unemployment compensation program purposes by the States. The wage index for each SMSA and non-SMSA was computed by dividing the BLS data for the area in question by the nationwide data.

To obtain data on which to base its proposed revisions, in April 1979 HCFA asked all its intermediaries (organizations that reimburse home health agencies under contracts with HCFA) to send the most recent cost report for each home health agency reimbursed by the intermediary. HCFA used 1,926 of the cost reports received from the intermediaries as its data base for the proposed revisions.

HCFA extracted data from the 1,926 home health agency reports and entered it in a computerized data base. It also entered information from its paid claims data base, which was used to allocate the costs on some cost reports among the various types of visits. To make all these costs comparable, the cost data for each home health agency were adjusted for inflation for the period between the end of the cost reporting year and September 1978. This was accomplished

by using actuarial estimates of monthly cost increases. This adjusted data were then divided into wage and nonwage portions using the percentages discussed above. The wage portion for each agency was further adjusted by dividing it by the wage index for the agency's geographic area. This was done to make the wage portion of the costs comparable among agencies.

Each agency's adjusted wage portion was added to its adjusted nonwage portion to arrive at a total adjusted cost. The total adjusted costs were then arrayed in descending order for each type of visit and both types of agencies (freestanding and facility based). Using a mathematical formula the 80th percentile of costs 1/ was determined for each type of visit by provider type. The amount arrived at was increased for anticipated inflation through June 30, 1981. This level is the proposed basic home health care reimbursement limit.

To obtain the limit for each type of visit for a particular agency, the wage portion of the base limit is multiplied by the wage index for the agency's geographic location, and this amount is added to the nonwage portion of the base limit.

To estimate the savings that would result under the proposed limits, HCFA computed for each home health agency in its data base the limits that would result from the proposed revision and compared these with the adjusted cost per type of visit of the agency. For agencies where the limits were below the adjusted costs, HCFA multiplied the difference by the number of visits in the data base for those agencies to arrive at an estimate of the costs to be avoided. This estimate was divided by the total payments to all agencies and the resulting ratio was multiplied by total estimated home health care expenditures during fiscal year 1981. The resulting amount--$34 million--was the estimated savings.

Using the methodology HCFA estimated that payments for about 2.1 million home health care visits would be reduced because of the proposed limits for a total savings of $34 million. Under this method of estimating savings, every 10-cent error in the level of the limits results in an error of about $210,000 in the overall cost savings estimate.

1/The 80th percentile of costs is that level of cost below which 80 percent of the agencies provide services.

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We identified a number of problems with the data used in applying this methodology. Below, they are discussed independently and the impact of each is computed separately. The separate impacts cannot be totaled to arrive at an overall impact.

PROBLEMS WITH BLS DATA

HCFA used the BLS wage data for the hospital industry segment of the overall wage level data. Currently there is no segment specifically for home health agencies. HCFA does not know how closely the hospital segment reflects the actual wage level for home health agencies but believes it should be a good approximation because the two industries compete for the same types of employees and should pay comparable wages. If the hospital segment data do not accurately reflect the situation for home health agencies, the data would affect the accuracy of the proposed limits as applied to particular agencies.

Another problem with the BLS data is that it contains some anomalies. For example, the data shows that the highest hospital wage level in the country is in the Fayetteville, North Carolina, SMSA (with an index of 1.44 compared to New York City's index of 1.28), and one of the lowest hospital wage level areas in the country is the Minneapolis-St. Paul, Minnesota, SMSA (with an index of .757 compared to an index of 1.028 for the rural areas of Iowa). When we asked BLS officials about such anomalies, they told us that they recognize there are problems but that the data are the best available. They explained the low index for Minneapolis-St. Paul by pointing out that Minnesota had reported data only for private hospitals.

PROVIDERS INCORRECTLY INCLUDED AND EXCLUDED FROM THE DATA BASE

HCFA asked each intermediary to provide a cost report for each home health agency reimbursed. The cost reports were to be for cost reporting years which ended October 1, 1977, through September 30, 1978. HCFA provided each intermediary with a list of home health agencies HCFA records showed were served by the intermediary and HCFA asked the intermediaries to add any agencies omitted from the list. Only full year cost reports were to be sent. Newly established agencies and agencies without Medicare utilization were not to be included.

