United States General Accounting Office 131879

GAO

Report to the Chairman, Special Committee on Aging United States Senate

December 1986

MEDICARE

Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs

GAO

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

Human Resources Division

B-225004

December 2, 1986

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate

Dear Mr. Chairman:

This report on the Medicare home health program covers three broad themes—(1) the effectiveness of program controls, (2) the characteristics of home health users, and (3) the extent of unmet home care needs reported by a sample of chronically ill elderly.

As you have requested, we did not discuss the report's contents with, or obtain comments from, the Department of Health and Human Services. Also, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will provide copies to the Secretary of Health and Human Services; the Director, Office of Management and Budget; and other interested parties.

Sincerely yours,

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

About 5 million chronically ill elderly live in the community. Because of their illnesses, such individuals typically need assistance with some of their daily activities (such as getting in and out of bed or dressing). Other elderly need similar home care assistance on a short-term basis after hospital care.

While families and friends provide most home care assistance, Medicare paid about $1.7 billion for home health care services in fiscal year 1985— more than six times the amount paid in 1976. The Medicare home health benefit is intended to provide skilled nursing assistance to the elderly. In addition to medical services, the benefit covers personal care and, to a limited extent, homemaker services (such as washing clothes).

Because of the lack of adequate alternative sources of home care services, the Medicare home health benefit is also being used to meet the needs of the chronically ill. Attempting to limit the benefit to short-term assistance could, therefore, increase these persons' unmet need for home care assistance. This, coupled with the rapidly expanding elderly population, heightens the need to consider alternative ways to meet the home care needs of the chronically ill.

The Chairman, Senate Special Committee on Aging, requested that GAO review the Medicare home health program to determine

- the status of efforts to strengthen internal controls to prevent payment for services not covered by Medicare and
- how many chronically ill elderly have home care needs that are unmet by either Medicare or other caregivers.

Background

To be eligible for home health care, a Medicare beneficiary must be confined to his or her residence (homebound), under a physician's care, and in need of part-time or intermittent skilled nursing care.

The Department of Health and Human Services (HHS) contracts with intermediaries, usually insurance companies such as Blue Cross and Aetna, to administer the home health benefit. To prevent and recover payments for noncovered home health services, intermediaries evaluate claims both before payment (prepayment utilization review) and after payment (postpayment utilization review).

GAO reviewed records and interviewed appropriate officials at HHS headquarters, at 7 of its regional offices, and at 13 of the 47 home health intermediaries to evaluate the adequacy of internal controls over payments for Medicare home health services.

Results in Brief

Reviews by GAO in 1981 and by HHS in 1984 identified material weaknesses in internal controls over payment for Medicare home health services. HHS's review estimated that these weaknesses resulted in improper payments of almost $600 million in fiscal year 1984. HHS, however, has been slow to implement changes to strengthen management controls in response to GAO's 1981 recommendations. More information is now available on which intermediaries can base payment decisions, but HHS needs to better explain what services are covered and how to review payment claims to identify noncovered services. In addition, HHS needs to make intermediaries more accountable for their payment decisions and strengthen sanctions against home health agencies that consistently abuse the program.

Concerns expressed by the home health industry and others about the effects tighter program controls would have on Medicare beneficiaries' ability to obtain needed home care services have been cited by HHS as a major cause for delays in implementing such controls. HHS has not, however, evaluated available data to determine what effect stronger controls would have on unmet need for home care assistance.

GAO presents two analyses of the characteristics and unmet needs of the chronically ill elderly that could provide a starting point for such an evaluation. Further analyses are needed, however, to determine such things as (1) why Medicare beneficiaries were unable to obtain all the help they needed and (2) what types of home health users are most likely to have unmet needs or to receive noncovered services. Such information could assist the Congress, HHS, and the states in considering policy options for meeting the future home care needs of the growing elderly population.

Principal Findings

Audit Findings Not Promptly Resolved

Standards for internal controls in the federal government require prompt resolution of audit findings. HHS agreed with, but has not implemented, GAO's recommendation that it develop prepayment screens to help detect noncovered services and that it clarify criteria for determining such things as when a beneficiary is homebound and when home health aide services are covered by Medicare. Another GAO recommendation, that intermediaries obtain sufficient information from home health agencies to make appropriate payment decisions, was not implemented until August 1985. (See ch. 3.)

HHS did promptly implement GAO's recommendation to establish a postpayment utilization review program for home health agencies. The program, established in 1982, focuses on home health agencies that provide significant amounts of noncovered care. Its effectiveness could be improved, however, by strengthening the sanctions against aberrant home health agencies.

Although intermediaries denied about 14.4 percent of the home health visits reviewed during calendar year 1984, cost recoveries from the aberrant agencies were limited to the cost of the services denied for a sample of 20 beneficiaries provided services by the agency during a 3-month period. By using statistically valid sampling techniques, overpayments to the home health agencies could have been projected over the sampling period, increasing recoveries about 400 percent. In calendar year 1984, that would have resulted in an additional $12.9 million in home health claims being denied. (See ch. 4.)

Appropriateness of Payment Decisions Not Reviewed

HHS assesses the performance of intermediaries annually to determine whether they should continue processing Medicare claims. The assessments do not, however, evaluate the appropriateness of intermediaries' payment decisions on home health claims. A 1984 HHS review found that intermediaries denied only one-fifth of the claims that should have been denied under postpayment reviews. An HHS official said that similar performance problems exist with prepayment reviews. (See ch. 5.)

Unmet Home Care Needs

Medicare was not intended to meet all of the home care needs of the elderly. To determine whether other caregivers were meeting those

needs that were not being met through Medicare, GAO analyzed data from a 1982 national sample of chronically ill elderly, the most recent nationally available data.

About 168,000 (5 percent) of the chronically ill elderly lacked needed assistance with activities of daily living, such as bathing, dressing, getting around inside the house, getting in and out of bed, using the toilet, and eating. Another 1.1 million chronically ill elderly lacked needed assistance with such key day-to-day activities as grocery shopping, managing money, and transportation.

Several alternatives have been suggested for meeting the home care needs of the growing elderly population. The availability of home care services could be increased by expanding coverage under Medicare, Medicaid, or private health insurance. Tax incentives could be provided to family and friends to encourage informal caregiving. Additional funds could be made available under block grants to encourage expansion of community-based services. But the analytical work needed to assess the advantages and disadvantages of such options is far from complete. (See ch. 6.)

Recommendations

GAO is making several recommendations to the Secretary of HHS to strengthen the utilization review programs, improve the performance of fiscal intermediaries, and study ways to meet the home care needs of the elderly. (See pp. 37, 42, 48, and 58.)

Agency Comments

GAO did not request official agency comments on a draft of this report.

Contents

Executive Summary		2
Chapter 1 Introduction		10
	Medicare Home Health Care	10
	Home Health Agencies	11
	Program Administration	12
	Noncovered Services Continue to Add Millions to Medicare Costs	13
	Objectives, Scope, and Methodology	13
Chapter 2 Types and Characteristics of Medicare Home Health Users		18
	How the Analysis Was Performed	18
	Characteristics of Medicare Home Health Users	20
	Types of Home Health Users	22
	Conclusions	27
Chapter 3 Progress and Problems in Developing an Effective Prepayment Utilization Review Program		28
	HHS Has Not Reported Internal Control Weaknesses	28
	New Forms Provide Uniform Data	29
	Uniform Screening Guidelines Have Not Been Developed	31
	Coverage Criteria Have Not Been Clarified	32
	Conclusions	37
	Recommendations	37
Chapter 4 Improvements Needed in Postpayment Utilization Review Program		38
	Description of the Program	38
	Use of Valid Sampling Techniques Could Increase Recovery of Overpayments	39
	Poor Intermediary Performance Limits Program Effectiveness	40
	Conclusions	41
	Recommendation	42

Chapter 5 Actions Needed to Improve Intermediary Performance — 44
Better Intermediary Evaluations Needed — 44
Prepayment Utilization Review Denial Rates Should Not Be Used to Compare Intermediary Performance — 45
Switch to Regional Intermediaries May Not Improve Program Management — 47
Conclusions — 48
Recommendations — 48

Chapter 6 Elderly Who Lack Long-Term Care Assistance — 50
Elderly With Unmet Home Care Needs — 50
Characteristics of the Unmet Needs Groups — 52
Further Analyses of Unmet Need Would Be Helpful in Reaching Policy Decisions — 54
Conclusions — 57
Recommendation — 58

Appendixes
Appendix I: Prior GAO Reports on Home Health Care — 60
Appendix II: Methodology for Analysis of Home Health Users — 61

Tables
Table 2.1: Characteristics of a National Sample of Medicare Home Health Users, 1982 — 21
Table 2.2: Types of Home Health Users From the 1982 National Long-Term Care Survey — 24
Table 2.3: Personal Characteristics of Five Home Health User Types — 27
Table 4.1: Denial Rates for a Sample of Services — 41
Table 6.1: Percent Distribution of the Elderly With Unmet and Met Needs by Their Disability Levels — 52
Table 6.2: Source and Amount of Caregiver Assistance for the Chronically Ill Elderly — 53

Figure
Figure II.1: 1982 Data Bases Used in Analysis of Home Health Users — 65

Abbreviations

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services

Introduction

Home health care is generally defined as health care prescribed by a physician and provided to a person in his or her own home. The Medicare program, the largest single payer of home health services, paid home health agencies over $1.7 billion during fiscal year 1985, about six times the $287 million paid in 1976. The Congressional Budget Office has predicted that, largely because of the growing number of elderly beneficiaries, Medicare home health expenditures will increase an average of 20 percent a year between 1985 and 1989.

In 1981 we identified numerous problems in the internal controls over payments for Medicare home health services. We reported that the internal control weaknesses resulted in improper or questionable payments for 27 percent of the Medicare home health visits reviewed.[1] Similar internal control problems had been cited in a series of GAO reports dating from 1974 (see app. I).

In response to a request from the Chairman, Senate Special Committee on Aging, and later discussions with the Chairman's office, we reviewed the Medicare home health program to determine (1) whether internal controls have improved since our 1981 report, (2) the characteristics of Medicare home health beneficiaries, and (3) the extent to which the chronically ill elderly have home care needs that are unmet by Medicare, informal caregivers, and other sources.

Medicare Home Health Care

Medicare, administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS), is a health insurance program that covers almost all Americans age 65 and over and certain individuals under 65 who are disabled or have chronic kidney disease. The program, authorized under title XVIII of the Social Security Act, provides protection under two parts. Part A, the hospital insurance program, covers inpatient hospital services and certain post-hospital care in skilled nursing homes and patients' homes. Part B, the supplementary medical insurance program, covers primarily physician services. Although home health care is financed under both parts, over 98 percent of home health is paid under part A.

Medicare home health benefits are, by law, oriented toward skilled nursing care. They were not designed to provide coverage for care related to helping with daily living needs unless the patient also

[1] Medicare Home Health Services: A Difficult Program to Control (GAO/HRD-81-155, Sept. 25, 1981).

required skilled nursing care or physical or speech therapy. Medicare home health services include

- part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse,
- physical, occupational, or speech therapy,
- medical social services to help patients and their families adjust to social and emotional conditions related to the patients' health problems,
- part-time or intermittent home health aide services,[2] and
- certain medical supplies and appliances.

To qualify for Medicare home health care, a person must be confined to his or her residence (homebound), be under a physician's care, and need part-time or intermittent skilled nursing care and/or physical or speech therapy. The services must be furnished under a plan of care prescribed and periodically reviewed by a physician.

Home Health Agencies

Medicare home health services can be furnished by a Medicare-certified home health agency or by others under contractual arrangements with such an agency. To participate in the program, home health agencies must meet specific requirements of the Social Security Act. The act defines a home health agency as a public agency or private organization primarily engaged in providing skilled nursing services and other therapeutic services.

The number of Medicare-certified home health agencies increased from 2,212 in 1972 to 5,755 in 1985. The growth has primarily taken place in facility-based and for-profit home health agencies, while the number of more traditional nonprofit home health providers—visiting nurse associations and government agencies—has declined slightly.[3]

The growth in for-profit home health agencies can be attributed, in part, to provisions in the Omnibus Reconciliation Act of 1980, permitting for-profit agencies to participate in Medicare in states that do not require licensing of home health agencies. Before this legislation, only licensed for-profit agencies could be Medicare certified. Between 1982 and 1985,

[2]Home health aides, among other things, help patients bathe, groom, get into and out of bed, use the bathroom, take self-administered medications, and exercise.

[3]Visiting nurse associations are generally community-based agencies supported by contributions and patient fees. Official (government) agencies consist mostly of county or local public health departments. Facility-based agencies include hospitals, skilled nursing facilities, and rehabilitation-based agencies.

the number of for-profit agencies increased about 192 percent, from 628 to 1,832.

Program Administration

HCFA administers the home health care program through fiscal intermediaries. Intermediaries, which include Blue Cross and Blue Shield plans and other insurance companies, such as Aetna Life and Casualty and Prudential,

- make payments for services provided by home health agencies,
- serve as a communication channel between home health agencies and HCFA, and
- establish and apply payment safeguards to prevent program abuse.

As of December 1985 there were 47 intermediaries administering the home health program under HCFA's direction. HCFA plans to consolidate program administration under 10 regional intermediaries in October 1986.

To prevent and recover payments for noncovered home health services,[4] intermediaries can evaluate claims both before payment (called prepayment utilization review) and after payment (called postpayment utilization review). Prepayment reviews emphasize avoidance of an inappropriate payment, while postpayment reviews emphasize the analysis of paid claims data to identify home health agencies that provide services in excess of established norms.

At the time of our 1981 report, intermediaries performed only prepayment utilization reviews for home health services. In response to a requirement in the Omnibus Budget Reconciliation Act of 1981, HCFA implemented a postpayment utilization review program, known as coverage compliance review, in 1982.

[4]Noncovered services include those that are (1) not reasonable or medically necessary, (2) provided to beneficiaries who are not homebound, and (3) in excess of the approved plans of treatment.

Noncovered Services Continue to Add Millions to Medicare Costs

In 1984, HCFA completed a study of the extent of payments for services not covered under the Medicare home health benefit;[5] this study was similar to the one we completed in 1981. HCFA concluded that 34 percent of the services paid for by the intermediaries reviewed during the 3-month period were not covered by Medicare.

Extrapolating the amount of noncovered care found during its review to the total home health care payments for 1984, HCFA estimated that almost $600 million in payments may have been for noncovered services. While not a statistically valid projection, it provides an indication of the problem's magnitude. HCFA predicted that home health agencies could be reimbursed about $4.1 billion for noncovered services over the next 5 years[6] if expected increases in demand for home health services occur and program controls are not strengthened.

Objectives, Scope, and Methodology

Our overall objectives were to (1) evaluate HCFA's efforts to strengthen internal controls over payments for Medicare home health services, (2) assess the characteristics of Medicare home health beneficiaries (see ch. 2), and (3) estimate the number of chronically ill elderly whose home health care needs are not met by Medicare or other caregivers (see ch. 6).

Our 1981 report and HCFA's 1984 study identified a number of internal control weaknesses that resulted in extensive Medicare payments for noncovered home health services. We limited our follow-up efforts to evaluating actions to correct internal control weaknesses that permit improper payments to be made rather than again measuring the extent to which such weaknesses were actually resulting in improper payments. Accordingly, our specific objectives were to (1) identify and evaluate actions HCFA has taken to strengthen prepayment and postpayment utilization review of home health care claims (see chs. 3 and 4), (2) assess the effectiveness of HCFA evaluations of intermediary performance on home health reviews (see ch. 5), and (3) evaluate HCFA's selection of 10 regional fiscal intermediaries (see ch. 5).

[5]HCFA used a team of nurse reviewers to analyze medical records for 1,025 beneficiaries selected from a sample of 39 home health agencies. Five fiscal intermediaries serviced the agencies. The records represented 15,190 visits provided to the 1,025 beneficiaries starting in April and extending to June 1984. The nurse panel reviewed fiscal intermediaries' payment decisions on a sample of the 15,190 total visits.

[6]HCFA derived this figure by taking about one-third of projected payments for fiscal years 1985-89. It is a rough approximation made by extrapolating the extent of noncovered care (34 percent) found during the 3-month period of 1984. It is not a statistical projection.

Our work was done primarily at HCFA headquarters in Baltimore and its regional offices in Atlanta, Boston, Chicago, Dallas, Kansas City, New York, Philadelphia, and San Francisco. We also obtained data from 13 fiscal intermediaries: Aetna Life and Casualty Company of Florida; Prudential Insurance of New Jersey; and the Blue Cross and/or Blue Shield plans in California, Greater Philadelphia, Illinois, Iowa, Maine, Massachusetts, Michigan, New Mexico, South Carolina, Texas, and Wisconsin. We selected the 13 intermediaries to include the 10 selected by HCFA to become regional intermediaries. The 13 intermediaries accounted for about 60 percent of all home health claims submitted in fiscal year 1985. We visited 6 of the 13 intermediaries, including the 3 not selected as regional intermediaries (Blue Cross and/or Blue Shield plans of Massachusetts, Michigan, and Texas) and 3 of those selected (Aetna of Florida, Blue Cross of California, and Blue Cross of Greater Philadelphia) to obtain further information. We conducted structured interviews to obtain staffing, workload, and performance data and opinions concerning intermediary operations and HCFA's implemented and planned program changes.

We reviewed pertinent laws, regulations, and policies; agency and intermediary records; and studies relating to home health care. Specifically, we reviewed a 1984 HCFA study on intermediary controls over the use of home health services, which evaluated a sample of home health agency visits provided during April to June 1984 to determine if the services should have been paid by Medicare. To validate the study's results, we assessed its sampling design, scope, and methodology.

To identify and assess the effectiveness of changes in the prepayment utilization review program, we

- identified and evaluated HCFA's actions taken in response to our 1981 recommendations,
- compared the amount of information provided on HCFA's new medical information forms to information contained on forms developed by the fiscal intermediaries reviewed,
- discussed the new medical information forms and other changes in the prepayment utilization review process with officials from the intermediaries visited to obtain their views on the strengths and weaknesses of the new forms,
- discussed with HCFA officials the status of efforts to develop national prepayment screens, and

- obtained the views of the American Federation of Home Health Agencies and the National Association for Home Care on the implemented and planned changes in the prepayment review process.

To determine the effectiveness of the postpayment utilization review program, we

- reviewed HCFA's 1984 findings on the internal study of the home health benefit regarding postpayment reviews;
- obtained and analyzed data on postpayment utilization review costs, benefits (charges for denied and recoverable services), and results (number and percent of denials, types of denials);
- obtained data from the intermediaries reviewed on postpayment review staffing, workload, denials, and home visits;
- discussed the strengths and weaknesses of the postpayment review program with officials from the intermediaries visited;
- reviewed the sampling methodology used in physician postpayment utilization reviews to determine whether a similar method could be used to project results under the postpayment utilization review program; and
- compared the postpayment review denial rates for the intermediaries reviewed.

To assess the effectiveness of HCFA evaluations of intermediary performance and selection of regional intermediaries, we

- reviewed the methods the intermediaries visited used to calculate prepayment utilization review denial rates to determine whether the rates could be used for intermediary comparisons,
- obtained and analyzed denial rate data from HCFA and the intermediaries reviewed,
- reviewed the contractor performance evaluation program to identify and analyze the elements related to home health,
- obtained the views of HCFA officials and officials from the intermediaries visited on the strengths and weaknesses of the evaluations, and
- reviewed contractor performance evaluation program results and prepayment and postpayment utilization review denial rates for the 10 regional intermediaries to assess their prior performance related to home health.

To determine the characteristics of Medicare home health beneficiaries and their unmet needs for home health care, we

- matched data from 1982 Medicare part A and part B utilization records[7] to the 1982 National Long-Term Care Survey,
- applied a patient classification methodology known as Grade of Membership analysis to the matched data base to identify types of home health users and their characteristics,
- analyzed data from the National Long-Term Care Survey on unmet needs for assistance with activities of daily living and independent activities of daily living, and
- reviewed prior studies relating to unmet need.

Additional details on the development and analysis of the matched data base are discussed in appendix II.

At the request of the Senate Special Committee on Aging, we did not obtain comments on a draft of this report from HHS. Otherwise, our work was performed in accordance with generally accepted government auditing standards.

[7]Medicare admission information and billing forms are used by HCFA to create utilization records. These records include enrollment data, admission information, and billing data. These data indicate the volume and type of services used and program payments for such services.