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We were unable to determine, and HCFA was unable to tell us, how many home health agencies should have been included in the data base. As of June 30, 1978, 2,612 agencies were certified to participate in Medicare. As of December 1978, 2,774 agencies were certified; however, other data showed that 2,710 agencies were billing Medicare for services. 1/ When compiling the agency lists sent to the intermediaries, HCFA used data that showed that 2,375 agencies were certified to participate in Medicare as of February 1979. The intermediaries provided HCFA information on cost reports for 2,409 different agencies. We do not know which, if any, of these numbers is the correct total of home health agencies participating in Medicare.

Of the 2,409 cost reports, intermediaries provided information on, HCFA excluded 483. Thus, 1,926 agencies were included in the data base HCFA used to calculate the proposed limits. HCFA could not provide us with complete documentation on why the 483 cost reports were excluded from the data base. To determine if HCFA had properly excluded the cost reports, we randomly selected 12 intermediaries and selected HCFA's Office of Direct Reimbursement and checked whether the cost reports from them were properly excluded. The 13 intermediaries had provided 166 2/ cost reports which were excluded. Of these, 6 (4 percent) were improperly excluded. Four were excluded by HCFA because the intermediary provided the cost report for the wrong year or an incomplete cost report. HCFA did not attempt to obtain the proper cost reports, but we obtained them from the intermediaries and included them in the data base. HCFA lost one cost report and did not attempt to replace it. HCFA could not tell us why the sixth cost report was excluded and agreed it should have been included. In reviewing a sample of cost reports to assure that the data were correctly entered into the data base, we also identified a cost report which HCFA had included in the data base which should have been excluded because it did not cover a full year.

1/Some of the difference among the numbers can be explained by cost reporting practices of multilocation home health agencies. Subunits of such agencies have their own provider numbers. However, subunit costs are combined into one cost report for the agency. This explains to an extent the difference between the number of providers submitting claims (that is, with a provider number) and the number of cost reports.

2/Two of these were not reviewed because complete information was not received from the intermediary.

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To determine the impact of incorrectly excluding the six cost reports and improperly including one cost report, we corrected the data base for these errors. These 7 changes (out of a total of almost 2,000) resulted in decreasing 6 of the 21 proposed limits and increasing 7 of them, as shown in the following table.

Type of visit	Proposed limit	Adjusted limit	Increase or decrease (-)
SMSA freestanding:			
Skilled nursing	$46.67	$46.66	-$.01
Speech therapy	47.63	47.70	.07
Occupational therapy	48.96	49.04	.08
Medical social service	52.52	52.54	.02
SMSA facility-based:			
Skilled nursing	$58.33	$58.42	$.09
Physical therapy	51.73	51.74	.01
Speech therapy	51.53	51.56	.03
Occupational therapy	54.23	53.66	-.57
Medical social service	59.35	58.53	-.82
Home health aide	50.61	50.62	.01
Non-SMSA freestanding:			
Skilled nursing	$44.27	$44.17	-$.10
Physical therapy	47.54	47.11	-.43
Home health aide	30.64	30.56	-.08

USE OF UNSETTLED COST REPORTS COULD INFLATE LIMITS

Of the 1,926 cost reports in the data base, 795 (41 percent) had not been settled by the intermediaries. The settlement process includes desk audits and/or field audits of the cost reports. This process determines what portion of the reported costs Medicare determines to be reasonable costs for reimbursement purposes and normally results in increases or decreases to the amount of reported costs. Medicare intermediary provider cost report audit statistics show that on the average during the settlement process Medicare reasonable costs were lowered by about 3.5 percent.

HCFA made no adjustment to unsettled cost reports when computing the proposed limits to account for decreases in reported costs resulting from the settlement process. Therefore, we adjusted downward the costs of the unsettled reports and rearrayed the resulting costs per visit. We

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made this adjustment only for freestanding agencies; we did not attempt to do so for facility-based agencies. The resulting changes in the proposed limits are presented in the following table.