Types and Characteristics of Medicare Home Health Users

HHS has had little information about who has been using home health care, how they have been using it, and whether their characteristics have been changing over time. As discussed in chapter 6, this information could be used to identify patterns of home health overuse and underuse and could assist HHS in better conveying to intermediaries, providers, and beneficiaries the appropriate role of Medicare home health in meeting the needs of the elderly.

Our analysis of a national sample of 1982 Medicare beneficiaries showed that the home health benefit was normally used on a relatively short-term basis by persons who had been hospitalized. On average, chronically ill Medicare beneficiaries—about half of all home health users—used more home health care and were considerably more disabled. We identified five distinct types of chronically ill home health users ranging from beneficiaries with no serious medical conditions or physical impairments to beneficiaries with multiple health problems who were unable to perform any functional activities.

How the Analysis Was Performed

We matched respondents from the 1982 National Long-Term Care Survey with their Medicare payment data for 1982. The matched data were then separated into two data bases. The first was of a national sample of home health users—about 3.5 percent of all elderly Medicare enrollees. The second represented a national sample of chronically ill home health users—about half of all home health beneficiaries.

HHS had the Bureau of the Census conduct the National Long-Term Care Survey to identify the personal characteristics of the long-term care elderly population living in the community. To identify this long-term care population—defined as persons with functional impairments of 3 months or longer—Census telephoned a random sample of 36,000 of the estimated 28.3 million elderly beneficiaries and asked them questions about their functional limitations. Census interviewers then conducted in-person detailed interviews with about 5,600 persons identified from the telephone interviews as chronically ill. This survey gathered information about medical conditions, functional limitations, availability of paid and unpaid help, housing arrangements, and medical care utilization. These 5,600 persons represented 4.6 million elderly.[1] In 1984, follow-up interviews were conducted to determine changes in the health

[1]Initially 6,393 elderly persons contacted by telephone were identified as chronically disabled, and 6,088 were located for the in-person household survey. Of the 6,088, 5,583 persons fully completed the survey and were considered to have long-term care needs.

status of the chronically ill. These data were not available when we completed our analysis.

One component of the survey identified chronic functional limitations. The first set of limitations identified were activities of daily living limitations. These limitations form a ranking of personal care dependencies that have been developed as a way of defining level of long-term care service needs. The limitations in activities of daily living were problems in (1) bathing, (2) dressing, (3) getting around inside the house, (4) getting in and out of bed, (5) getting to the bathroom or using the toilet, and (6) eating. The second set of limitations identified were limitations in instrumental activities of daily living, which measure the ability to conduct household and mobility tasks. These limitations caused problems in (1) preparing meals, (2) doing laundry, (3) doing heavy work, (4) grocery shopping, (5) managing money, (6) taking medicine, (7) making telephone calls, (8) doing light work, (9) getting around outside, and (10) going places outside of walking distance. Limitations in instrumental activities of daily living are considered less serious than limitations in activities of daily living.

To determine the survey respondents' use of Medicare hospital, home health, and skilled nursing facility services, we obtained 1982 Medicare claims data for the 36,000 elderly selected as the survey's sample universe. The data we used included the number of bills, total charges and reimbursements, and the number of home health visits.[2]

We matched the Medicare claims data to both the 36,000 national sample and the 5,600 long-term care sample and developed information about the use of Medicare hospital, skilled nursing facility, and home health care among both groups. Our analysis of the national data is more limited than our analysis of the long-term care data, however, because the telephone interviews collected only limited data. The methodology used to develop the information presented in this chapter is discussed in more detail in appendix II.

[2]These data did not reflect payment changes that may have occurred after provider cost reports were settled and audited.

Characteristics of Medicare Home Health Users

Nationally, home health beneficiaries were likely to be (1) older women, (2) in poor health, and (3) hospitalized twice during the year they received home health care. About 13 percent of all Medicare beneficiaries who were hospitalized and about 22 percent of those who were admitted to a Medicare skilled nursing facility received home health care at some time during the year. Because of their extensive use of other Medicare services, home health users accounted for a disproportionate share of Medicare expenditures. While only about 15 percent of Medicare beneficiaries using part A services during 1982 received home health care, the home health users accounted for about 29 percent of part A expenditures.

Overall, about 1 million (3.5 percent) Medicare enrollees used home health services in 1982, receiving an average of 33 visits.[3] The short-term nature of the benefit was further exemplified by the median number of visits provided in 1982—half of all elderly home health beneficiaries received 16 or fewer visits. Only a small percentage, 6.3 percent, received over 100 visits.

Home health beneficiaries' extensive use of medical services could be partly explained by their limitations in activities of daily living and instrumental activities of daily living. Almost half had one or more limitations in activities of daily living. Another 14.4 percent had one or more limitations in instrumental activities of daily living. Table 2.1 summarizes the characteristics of our national home health sample.

[3]Nationally, an estimated 24.2 percent used one or more part A services. Of these beneficiaries, 23.6 percent used hospital care, 3.5 percent used home health care, and 1.4 percent used skilled nursing facility care. These estimates were similar to HCFA statistics, which showed that 29 percent of all elderly enrollees used hospital, skilled nursing facility, or home health services in 1982; 24.2 percent used hospital care, 0.9 percent used skilled nursing facility care, and 4.1 percent used home health care. The average number of home health visits per person was 26.3.

Table 2.1: Characteristics of a National Sample of Medicare Home Health Users, 1982[a]

Characteristics	Values
Female	63.6%
Male	36.4%
Average age in years	77.1
Dependency score:	
No problems	37.3%
Instrumental activities of daily living only	14.4%
1 activity of daily living	12.4%
2 activities of daily living	8.1%
3 activities of daily living	5.7%
4 activities of daily living	4.9%
5 activities of daily living	8.8%
6 activities of daily living	8.6%
Average number of activities of daily living problems	3.3
Average number of home health visits	33.0
Reimbursement per visit	$36.09
Percent with 20+ visits	41.3%
Percent with 100+ visits	6.3%
Percent with hospital admission	86.3%
Average number of hospital admissions	2.1
Reimbursement per hospital admission	$4,172
Percent with skilled nursing facility admissions	7.0%
Average number of skilled nursing facility admissions	1.2
Reimbursement per skilled nursing facility admission	$1,181
Total reimbursement per person	**$8,785**

[a]Excludes an estimated 141,153 cases (14.2 percent) with missing data.
Source: The 1982 National Long-Term Care Survey and Medicare bill records.

Chronically Ill Use More Home Health Services

The chronically ill elderly were over three times more likely than other elderly Medicare beneficiaries to use home health. In addition, they used twice as much home health care as those who were not chronically ill (40.9 versus 21.2 visits). Their poor health was also suggested by their Medicare skilled nursing facility use. Almost twice as many chronically ill patients had skilled nursing facility admissions (7.9 percent versus 4.5 percent).

Most of the chronically ill beneficiaries were highly impaired. Almost 41 percent had limitations in five or six activities of daily living. Another 45 percent had between one and four limitations in activities of daily

living, while the other 14 percent had limitations in instrumental activities of daily living. Compared to home health users who were not chronically ill, chronically ill users were also an average of 2 years older (77.9 years versus 75.7 years), twice as likely to be nonwhite (14.7 percent versus 7.7 percent), and more likely to be female (67.4 percent versus 59.6 percent).

Types of Home Health Users

We developed profiles of five types of chronically ill Medicare home health beneficiaries from data collected from respondents to the National Long-Term Care Survey using a methodology known as Grade of Membership analysis. Among the five types of users, four represented very different epidemiological patterns of deteriorating health with varying patterns of home health use. The other type was not strongly characterized by any medical conditions or physical impairments and appeared to be the most healthy. Factors, such as age, marital status, amount of caregiver assistance, and self-reported health status, also differed by home health type.[4]

Type I

About 25 percent of the chronically ill home health beneficiaries were not distinguished by any serious medical conditions[5] or physical impairments. This type of user typically had no limitations in activities of daily living and needed assistance in only two instrumental activities of daily living—heavy housework and laundry. The likelihood of them needing assistance with instrumental activities of daily living, however, was lower than for the other four types. Similarly, they had only a few medical problems.

Type II

About 21 percent of the chronically ill home health beneficiaries had hip and bone fractures and functional limitations associated with them—needing assistance in getting in and out of bed, getting around inside the house, and bathing. This type of home health user also had mobility problems—getting around outside, transportation beyond walking distance, and grocery shopping. Type II beneficiaries also included those with rheumatism and glaucoma, conditions that would also affect one's needs for mobility assistance.

[4]See appendix II for a further discussion of Grade of Membership analysis.

[5]See pages 62 and 63 for a list of the 29 medical conditions included in our review.

Type III

Another 24 percent of home health beneficiaries had severe functional limitations. Typically, they needed assistance in all activities of daily living except eating (considered the most basic and most serious limitation) and all instrumental activities of daily living. They needed help in such activities as housework, cooking, and transportation as well as managing money, taking medications, and making telephone calls. Only two medical conditions characterized Type III—cancer and glaucoma—but the many functional limitations would suggest that these medical conditions were fairly acute.

Type IV

About 15 percent of home health beneficiaries had extensive medical problems, primarily circulatory and respiratory problems. Specifically, they were most likely to have had a heart attack, other heart problems, bronchitis, flu, or asthma. Furthermore, they were most likely to have other respiratory and circulatory problems, such as pneumonia, emphysema, arteriosclerosis, and general circulation problems. These medical problems, however, did not appear to greatly affect their ability to perform daily activities. The only activity of daily living need was for bathing assistance—one of the more common and less severe needs. They did, however, need assistance in all instrumental activities of daily living except the two that require cognitive functioning but little physical strength (managing money and making telephone calls).

Type V

About 14 percent of chronically ill home health beneficiaries were in very poor health. Typically, they had several medical problems, primarily neurological disorders, and were unable to perform any functional activities. In addition, they were the most likely type to be bedfast, confined to a wheelchair, and unable to perform any activities in the house. Type V users were also most likely to be senile or to have had a recent stroke or other neurological problems, such as mental retardation, paralysis, multiple sclerosis, cerebral palsy, and Parkinson's disease. They needed assistance in all six activities of daily living—from help in dressing to help in toileting and eating. They also needed assistance in all 10 instrumental activities of daily living. Their inability to make telephone calls, take medications, or manage money may be due to their cognitive impairments more than their functional limitations.

Table 2.2 summarizes the major characteristics differentiating the five types of chronically ill home health beneficiaries.

Table 2.2: Types of Home Health Users From the 1982 National Long-Term Care Survey

Type I (25.4%)	Type II (20.9%)	Type III (24.4%)	Type IV (15.3%)	Type V (13.9%)
Medical condition				
Absence of problem in 20 of 29 medical conditions[a]	Absence of problem in 16 of 29 medical conditions Distinguishing conditions: broken hip other broken bones glaucoma rheumatism	Absence of problem in 20 of 29 medical conditions Distinguishing conditions: cancer glaucoma	Absence of problem in 10 of 29 medical conditions Distinguishing conditions: heart attack other heart problems bronchitis flu asthma rheumatism permanent stiffness glaucoma diabetes constipation insomnia obesity arteriosclerosis circulatory problems pneumonia emphysema	Absence of problem in 9 of 29 medical conditions Distinguishing conditions: paralysis multiple sclerosis cerebral palsy Parkinson's disease mental retardation senility stroke permanent stiffness constipation arteriosclerosis circulatory problems
Activities of daily living				
Absence of problem	getting in and out of bed getting around house bathing using the toilet	getting in and out of bed getting around house bathing dressing using the toilet	bathing	Assistance needed in all 6 activities of daily living
Instrumental activities of daily living				
Absence of problem in 8 of 10 activities[b]	heavy housework grocery shopping transportation getting around outside	Assistance needed in all 10 activities	Assistance needed in 8 of 10 activities	Assistance needed in all 10 activities
Other				
	•	•	•	bedfast wheelchair fast unable to do inside activities

[a]Although Type I was not distinguished by specific medical conditions, the following conditions were present within the type: rheumatism, diabetes, cancer, insomnia, obesity, hypertension, circulatory problems, pneumonia, and emphysema.

[b]Although Type I was not distinguished by specific instrumental activities of daily living, they had limitations in heavy housework and laundry.

Source: The 1982 National Long-Term Care Survey and Medicare bill records.

Relationship Between Types of Users and Their Use of Home Health Care

The amount of home health used by the five types generally corresponded with their medical conditions and functional limitations. Therefore, as the severity of impairment increased, the percentage of beneficiaries reporting poor health and the presence of informal caregivers increased. Other factors—such as age, sex, marital status, hospital use, and Medicaid eligibility—were also considered in distinguishing the five types of beneficiaries.

The relative good health of the first type of home health beneficiaries corresponded to their personal characteristics and home health utilization data. Across the five types of users, Type I averaged the fewest home health visits (21.4) and, consequently, accounted for the smallest percentage of Medicare home health reimbursement (13.9 percent). Perhaps most indicative of their relative well-being was the fact that, in responding to the survey, they did not consider themselves to be in poor health. In addition, Type I users were less likely to have informal caregivers (one-third reported having no informal caregivers) than other types of home health users. Lastly, Type I beneficiaries were less likely to have out-of-pocket expenses for home health care than the other four types.

Because broken hips are a fairly common accident among older women, the personal characteristics of the second type of home health user appeared consistent with the conditions that distinguished this group. Almost all were women; their average age was 79.5 years—the second oldest across the five types; and most were single. In addition, 19 percent had been in a nursing home.

While nursing home admission is often the result of a catastrophic event or crisis combined with personal and physical characteristics, there appears to be some element of planning for nursing home placement among Type II beneficiaries. Although only 17.5 percent reported poor health, they had the highest percentage who also reported being on a waiting list for nursing home admission. Because they are older, have chronic mobility problems, do not have a spouse, and have lived in a nursing home at one time, this may have contributed to their decision to plan for nursing home admission. Lastly, less than 5 percent were Medicaid eligible, by far the smallest percentage among the five types.

Type III home health beneficiaries were distinguished more by their severe functional limitations than by their medical conditions. Although

they needed a great deal of personal care assistance and could not perform any instrumental activities of daily living, they averaged a relatively low 36 home health visits a year. Virtually all, however, had one or more informal caregivers. Their need for assistance in all dimensions of daily living indicated that a great deal of continual or frequent personal care was necessary.

Unlike Type III, Type IV care needs appeared to be more related to medical problems than functional limitations. The beneficiaries were the most likely to have been hospitalized (92.4 percent), and most considered themselves to be in poor health (80.4 percent). Type IV typically was the youngest home health user and the most likely to be married and have at least one informal helper (e.g., spouse). Lastly, over half were eligible for Medicaid, suggesting low income and/or high medical expenses.

Type V beneficiaries were the oldest of the five types, but contrary to general mortality rates, they were also the most likely to be male. Their poor health status undoubtedly contributed to their extremely high home health care use—they averaged almost 100 visits in 1982. As a result, they accounted for the highest percentage of Medicare home health reimbursement (34.8 percent) while representing about 14 percent of chronically ill beneficiaries.

While almost all of Type V beneficiaries reported that their health was poor and over half had two or more informal caregivers, they were the least likely to be hospitalized in 1982. Their high home health use and their relatively high probability of nursing home use (26.2 percent) suggested that their care needs were less acute and more long term than those of the other four types. Table 2.3 summarizes selected personal characteristics of the five types of home health beneficiaries.

Table 2.3: Personal Characteristics of Five Home Health User Types

Total	Type I (25.4%)	Type II (20.9%)	Type III (24.4%)	Type IV (15.3%)	Type V (13.9%)
Average number of visits	21.4	31.9	26.0	41.5	99.6
Percent of total Medicare home health reimbursement	13.9	15.1	20.5	15.7	34.8
Average age	78.4	79.5	78.1	73.5	81.3
Percent female	56.3	96.1	56.9	85.4	47.3
Percent single	65.4	85.2	45.0	32.2	59.6
No. of informal caregivers					
Percent with 0	33.5	16.2	1.7	0.0	0.0
Percent with 1	44.5	40.3	46.6	59.1	45.2
Percent with 2+	22.1	43.5	51.7	40.9	54.8
Percent with any out-of-pocket spending	24.7	56.7	55.7	52.9	46.7
Percent with monthly spending of					
$1-$124	52.2	34.8	3.3	17.4	21.9
$125+	12.0	5.9	27.4	0.0	13.9
Unknown amount	35.8	59.3	69.3	82.6	64.2
Percent hospitalized	86.5	79.6	83.3	92.4	64.4
Percent Medicaid eligible	19.7	4.7	33.1	53.7	26.8
Percent reporting poor health	0.0	17.5	53.2	80.5	94.6
Percent ever in nursing home	6.9	19.0	15.1	2.4	26.2
Percent on waiting list for nursing home admission	0.8	4.7	0.0	0.0	1.7

Source: 1982 National Long-Term Care Survey and Medicare bill records.

Conclusions

HHS has had virtually no national information about who has been using home health care, how they have used it, and whether use patterns have changed over time. Although our analysis was only a first step, it identified unique types of home health beneficiaries who used varying amounts of the benefit. In chapter 6, we discuss how further analysis of this kind could be used in several ways to determine the effect that improved Medicare control over payment for noncovered home health services will have on unmet need and to develop programs to ensure that the home care needs of the elderly are met.

Progress and Problems in Developing an Effective Prepayment Utilization Review Program

At the time we initiated our follow-up review in March 1984, HCFA had not implemented any of our 1981 recommendations to improve the prepayment utilization review program. Since then, HCFA has intensified its efforts to strengthen prepayment reviews. The principal action completed to date—development of standardized medical information forms—should improve the process by providing more data on which to base coverage decisions. However, HCFA still needs to clarify coverage criteria and develop prepayment screens to help intermediaries identify questionable claims. Until those actions are completed and their effectiveness evaluated, HCFA should identify them as internal control weaknesses in reports prepared under the Federal Managers' Financial Integrity Act.

HHS Has Not Reported Internal Control Weaknesses

The Federal Managers' Financial Integrity Act of 1982 requires the heads of executive agencies to periodically evaluate the agencies' internal controls and annually report to the President and the Congress on weaknesses identified and corrective actions planned. Standards for internal controls in the federal government require prompt resolution of audit findings. Specifically, managers are to (1) promptly evaluate findings and recommendations reported by auditors; (2) determine proper actions in response to audit findings and recommendations; and (3) complete, within established time frames, all actions that correct or otherwise resolve the matters brought to management's attention.

In our 1981 report, we identified material internal control weaknesses in HCFA's system to ensure proper payments for Medicare home health services and made recommendations to strengthen program controls. HHS has not, however, (1) resolved the audit findings in accordance with internal control standards or (2) included the internal control weaknesses in its annual reports to the President and the Congress.

In a June 1982 letter, HHS concurred with our recommendations that it clarify coverage criteria, develop prepayment screens, and require intermediaries to obtain more detailed information from home health agencies. HCFA anticipated completing action to implement most of the recommendations by September 1983. The standardized medical information forms developed to give intermediaries more detailed data on which to make coverage decisions were not implemented until August 1985, however. Coverage criteria had not been clarified and prepayment screens had not been implemented as of September 1986.

HCFA officials generally attributed the delays in implementing many of the recommendations to concerns raised by the home health industry and congressional committees that stronger program controls would deprive elderly beneficiaries of needed home care services.

Despite the delays in implementing improved program controls, HHS did not report any internal control weaknesses in the home health program in its first two annual reports under the Federal Managers' Financial Integrity Act.

New Forms Provide Uniform Data

In 1981, we reported that a major cause of the problems in the prepayment utilization review process was a lack of sufficient information to allow intermediaries to make appropriate coverage decisions. We stated that the documentation received by intermediaries generally consisted of a start of care notice, a bill for reimbursement, and a plan of treatment or medical information summary, which generally provided little information on which to base coverage decisions.

HCFA agreed that better information was needed and originally planned to implement new medical information forms in May 1983. Implementation was delayed until August 1985, however, because of concerns expressed by the home health industry over the time required to complete the detailed forms on each home health beneficiary.

The forms, which must accompany specified home health payment claims, should improve the quality and consistency of coverage decisions. The forms include (1) a patient certification and plan of treatment form (the 485 form), generally required at the start of care and every 60 days thereafter, and (2) a medical update and patient information form (the 486 form), required with every claim.[1] These new forms elicit detailed data on such items as the services received, general physical condition, homebound status, functional limitations, nutritional requirements, and services prescribed.

[1]Two other forms, an addendum to the plan of treatment and patient information form (the 487 form) and an intermediary medical information request form (the 488 form), were implemented at the same time.