Type of visit	Proposed limit	After settlement adjustment	Decrease
SMSA freestanding:			
Skilled nursing	$46.67	$45.40	$1.27
Physical therapy	45.87	45.21	.66
Speech therapy	47.63	47.03	.60
Occupational therapy	48.96	48.24	.72
Medical social service	52.52	51.77	.75
Home health aide	34.94	34.59	.35
Non-SMSA freestanding:			
Skilled nursing	$44.27	$43.60	$ .67
Physical therapy	47.54	47.54	-
Speech therapy	46.14	45.48	.66
Occupational therapy	56.85	54.89	1.96
Medical social service	42.78	42.78	-
Home health aide	30.64	30.38	.26

DIFFERENT COST REPORTING METHODS AFFECT PROPOSED LIMITS

Home health agencies can report their costs to Medicare by using one of five methods:

--A single combined cost for all types of services (used by 133 of the 1,926 agencies in the data base).

--A single combined cost for all types of services computed by applying the ratio of Medicare charges to total charges multiplied by covered costs (used by 443 agencies).

--A separate cost for each type of service provided (used by 1,008 agencies).

--Two separate costs, one for home health aide visits and for the other for all other types of visits (used by 284 agencies).

--Any other method approved by the agency's intermediary (used by 58 agencies).

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For agencies using the first method, HCFA used the same cost per visit for all of the types of visits provided when computing the proposed limits. This could result in distorted limits because the costs are not the same for each type of visit. The cost reports which give cost by type of visit clearly show that costs vary significantly by type of visit. Skilled nursing visits normally cost substantially more to provide than home health aide visits. Also, the various therapy visits and medical social service visits generally cost more to provide than skilled nursing visits. Using the same cost per visit for all types of visits could result in lowering the limit for skilled nursing visits and increasing the limit for home health aide visits.

For agencies using the ratio of charges method, HCFA used procedures designed to allocate the costs among the various types of service. Because of deficiencies in the procedures, a number of problems arose. These are discussed in more detail in the next section.

For agencies using the fourth method (a cost for home health aide visits and a cost for all other types of visits), HCFA used the same cost for all visits except home health aide. This could lead to the same problems as discussed under the first method; that is, lowering the limits for higher cost visits and raising the limits for lower cost visits. However, because this method does separate home health aide visits, the least costly, from the other types of visits, the impact of this method on the limits should have been less.

On February 15, 1980, HCFA issued proposed regulations which would require all home health agencies other than those associated with a facility to use a uniform cost finding method. Such a change would allow HCFA to make a more meaningful analysis of cost. For agencies associated with a facility, cost would continue to be reported under the cost finding method of a ratio of Medicare charges to total charges as applied to covered costs. A HCFA official informed us that they planned to require facility-based providers to eventually report on a cost per visit basis.

INADEQUATE PROCEDURES FOR DETERMINING NUMBER AND COSTS OF EACH TYPE OF VISIT

For agencies which report their costs without breaking them down by type of visit (at least 850 of the 1,926 agencies in the data base) and for agencies which do not report

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the number of visits by type of visit (again at least 850 agencies), HCFA had to design procedures for allocating the total costs and total visits among the different types of visits. These procedures involved the use of data from HCFA's paid claims data base. This data base maintains for each home health agency by its cost reporting year the number of, and charges for, each type of visit provided during the cost reporting year, which have been paid up to the date data are extracted. For example, if home health agency A has a cost reporting year ended June 30, 1978, and the paid claim data base is queried in September 1979, it will provide the number of and the charges for each type of visit provided during the year ended June 30, 1978, which had been paid through August 1979.

Medicare cost reporting requirements provide that normally cost reports are to be completed on an accrual basis; that is, costs are reported in the year they are incurred regardless of when they are paid and revenues are reported in the year they are earned regardless of when payment is received. Thus, cost reports should include all of a home health agency's incurred costs and all of its earned revenue. However, in reviewing a sample of cost reports and the information in the paid claims data base, we identified a number of problems which lead us to question whether some cost reports had been prepared accurately. Also, we identified problems with HCFA's procedures for allocating visits and costs among the different types of visits.

To allocate the aggregate number and costs of visits among the types of service, HCFA used the information in the paid claims data base as of April 1979. HCFA developed a set of three formulas to do this allocation. The net effect of the formulas was to allocate the total data on the cost report on the basis of the ratio of the information in the paid claims data base. However, the procedures for determining which data to use in applying the formulas were incomplete and did not cover all possible situations. As a result, the total number of visits on the cost reports was used even in cases where the paid claims data raised questions about the accuracy of the cost report data. This in turn could result in an understatement of the number of visits and overstatement of the cost per visit, which could result in the proposed reimbursement limits being set too high. The following example illustrates the problem.