HCFA requires intermediaries to validate information on the new forms annually by comparing them with the medical records for 20 beneficiaries from each home health agency serviced. If problems are discovered, home health agencies may be required to submit medical records with future claims until the problems are corrected.

The new forms provide more information than many of the intermediaries we reviewed had routinely been receiving. Of the 13 intermediaries reviewed, 9 were using their own forms before introduction of the 485 and 486 forms. However, none of the forms contained as much coverage information as the new HCFA forms. The other four intermediaries did not routinely obtain patient information on standard forms, but relied on nurse reviewers to identify questionable claims and request medical records.

Officials from three of the six intermediaries visited agreed that the new forms will improve the prepayment review process because they require more information than the intermediaries' forms. They believed the additional information, particularly regarding diagnosis, date of most recent onset or exacerbation of illness, functional limitations, activities permitted, services provided, ability of the beneficiary to leave home, and rehabilitation and discharge goals, will allow them to make better coverage decisions.

The other three intermediaries visited, however, did not believe the new HCFA forms will improve their coverage decisions. Blue Cross of Michigan officials preferred their form because the HCFA forms rely on a narrative assessment that needs to be fully completed to be useful. Blue Cross of California officials, however, preferred their form because the HCFA forms do not provide enough narrative about permitted patient activities and functional limitations. The third intermediary, Blue Cross of Massachusetts, did not believe the new forms will make a significant difference because nothing short of the patient's medical record will be useful. This intermediary was routinely receiving patient medical records to evaluate the need for services. The new forms do not, however, prevent Blue Cross of Massachusetts from receiving patient medical records or prevent other intermediaries from requesting additional data.

An official from HCFA's Health Standards and Quality Bureau told us that he believes the new medical information forms have helped strengthen the prepayment utilization review program but that denial rates are still too low. He said that intermediaries denied 3.5 percent of

home health visits in 1985, but denied 6.9 percent during the first 6 months of 1986. According to the official, they should be denying more of the visits claimed.

The home health industry has generally complained about the information requested on the HCFA forms and the time and cost required to complete them. HCFA is working to simplify the forms.

Uniform Screening Guidelines Have Not Been Developed

Screens are parameters used to identify, during initial prepayment claims review, claims that should be paid and those that should be subjected to more detailed review. Home health claims might be identified for further review if, for example,

- the number of skilled nursing visits for a given diagnosis exceeded the norm on either a weekly, monthly, or bimonthly basis;
- the treatment exceeded a given number of months; or
- the claims were being submitted by a new home health agency.

In 1974, we reported that intermediaries were using various screens to detect possible unnecessary utilization of services and recommended establishing more uniform screens.[2] We noted that the variation in screening guidelines indicated that benefits provided to program beneficiaries were different based on the intermediaries' interpretation of coverage criteria. In a 1977 follow-up report, we noted that these conditions continued to exist and that (1) the average number of visits intermediaries would allow for certain diagnosed conditions varied significantly and (2) the number of visits an individual intermediary would allow varied from case to case.[3]

We again identified the absence of uniform screens as a problem in our 1981 report. At that time, we concluded that prepayment utilization review could be improved if intermediaries used norms to identify questionable claims for more detailed review using medical records or other information submitted by the home health agency.

In June 1982, HHS advised us that by fiscal year 1983 it expected to develop an instruction on what constitutes acceptable intermediary practices for identifying aberrant home health utilization patterns. In

[2]Home Health Care Benefits Under Medicare and Medicaid (B-164031(3), July 9, 1974).

[3]Home Health—The Need for a National Policy to Better Provide for the Elderly (GAO/HRD-78-19, Dec. 30, 1977).

addition, HHS said that it was reviewing types of available information that might be used to generate an improved data base for comparing and monitoring home health utilization patterns.

According to a HCFA official, the development of national prepayment screens was delayed until after implementation of the new medical information forms because the limited information on the old payment claim form was not adequate for use in screening claims. HCFA staff and selected intermediaries are now developing screens based on diagnosis, and full implementation of national prepayment screens is expected to occur around January 1987. A HCFA official said that they are having technical problems controlling the number of claims identified for further review by the screens.

HCFA pointed out, however, that intermediaries will collect information about the services provided by home health agencies from information provided on the new medical information forms. According to HCFA officials, the forms enable intermediaries to gather uniform data about services provided to individual beneficiaries and can be used to identify aberrant home health agencies.

We agree that the additional information obtained on the new medical information forms will enhance the ability of intermediaries to develop screens. Until national prepayment screens are implemented, however, the variation in the use of screens identified in our 1974 and 1977 reports will likely continue. For example, Blue Cross of Michigan used a computer to screen claims against 54 parameters. In contrast, Aetna of Florida did not use any computer screens to identify claims for further review based on coverage criteria. Instead, it manually reviewed all claims to identify problems in the documentation submitted but examined only a small sample of claims to identify noncovered or inappropriate services based on coverage criteria.

Coverage Criteria Have Not Been Clarified

In 1981, we reported that vague coverage criteria contributed to the high level of noncovered or questionable home health services being provided. HCFA, however, has not clarified coverage criteria relating to intermittent care, homebound status, or the use of home health aides or provided enough training on how to interpret existing criteria. Inconsistent interpretations of the criteria can result in unequal access to home health services for Medicare beneficiaries depending on the intermediary processing the claim.

Intermittent Care

According to HCFA's home health agency manual, Medicare will pay for part-time medically reasonable and necessary skilled nursing care 7 days a week for a short period (2-3 weeks). The manual also recognizes, however, that there may be cases involving unusual circumstances where the patient's medical prognosis indicates that the need for daily skilled nursing care will extend beyond 3 weeks. The manual requires the home health agency to provide justification for additional services and an estimate of how long they will be required. Finally, the manual states that a person expected to need more or less full-time skilled nursing care over an extended period of time would not qualify for home health benefits.

A May 1984 HCFA clarification of the manual states that the amount of additional daily care need not be for a fixed period of time, but should be dictated by the beneficiary's medical need. The clarification adds that such extensions should occur only in unusual circumstances. Finally, it states that it is not appropriate for intermediaries to set fixed limits on the amount of daily care covered or to authorize daily skilled care of an indefinite duration.

At the request of the Senate Committee on Finance, in June 1984 we obtained information from 13 fiscal intermediaries to determine whether they consistently interpreted the new provisions relating to daily care. Intermediaries' interpretations of the criteria allowing daily visits beyond the initial 2- to 3-week period ranged from allowing an additional 10 days on a case-by-case basis after an evaluation of the individual patient's progress and need for continued care to allowing daily visits for an unlimited period. Contrary to HCFA's May guidance, two intermediaries allowed daily care for an indefinite period, four set fixed limits on the amount of care covered beyond the initial 3-week period, and one allowed daily care for up to 8 weeks. The other six intermediaries followed HCFA's guidance.

The conference report on the Deficit Reduction Act of 1984 directed the Secretary of HHS to quickly identify the factors responsible for the lack of uniformity in the application of existing policy. The report also directed the Secretary to clarify and take additional steps, as necessary, to remedy the problem.

HCFA, however, identified lack of information and training as the factors responsible for the lack of uniformity in interpreting the policy and, according to a HCFA official, does not plan to clarify the policy. The official said that HCFA will rely instead on the consolidation to 10 regional

fiscal intermediaries to improve the uniformity of coverage decisions. While reducing the number of intermediaries should reduce the number of interpretations, we believe HCFA still needs to ensure consistent interpretation of the home health manual instructions by the regional intermediaries. Our June 1984 survey of 13 intermediaries included 3 selected to become regional intermediaries, each of which had a different interpretation of intermittent care. The three intermediaries still had different interpretations when we contacted them again in September 1986.

Homebound

In our 1981 report, we noted that the requirement that Medicare beneficiaries be homebound to qualify for home health care was especially difficult to administer because key terms were vague or undefined. Among the terms we identified as unclear were those that state that a homebound individual must have a "normal inability to leave home," which would require a "considerable and taxing" effort. Similarly, the coverage criteria refers to the acceptability of leaving home for periods of "relatively short duration" and indicates that an individual who does not leave home only because of "feebleness" and "insecurity" cannot be considered homebound.

Although HCFA proposed a revised definition of homebound in 1983, deleting "ambiguous terms" and requiring additional documentation to support a homebound determination, HCFA withdrew the proposal in early 1984 after meeting with representatives of the home health industry and congressional committee staff. In a June 1984 status report on implementation of our 1981 recommendation, HCFA said it believed that clarification can be handled through a training effort for intermediaries to ensure greater consistency and appropriate application of existing criteria. We found, however, that very little training has occurred.

Home Health Aides

The home health manual states that the primary function of a home health aide is the patient's personal care. Personal care includes assistance in the activities of daily living, such as helping the patient bathe, get in and out of bed, care for hair and teeth, exercise, and take medications. The manual also permits home health aides to perform certain household services, such as changing the bed, light cleaning, laundering, and preparing meals if these services are "incidental" and do not "substantially increase" the length of the aide visit. Household services that

would "materially increase" the length of the aide visit are, according to the manual, not reimbursable.

In our 1981 report, we identified extensive payments for noncovered home health aide visits and attributed much of the problem to the vague coverage criteria. Among the questions we said needed to be addressed were:

- To what extent are aide services available under Medicare when other forms of support, such as family and friends, are available?
- When are household services (cleaning, laundering, etc.) to be considered "incidental"?
- How much time can a home health aide spend on household services without "substantially" or "materially" increasing the amount of time for the visit?
- To what extent is respite care covered under Medicare?

We recommended that HCFA clarify coverage criteria and develop a form to assess the beneficiary's need for personal care services. We said that the form should identify (1) services the beneficiary cannot perform without assistance and (2) the availability of family or friends to provide the needed services. We recommended that HCFA require home health agencies to submit a copy of the form with their bills.

Although HCFA has developed new medical information forms that provide additional information on aide visits, the forms do not adequately assess the beneficiary's need for aide services and the availability of family and friends to provide needed services. For example, the forms indicate whether the beneficiary has functional limitations and what activities are permitted but not the extent of the help needed. The forms ask about the availability of informal caregivers (family and friends) to provide assistance; but without knowing the extent of assistance needed, the intermediaries cannot identify the capability of family and friends to provide all needed assistance. Such information would help intermediaries evaluate the frequency and length of home health aide visits needed.

Because many Medicare home health beneficiaries depend on informal caregivers for personal care assistance, caregivers generally get a rest by finding someone else willing to temporarily provide the needed care. In our 1981 report, we noted that HCFA has not provided guidance on

whether or to what extent such "respite" care is covered under Medicare. We recommended that HCFA state whether respite care is a justifiable reason for covering home health aide services and, if so, under what circumstances.

In comments on our 1981 report provided to the House and Senate Appropriations Committees, the Secretary of HHS said that respite care is not covered under Medicare. A December 1983 status report on implementation of our recommendations noted that revisions to the intermediary and provider manuals addressing respite care were to have been published in September 1983, but were temporarily delayed "due to issues which were recently raised." The next status report in June 1984, however, indicated that HCFA now believed existing guidance was adequate and that no action would be taken on the recommendation. According to a HCFA official, HCFA decided not to address respite care because of opposition from the home health industry and congressional committee staff.

HCFA agreed with our recommendation that it clarify criteria on the use of aides for homemaker-type services and planned to publish intermediary and provider manual revisions in September 1983. According to a December 1983 HCFA status report on implementation of the recommendation, publication was also temporarily delayed "due to issues which were recently raised." The next status report in June 1984 indicated that HCFA had since decided that existing criteria were adequate and that training would be provided to intermediaries to ensure consistent and appropriate application of the criteria. Limited training has been provided, however.

According to a HCFA official, the decision not to clarify coverage criteria resulted from opposition to the proposed manual revisions from the home health industry and congressional committee staff. He said that concern was expressed that the proposed manual revision would deny needed home health care services to Medicare beneficiaries.

Unclear coverage criteria for homebound, intermittent care, and aide services contribute to the large amount of noncovered care reimbursed under Medicare. For example, in HCFA's 1984 study, 35 percent of the noncovered services were denied because coverage guidelines were not followed for the use of home health aides.

Conclusions

In 1981 we identified serious internal control problems in the Medicare home health benefit stemming from the (1) limited information intermediaries were receiving from home health agencies on the beneficiaries' needs for home health care; (2) vagueness of coverage criteria, making it difficult for intermediaries to determine whether beneficiaries were, for example, homebound or entitled to home health aide services; and (3) lack of uniform screens to help intermediaries identify beneficiaries most likely to be receiving noncovered services.

HHS has not promptly resolved our findings in accordance with standards for internal controls. It took HCFA almost 4 years to implement medical information forms to give intermediaries additional information on which to base coverage decisions. HCFA still has not implemented uniform screens or clarified coverage criteria. The continuing internal control weaknesses have not, however, been included in HHS's annual reports under the Federal Managers' Financial Integrity Act.

Intermediaries' limited use of prepayment screens reduces their ability to identify noncovered services. Similarly, uncertainty over the meaning of such terms as homebound and intermittent care can result in inconsistent interpretations of coverage criteria. Noncovered care identified by one intermediary may be covered under another intermediary's interpretation of the same criteria.

Recommendations

We recommend that the Secretary of HHS direct the Administrator of HCFA to implement the recommendations in our 1981 report to develop national prepayment utilization review screens for home health and clarify coverage criteria. In addition, we recommend that the Secretary include the internal control weaknesses in the Medicare home health program in the next annual report under the Federal Managers' Financial Integrity Act and set a timetable for completing actions to correct the deficiencies.

Improvements Needed in Postpayment Utilization Review Program

In 1982 HCFA implemented a selective postpayment utilization review of home health agencies. The program, known as coverage compliance review, has identified extensive noncovered services paid for by Medicare. The use of statistically valid sampling methods and improved intermediary performance, however, could result in the recovery of millions of dollars in additional overpayments.

Description of the Program

Postpayment utilization review differs from prepayment review in that its principal focus is on home health agencies providing significant amounts of noncovered care rather than on the services provided to specific beneficiaries.

Each year, fiscal intermediaries must perform postpayment utilization reviews at home health agencies that

- are among the top 10 percent of home health agencies based on a composite score developed from (1) average Medicare cost per patient, (2) average number of visits per Medicare patient, (3) percentage of Medicare business, and (4) percentage of home health aide visits provided by Medicare;
- exceed the 2.5-percent favorable waiver of liability limit determined under prepayment review;[1]
- failed their previous postpayment review because they had a 5-percent or greater rate of denied visits to visits reviewed; or
- have completed their first year of Medicare participation.

At each home health agency reviewed, the intermediary audits the prior 3 months of services for 20 randomly selected beneficiaries. The intermediary assesses compliance with Medicare regulations, identifies noncovered services, determines educational needs of agency staff, and recommends corrective actions to achieve better program compliance. The intermediary's nurse reviewers also look for compliance with technical requirements—that the home health agency's records are adequate, a physician signed the beneficiary's plan of treatment, the patient was homebound, and the patient needed intermittent skilled nursing care. In addition, in December 1984, intermediaries started making home visits to a sample of five beneficiaries per agency reviewed to assess their coverage status.

[1]The waiver of liability, section 1879 of the Social Security Act, protects beneficiaries and providers from having to pay for services that were later reviewed and determined to be noncovered. To be protected, a home health agency must not have more than 2.5 percent of its provided services denied under prepayment review.

Use of Valid Sampling Techniques Could Increase Recovery of Overpayments

The postpayment utilization review program has been cost effective, resulting in savings to the Medicare program. However, because fiscal intermediaries do not select a projectable sample of home health visits, recoveries are limited to the cost of services actually denied. By using statistically valid sampling techniques, overpayments to home health agencies for noncovered services could be projected to all claims submitted by the agency during the sampling period. Such methods, currently being used to estimate physician overpayments under Medicare part B, could result in millions in additional recoveries.

Between July 1982 and June 1985, over 3,000 postpayment utilization reviews were completed. Of the approximately 1.2 million home health visits reviewed, about 168,000 (13.7 percent) were denied.

During the 6 months ended June 30, 1985, Medicare paid about $1.7 million for 38,010 noncovered visits identified through postpayment reviews, about $1 million of which was recoverable.[2] Because personnel and travel costs to perform the reviews cost about $706,000, net savings from postpayment reviews totaled about $300,000.

We believe the methodology used by insurance companies, known as carriers under Medicare part B, to estimate physician overpayments for inappropriate utilization could be adapted to the home health postpayment review program. After carriers have identified a potentially aberrant physician, they review a sample selected from the universe of claims submitted by the physician during a given period of time. The claims sample is selected in a statistically valid manner to permit a projection of the results to the total claims submitted. Accordingly, recoveries are made from the claims universe, not just a sample, as is the case with postpayment utilization reviews of home health agencies.

We believe that applying similar methods in the home health postpayment review program could have increased recoveries by roughly 400 percent without appreciably increasing review costs to operate the program. A HCFA official agreed that the use of statistically valid sampling techniques would improve the program's effectiveness.

At most home health agencies, this would require a change in the method of selecting visits for review but would not require an appreciable increase in the number of visits reviewed. Because of the large number of visits now reviewed for each beneficiary, only at the larger

[2]The other $700,000 was not recoverable because of the waiver of liability.

home health agencies would it be necessary to increase the number reviewed.

In calendar year 1984, coverage compliance reviews were completed at 1,391 home health agencies. Of the approximately 520,000 home health visits reviewed, about 75,000 (14.4 percent) were denied. Data on the total number of visits provided by the 1,391 home health agencies were not readily available. Assuming that the average number of visits by each of the 1,391 home health agencies was the same as the national average, we estimate that they provided about 2.5 million visits during the period covered by the reviews. Using the 14.4-percent denial rate and applying it to the 2.5 million visits indicates that an additional 285,000 visits might have been denied. Based on the average cost of a Medicare home health visit in 1984 ($46), an additional $12.9 million in home health claims would have been denied.

Poor Intermediary Performance Limits Program Effectiveness

Although postpayment utilization reviews have resulted in the denial of 13.7 percent of the claims reviewed nationally, HCFA's 1984 study (see p. 13) showed that intermediaries were not denying nearly enough services.

As part of its 1984 study, a panel of HCFA nurses reviewed 350 selected beneficiaries' medical records from 35 different home health agencies. The beneficiaries' records had already been reviewed by the intermediaries under postpayment utilization reviews. Comparing their results to the intermediaries' results, HCFA determined that the intermediaries had not denied nearly enough services. For six of the seven intermediaries, HCFA determined that the shortfalls were substantial. For example, one intermediary had not identified any noncovered services for the 50 beneficiaries reviewed during its on-site audits at five home health agencies, while HCFA determined that 47 percent of the services reviewed for these beneficiaries were not covered by Medicare.

Table 4.1 presents the differences in denial rates between intermediaries and HCFA.

Table 4.1: Denial Rates for a Sample of Services

Intermediary[a]	Denial rates		
	Intermediary	HCFA	Difference
A	0	47	47
B	1	37	36
C	1	53	52
D	12	47	35
E	17	23	6
F	27	62	35
G	22	56	34
Average	**8**	**45**	**37**

[a]Intermediary names were omitted at HCFA's request.

HCFA officials attributed the difference in denial rates to poor performance by the intermediaries whose denial rates were substantially below HCFA's. Because medical records are reviewed during postpayment utilization reviews, lack of information was not a cause. We discussed the results of the HCFA study with two intermediaries included in the study when we visited them. One could not offer any reasons why such differences existed, while the second thought lack of trained staff may have contributed to the low denial rate.

HCFA's study provides significant evidence that adequate internal controls do not exist to identify intermediaries who do not adequately perform postpayment reviews. HCFA's denial of over five times as many claims as the intermediaries indicates that serious internal control problems exist. We discussed this matter with HCFA program officials to determine what actions were planned to strengthen internal controls. They informed us that they expected the change to regional intermediaries to result in better intermediary performance of postpayment utilization reviews because of greater uniformity of coverage decisions and do not plan further actions to improve intermediary performance. Intermediary performance is discussed further in the next chapter.

Conclusions

Poor intermediary performance in making coverage determinations limited the effectiveness of the postpayment reviews in recovering overpayments for noncovered care. Also, by applying statistical sampling techniques to the postpayment utilization review program, HCFA could have turned a marginally effective program into an effective enforcement tool, increasing cost recoveries 400 percent from aberrant home health agencies.

Recommendation

We recommend that the Secretary of HHS direct the Administrator of HCFA to revise the home health postpayment utilization review program guidance to require intermediaries to use statistically valid sampling techniques for identifying and projecting the amount of noncovered care to the universe of claims paid.