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For one SMSA facility-based agency we reviewed, HCFA used 2,461 visits from the cost report although the number of visits in the paid claims data base was 3,708, thus understating the number of visits by 1,247. This resulted in HCFA's using a cost per vsit of $49.33 in its methodology for establishing the proposed limits for skilled nursing visits instead of $40.36 which would result from using the paid claim data base visits. This represented a possible overstatement of $8.97 for this agency.

We noted a number of instances where the paid claims data base showed that more visits had been provided by an agency than was shown on the cost report but the number of visits on the cost report was used because it was HCFA's policy to use the cost report data. Because the paid claims data base includes information on claims actually paid, we believe that the number of visits in that data base could be more accurate than the data on the cost reports, especially when visits in the paid claims data base exceeded visits on the cost reports. 1/

Therefore, we obtained the information included in the paid claims data base and recomputed the cost per visit for SMSA facility-based skilled nursing and home health aide visits and for non-SMSA facility-based physical therapy visits. For all agencies with costs above HCFA's proposed limits and for the first 20 agencies with costs below these limits, we recomputed the cost per visit by dividing HCFA's allocated costs for the type of visit in question by the number of visits of that type in the paid claims data base as of January 1980. 2/ We rearrayed the agencies in descending order of cost per visit and found that this analysis would significantly change the limits proposed by HCFA as follows:

1/Theoretically, the number of visits in the paid claims data base cannot exceed the number of visits on the cost report because the cost report is supposed to be prepared on an accrual basis. However, if the cost report is incorrectly filled out, this situation can occur.

2/This computation assumes that the proportion of each type of visit to the overall total number of visits in the paid claims data base did not change from April 1979 (the date HCFA used to allocate costs) and January 1980. We have no reason to believe these proportions would have changed significantly.

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SMSA	Number of agencies for which new cost computed	Proposed cost limit	Recomputed cost limit	Increase or decrease (-) in cost
Skilled nursing	53	$58.33	$57.61	$-.72
Home health aide	52	50.61	49.26	-1.35
Non-SMSA				
Physical therapy	38	$44.68	$46.10	$1.42

In doing the above analysis, we found that, for 7 of the 53 (13 percent) SMSA facility-based agencies reviewed, the sum of the charges per type of visit in the paid claims data base did not equal the total charges listed in that data base. In computing its proposed limits, HCFA used the sum of the charges rather than the total charges. Information we obtained from the intermediaries for the seven agencies showed that the total charges data represented the correct amount. Using the sum of charges could result in substantial errors in the HCFA computed cost per visit for the 7 agencies. Because we could not satisfactorily determine the data necessary to determine the cost per visit for these agencies, we deleted them from the data base (as HCFA had done for some other agencies for which it could not identify all necessary data). This had a substantial impact on the level of the 80th percentile of costs as follows.

Type of service	Proposed limit	Recomputed limit	Decrease
Skilled nursing	$58.33	$55.42	$2.91
Physical therapy	51.73	51.16	.57
Speech therapy	51.53	51.41	.12
Occupational therapy	54.23	53.14	1.09
Medical social service	59.35	56.16	3.19
Home health aide	50.61	50.23	.38

In addition we found that for 6 of the 191 agencies' cost reports (3 percent) we reviewed during the various analyses discussed in this report, HCFA had used data from the paid claims data base for periods which did not match the period of the cost report. Therefore, we excluded these agencies from the data base and recomputed the 80th percentile of costs with the following results:

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Type of service	Proposed limit	Recomputed limit	Increase or decrease (-)
SMSA facility-based:			
Skilled nursing	$58.33	$58.26	$-.07
Physical therapy	51.73	50.20	-1.53
Speech therapy	51.53	50.91	-.62
Occupational therapy	54.23	53.91	-.32
Medical social service	59.35	58.28	-1.07
Home health aide	50.61	50.81	.20
Non-SMSA facility-based:			
Skilled nursing	$46.83	$46.08	$-.75
Physical therapy	44.68	42.83	-1.85
Home health aide	42.37	41.89	-.48
SMSA freestanding:			
Skilled nursing	$46.67	$46.66	$-.01
Physical therapy	45.87	45.80	-.07
Speech therapy	47.63	47.42	-.21
Occupational therapy	48.96	48.87	-.09
Medical social service	52.52	52.40	-.12
Home health aide	34.94	34.90	-.04

INCORRECT APPLICATION OF THE 80th PERCENTILE FORMULA

HCFA's methodology called for using a standard statistical formula for determining where in the arrayed cost per visit data the 80th percentile of costs fell. As a result of an error in the computer program designed to use the formula, the 80th percentile was incorrectly calculated. We computed the 80th percentile, which resulted in lowering the proposed limits as follows.