Recommendations regarding intermediary performance are made in chapter 5.

Actions Needed to Improve Intermediary Performance

The consolidation of home health utilization reviews under 10 regional intermediaries may not fulfill its intended purpose of improving program management unless HCFA acts to improve the appropriateness of payment decisions. The primary method HCFA uses to assess intermediary performance does not, however, have sufficient elements to thoroughly evaluate intermediaries' performance on home health reviews. Another potential indicator of intermediary performance, prepayment utilization review denial rates, does not provide a valid basis for comparing the performance of intermediaries because the rates are not consistently calculated.

Better Intermediary Evaluations Needed

The contractor performance evaluation program calls for an annual review of intermediary performance and provides the basis for HCFA's decisions to continue or terminate an intermediary's contract. At the time of our 1981 report, the program did not include any specific measures of intermediaries' utilization review performance for home health claims. Although HCFA has added elements to the program that evaluate certain aspects of intermediaries' performance both on prepayment and postpayment utilization reviews, the contractor evaluation program still does not provide adequate internal controls to ensure that intermediaries are adequately identifying noncovered home health services.

In fiscal year 1986, 6 of the 80 contractor performance evaluation program elements measure intermediary efforts to control inappropriate use of the home health benefit. Of the six elements, three relate specifically to the postpayment utilization review of home health agencies, while the other three relate to all prepayment utilization review activities, including home health.

The elements assessing prepayment utilization review activities are, in our opinion, too broad to evaluate intermediary performance on home health reviews. For example, one element measures the cost benefit of an intermediary's prepayment review activities. It requires intermediaries to spend at least 95 percent of their prepayment utilization review budgets and identify at least $5 in noncovered care for every $1 spent. Because the ratio is based on all prepayment review denials—including skilled nursing home, outpatient, and hospital inpatient in addition to home health—and the total cost of performing the reviews, it does not give HCFA data on the effectiveness of intermediaries' review of home health claims. Further, intermediaries may focus their review efforts on inpatient care because the higher cost of these services could make it easier to achieve the required savings-to-cost ratio.

The other two prepayment utilization review elements determine whether the intermediary appropriately reviewed claims and made correct medical determinations. Again, HCFA cannot identify how well the intermediaries performed the home health portion of the reviews.

The three elements that evaluate the postpayment utilization review of home health agencies do not allow HCFA to determine the quality of intermediaries' coverage decisions. As discussed on page 40, HCFA's 1984 study showed that intermediaries were not effectively identifying noncovered services during postpayment reviews. The three postpayment review elements assess how well an intermediary (1) ranked home health agencies for review, (2) completed timely reviews of the agencies selected, and (3) conducted the reviews. The first two elements evaluate important aspects of the postpayment utilization review program not related to the quality of coverage decisions. Although the third element would appear to evaluate the quality of coverage decisions, it actually assesses the effectiveness of the intermediary in recovering overpayments once a decision has been made that a service should not have been paid for by Medicare. HCFA does not evaluate how well the intermediary reviewed the claims selected for review.

An official from HCFA's Health Standards and Quality Bureau agreed that the contractor performance evaluation program is not an effective tool in ensuring adequate intermediary performance on home health utilization reviews.

Prepayment Utilization Review Denial Rates Should Not Be Used to Compare Intermediary Performance

If consistently calculated, prepayment review denial rates could provide a valuable indicator of intermediary and home health agency performance. Intermediaries calculate denial rates by dividing the number of services they denied by the number they reviewed. However, because HCFA has not defined what constitutes a review, intermediaries have varying definitions. As a result, denial rates have not been consistently calculated.

Prepayment review denial rates for the 45 intermediaries processing home health claims in 1985 varied significantly. About half of the intermediaries reported denial rates of less than 1.0 percent. At the other extreme, Aetna of Illinois reported a denial rate of 29.5 percent; Blue Cross of Georgia, 13.8 percent; and Aetna of Connecticut, 9.9 percent.

While a high denial rate would appear to indicate a good prepayment utilization review program, intermediary methods for reviewing claims and calculating denial rates were so different that denial rates could not be used for comparing performance. For example, the Blue Cross and Blue Shield plans of Greater Philadelphia, Michigan, and Texas used prepayment screens to select claims for further review. The screens identified claims for potentially noncovered care based on comparisons of the type and frequency of services provided for a specific diagnosis to norms for that diagnosis. The Philadelphia and Michigan plans defined the number of services reviewed to be the number of services identified by the screens for review by registered nurses. The Texas plan, however, defined the number of services reviewed to be the total number of services for which claims were processed. For example, if each intermediary processed claims for 1,000 services, identified 100 for further review based on the prepayment screens, and denied 10, the Texas plan would have reported a denial rate of 1 percent (1,000 services reviewed divided by 10 services denied), while the Philadelphia and Michigan plans would have reported denial rates of 10 percent (100 services reviewed divided by 10 services denied).

Aetna of Florida defined the number of services reviewed to be the total number of claims processed by licensed practical nurses (about 40 percent of the total claims received). Unlike the above intermediaries, Aetna did not review all claims using computerized prepayment screens to identify potentially noncovered or inappropriate services. The licensed practical nurses review most claims only for completeness of documentation and refer questionable claims to registered nurses for further review. If Aetna processed 1,000 claims, reviewed 10 to identify potentially noncovered or inappropriate services, and denied 5 of the 10 claims reviewed, it would report the denial rate as 0.5 percent rather than 50 percent.

Because of the inconsistent calculation of denial rates, such rates do not provide a sound basis for comparing intermediary performance.

Switch to Regional Intermediaries May Not Improve Program Management

The Deficit Reduction Act of 1984 required HHS to reduce to 10 or fewer the number of intermediaries administering the home health program. The reduction, which was to be implemented by October 1986, is intended to improve program management and promote consistency by selecting the best intermediaries to administer the home health benefit. However, information used by HCFA in the selection process raised questions about the prior performance of all 47 intermediaries assessed, including the 10 selected to serve as regional intermediaries.

Among the criteria HCFA considered were the accuracy of payment determinations, utilization review denial rates, savings-to-cost ratios for prepayment review activities, and contractor performance evaluations in selecting the 10 regional intermediaries. As discussed above, these data do not provide an adequate basis for comparing the performance of intermediaries in administering home health benefits. They can, however, provide an indicator of potential problems in an individual intermediary's performance. Our review of the same information HCFA used in selecting the 10 regional intermediaries identified poor performance on one or more of the performance indicators by each of the selected intermediaries. For example:

- Prudential of New Jersey denied 0.3 percent of the claims processed during prepayment reviews.
- Blue Cross of Maine denied 4.1 percent of the visits reviewed under the postpayment review program, and six other regional intermediaries had denial rates below the national average of 13.7 percent.
- Blue Cross of Wisconsin reported prepayment review savings of $2.69 for each dollar spent performing the reviews, well below the 5-to-1 ratio required by the contractor performance evaluation program.
- Aetna of Florida, which did not use computerized prepayment screens to identify potential noncovered services, denied only 0.5 percent of the claims processed.
- Blue Cross of Wisconsin and Aetna of Florida failed three of seven[1] contractor performance evaluation program elements relating to postpayment utilization reviews during 1984 and 1985; three other regional intermediaries failed two elements.

An official from HCFA's Health Standards and Quality Bureau agreed that the past performance of the regional intermediaries was not adequate. He said that a HCFA study of the 10 intermediaries completed in

[1]There were three elements assessing postpayment utilization review of home health agencies in 1984 and four in 1985.

1986 showed that some if not all of the intermediaries should be doing a better job. A follow-up study will be conducted by June 1987, according to the HCFA official, and intermediaries that are still not performing adequately may not have their contracts renewed.

Conclusions

The consolidation of home health utilization reviews under 10 regional intermediaries will not strengthen internal controls over Medicare home health payments unless HCFA acts to improve the intermediaries' performance in making payment decisions. The contractor performance evaluation program, HCFA's primary method for assessing intermediary performance, does not, however, assess the accuracy of intermediaries' payment decisions. In addition, HCFA needs to develop a uniform method for calculating prepayment review denial rates so that such rates can be used for comparing intermediaries' performance.

Recommendations

We recommend that the Secretary of HHS direct the Administrator of HCFA to expand the assessment of intermediary performance under the contractor performance evaluation program to include an assessment of the accuracy of intermediary home health coverage determinations. In addition, the Secretary should identify the limited assessment of the appropriateness of intermediaries' home health payment decisions as a material internal control weakness in the annual report under the Federal Managers' Financial Integrity Act and establish a timetable for prompt corrective action.

Elderly Who Lack Long-Term Care Assistance

The Medicare home health benefit was not designed to meet all of the home care needs of the elderly. Medicare is intended to provide assistance with personal care needs (activities of daily living) and homemaker needs (instrumental activities of daily living) only to beneficiaries who are homebound and require skilled nursing care on a part-time or intermittent basis. Other Medicare beneficiaries must find needed assistance from family, friends, and other caregivers. Similarly, beneficiaries whose needs exceed the limits of Medicare coverage must find other sources of support once their Medicare coverage ends.

To determine whether other caregivers were meeting the needs that were not being met through Medicare, we analyzed data from the 1982 National Long-Term Care Survey. We found that about 168,000 chronically ill elderly were not receiving all of the assistance they needed with activities of daily living and an additional 1.1 million needed more assistance with instrumental activities of daily living. Although these individuals received extensive paid and unpaid help, this assistance was reported by the disabled elderly to be inadequate. Typically, unmet needs limited the chronically ill's mobility, ranging from getting in and out of bed to getting around outside the home.

The improved program controls over use of the Medicare home health benefit recommended in chapters 3 through 5 should reduce Medicare payments for noncovered services. Because noncovered services are not necessarily unneeded services, improved controls could increase unmet need for home care assistance unless alternative sources of assistance are available. Further studies are needed, however, to determine the effect that stronger internal controls over payments for Medicare home health services will have on the number of Medicare beneficiaries with unmet home care needs.

Elderly With Unmet Home Care Needs

Our analysis of data from the 1982 National Long-Term Care Survey showed that of the 3.2 million elderly with one or more limitations:

- 168,000 (5 percent) reported that they lacked needed assistance in one or more activities of daily living.
- 1.1 million (36 percent) reported that they had all their activities of daily living needs met, but lacked needed assistance in one or more instrumental activities of daily living.
- 1.9 million (59 percent) reported that they had all their activities of daily living and instrumental activities of daily living needs met. (About

190,000 of these beneficiaries lived alone, were 75 or older, and relied solely on informal caregivers.)