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	Facility Based					
		SMSA			Non-SMSA	
	Proposed	Adjusted	Decrease	Proposed	Adjusted	Decrease
Skilled Nursing	$56.33	$57.91	$ .42	$46.83	$46.34	$ .49
Physical Therapy	51.73	51.66	.07	44.68	44.34	.34
Speech Therapy	51.53	51.45	.08	46.14	45.84	.30
Occupational Therapy	54.23	53.78	.45	56.85	56.84	.01
Medical Social Service	59.35	58.84	.51	42.78	42.74	.04
Home Health Aide	50.61	50.56	.05	42.37	42.23	.14

	Free Standing					
		SMSA			Non-SMSA	
	Proposed	Adjusted	Decrease	Proposed	Adjusted	Decrease
Skilled Nursing	$46.67	$46.65	$ .02	$44.27	$44.19	$ .08
Physical Therapy	45.87	45.77	.10	47.54	47.19	.35
Speech Therapy	47.63	47.55	.08	46.14	45.84	.30
Occupational Therapy	48.96	48.85	.11	56.85	56.84	.01
Medical Social Service	52.52	52.44	.08	42.78	42.74	.04
Home Health Aide	34.94	34.93	.01	30.64	30.57	.07

When we pointed out this error to HCFA officials, they said it would be corrected before the proposed limits are finalized.

DUPLICATION OF HIGH COST ALLOWANCE

In reviewing the application of the proposed cost limits, we noted that an add-on adjustment for providers in Alaska and Hawaii would be allowed. For example, a home health agency in Alaska could incur an additional 25 percent in cost over its basic computed cost limit because of the increased costs these agencies incur in operating their businesses. We pointed out to HCFA that the wage index and add-on were duplicative in nature. HCFA officials agreed and told us that before finalizing the proposal it would be made clear that the add-on would apply only to the nonwage portion of the agencies' costs.

OTHER PROBLEMS WERE IDENTIFIED BUT IMPACT NOT DETERMINED

During our review we noted several other problems. We did not fully evaluate the impact of these problems; however, the impacts could be substantial. For example, a facility-based home health agency rendered a full range of home health services. HCFA, in entering the agency's costs into the data

base, showed a cost per visit only for skilled nursing, physical therapy and home health aide visits. HCFA officials were unable to explain the reason for the error. It appears, from our analysis of the cost report and billing data, that HCFA used only part A 1/ visits for skilled nursing, physical therapy, and home health aides to determine the number of visits rendered. The visits rendered under part B and the remainder of the part A services were added together and entered as "other visits," for the purpose of allocating the agency's cost. This other visit category was not considered in developing the limits. We corrected this agency's data in the data base. This resulted in the limits for SMSA facility-based agencies for occupational therapy, medical social services, and speech therapy being decreased by $.57, $.70, and $.09, respectively.

IMPACT OF PROPOSED LIMITS

HCFA estimated that the proposed reimbursement limits would save the Medicare program $34 million in fiscal year 1981. 2/ These estimated savings would result from limiting the reimbursement for home health care provided by about 700 agencies whose costs would exceed the proposed limits. Because of the problems we found with the data base, we could not verify HCFA's estimate.

To determine what impact the proposed cost limits would have on home health agencies, we contacted intermediary officials and regional HCFA officials. Half of the 14 intermediary officials familiar with the proposed regulation and officials from both regional HCFA offices believed the proposed limits would have little impact on the agencies in their area. The other officials expressed various views with regard to the impact on home health agencies.

ALTERNATIVE PAYMENT METHODS

Because of the problems with HCFA's data base we were unable to evaluate any specific alternative payment methods.

1/Medicare provides two types of insurance programs--hospital insurance (part A) and supplemental medical insurance (part B). Home health services are covered under both parts.

2/The proposed limits apply only to Medicare. Currently there is no regulatory authority to apply Medicare reimbursement limits to Medicaid.