Among the 1.5 million elderly who had only limitations in instrumental activities of daily living, 412,000 reported that they were not getting the help that they needed. Because of our focus on the more seriously impaired population, we did not analyze this group further. Overall, most elderly received all the help they needed through informal and/or formal caregivers.

Although we found unmet needs for assistance in all activities of daily living and instrumental activities of daily living, the greatest problem appeared in obtaining assistance to improve mobility. Two of the three most frequently reported unmet activities of daily living needs were for assistance in getting in and out of bed and getting around inside the house. The most frequently reported unmet instrumental activities of daily living needs were for assistance in walking around outside the house and transportation. The following are lists of the types of unmet needs reported by the chronically ill elderly in 1982,[1] ranked in order of frequency, derived from the 1982 National Long-Term Care Survey. Listed first are the activities of daily living needs, which averaged 1.2 unmet needs per person.

- Getting in and out of bed (52,209).
- Dressing (43,423).
- Getting around inside the house (40,471).
- Bathing (28,229).
- Eating (18,859).
- Using the toilet (16,374).

Listed next are the instrumental activities of daily living needs, which averaged 1.7 unmet needs per person.

- Getting around outside the house (712,523).
- Transportation (526,105).
- Grocery shopping (181,754).
- Preparing meals (171,913).

[1]The number of projected cases with each type of unmet activities of daily living is given only to indicate their relative frequency. The actual numbers were too small to be projected with statistical reliability.

- Housework or laundry (148,856).
- Managing money (111,369).
- Taking medication (38,032).

Characteristics of the Unmet Needs Groups

Compared to the chronically ill elderly receiving all the assistance they needed, those with unmet needs were more likely to be seriously disabled, female, senile, or retarded. Additionally, the elderly with unmet needs received more help, both formal and informal, than the elderly who had all their needs met. The assistance needed by the unmet need group, however, appeared to be more extensive than caregivers could provide.

Overall, the more disabled the elderly were, the greater the likelihood that they had unmet needs. This was not unexpected given the fact that more assistance is needed when a person has more functional limitations. For example, most elderly who had all their needs met had only one or two activities of daily living limitations (55.8 percent), whereas most elderly with unmet instrumental activities of daily living had five or six limitations (48.5 percent). Most persons with only unmet instrumental activities of daily living needs also had few impairments—47.3 percent had one or two activities of daily living limitations. Table 6.1 indicates who had unmet needs by their disability level.

Table 6.1: Percent Distribution of the Elderly With Unmet and Met Needs by Their Disability Levels

	Number of activities of daily living limitations			
	1-2	3-4	5-6	Total
All needs met	55.8%	22.6%	21.6%	100%
Unmet instrumental activities of daily living needs only	47.3	20.6	32.1	100
Unmet activities of daily living needs[a]	29.5	22.0	48.5	100

[a]Includes persons who may also have unmet instrumental activities of daily living needs.
Source: 1982 National Long-Term Care Survey.

While most of the long-term care population is older women, a higher percentage of those with unmet needs are women over 75 years old. Over 20 percent of those with unmet activities of daily living needs and 15 percent of those with unmet instrumental activities of daily living needs were senile or retarded. Like all elderly with long-term care needs, informal caregivers represented the largest source of support. Those with unmet needs, however, were more likely to receive paid assistance

compared to the elderly with all their needs met.[2] These data indicate that while the elderly with unmet needs were able to receive a great deal of help, it appeared to be inadequate to meet all of their needs. Table 6.2 presents information on the source and amount of caregiver support for the chronically ill elderly.

Table 6.2: Source and Amount of Caregiver Assistance for the Chronically Ill Elderly[a]

	All needs met	Unmet instrumental activities of daily living needs	Unmet activities of daily living[b] needs
	59.0%	35.8%	5.3%
Source of help			
No help	4.2%	4.9%	2.8%
Help	95.8%	95.1%	97.2%
Nonpaid	70.6%	64.5%	53.9%
Paid	4.7%	4.7%	3.6%
Nonpaid and paid	20.5%	26.0%	39.7%
Helper days per week			
Nonpaid	7.9	8.5	9.5
Paid	4.2	4.5	7.3
Nonpaid and paid	9.3	10.3	12.2

[a]Includes persons with unmet instrumental activities of daily living needs.
[b]Figures may not add due to rounding.
Source: 1982 National Long-Term Care Survey.

Sources of informal support also shifted from the most immediate caregiver (i.e., spouse) as unmet needs increased. Those with all their needs met had the highest percentage who relied solely on their spouses for help (33 percent). Those with unmet instrumental activities of daily living needs relied more on their children for assistance, while those with unmet activities of daily living needs relied more on their children and others for support.

In addition to more informal assistance, the elderly with unmet activities of daily living needs received the most Medicare home health. Almost 29 percent had a home health visit in 1982 compared to about 12 percent of the elderly who had no unmet needs.

[2]As discussed in appendix II, another national health care survey has shown reliability problems in the elderly knowing the source of their paid help. The data presented here indicated the percentage with any paid help, not the source of such help. However, it may still underestimate the extent of paid help if the elderly reported paid help as free.

Further Analyses of Unmet Need Would Be Helpful in Reaching Policy Decisions

While our analysis of National Long-Term Care Survey data identifies who was not receiving all the home care help they needed in 1982, several important questions remain unanswered. For example:

- Why were 5 percent of the elderly unable to receive all the help they needed from the existing network of service providers (federal, state, and local programs, family and friends, and volunteers)?
- Will improved internal controls over payments for Medicare home health services increase unmet needs for home care assistance?
- Will Medicaid home and community-based services reduce unmet need?
- What effect has the prospective payment system for hospitals had on Medicare beneficiaries' ability to obtain home care assistance?

Further analyses to answer these and other questions should help the Congress, HHS, and the states in considering various policy options for dealing with the home care needs of a growing elderly population.

Why Were the Elderly Unable to Obtain Needed Home Care Assistance?

Our analysis identified the characteristics of Medicare beneficiaries who were not receiving all the home care assistance they needed, but did not determine why they were unable to obtain the needed help. Further studies of the unmet need population are needed to determine whether

- outreach efforts are adequate to make them aware of the availability of home care assistance from federal, state, and local government programs and voluntary organizations, such as "meals on wheels";
- the existing network of formal service providers (federal, state, and local programs and volunteer organizations) adequately fills the gap when informal caregivers are not available and willing to meet all the home care needs of the elderly; and
- private, long-term care insurance could meet the home care needs of the chronically ill elderly.

Effects of Improved Program Controls

Our 1981 report and HCFA's 1984 study showed extensive Medicare payments for noncovered services. Noncovered services include both those that are not reasonable or medically necessary (i.e., the beneficiary does not need the service) and those that are outside the limits of the Medicare benefit (i.e., the beneficiary needs the service but is not homebound or needs more extensive services than those available under Medicare). Neither our 1981 report nor HCFA's 1984 study differentiated between the two types of noncovered care.

To the extent that noncovered care is care that is needed but outside the limits of Medicare coverage, the improved program controls recommended in chapters 3 through 5 would tend to increase the unmet need for home care assistance unless other caregivers fill the void.

HCFA could better target utilization control efforts to the types of beneficiaries most likely to receive noncovered services and evaluate the potential effects stronger internal controls would have on Medicare beneficiaries' ability to obtain needed home care assistance by

- analyzing data from its prepayment and postpayment utilization review programs to determine the extent to which improper payments were made for needed but not Medicare-covered home care services,
- determining the types of Medicare beneficiaries who received noncovered services using the patient classification method described in chapter 2,
- developing prepayment screens to focus utilization review efforts on the types of beneficiaries found to be receiving the most noncovered care, and
- comparing the types of beneficiaries receiving noncovered services to the types most likely to have unmet home care needs.

If, for example, most noncovered services were provided to Type I beneficiaries but such beneficiaries typically are able to get all of their home care needs met through family and friends, stronger internal controls over Medicare payments may not significantly increase unmet need. If, on the other hand, noncovered services were generally provided to severely impaired Type V beneficiaries and such beneficiaries are those likely to have unmet needs, stronger program controls can be expected to significantly increase unmet need.

Will Medicaid Home and Community-Based Services Reduce Unmet Need?

Medicaid home and community-based services may be the most significant development to address the activities of daily living and instrumental activities of daily living needs of the chronically ill elderly living in the community. Since the passage of the Omnibus Budget Reconciliation Act of 1981, the Secretary of HHS has been authorized to waive statutory Medicaid requirements to permit states to provide a variety of services to individuals living in the community who would otherwise require Medicaid-financed nursing home care. As of March 1, 1986, 38 states were offering home and community-based services. Total fiscal year 1985 expenditures for home and community-based services were about $295 million.

Types of services that can be authorized under the waivers include case management,[3] homemaker, personal care, rehabilitation, respite care, and adult day care.

Based on the age and severe limitations in activities of daily living of the chronically ill elderly identified as having unmet needs, we believe many of them would meet the waiver requirement of being at risk of institutionalization. However, because only about 25 percent reported being Medicaid eligible, the overall benefit of waivers in reducing unmet need may be limited. Further analysis of data from the long-term care survey and the 1984 follow-up could determine the extent to which Medicare beneficiaries with unmet home care needs have been able to obtain needed assistance through the Medicaid program.

Effects of Medicare Hospital Prospective Payment

Several studies have shown an increase in the number of beneficiaries receiving home health after discharge from hospitals, since the implementation of Medicare's prospective payment system. Preliminary research has suggested that individuals receiving home health care require not only medically oriented care but also nutrition, homemaker, and chore services. A 1984 study of 335 nonprofit and public community-based, long-term care providers in 32 communities in eight states found that these providers were seeing an older and sicker clientele since prospective payment.[4] The study noted that the elderly with long-term care needs that are social rather than medical may be unable to receive in-home support services if funding is limited. Interviews were conducted with 104 umbrella agencies (e.g., United Way), 16 departments of health or welfare, 72 state and local political entities, 37 chambers of commerce, and 252 foundations. The study concluded that not only could the chronically ill elderly face increasing problems in obtaining community-based care but also these social service providers may not have adequately trained and experienced staff to provide care to an older and sicker population. The agencies, however, have been better able to obtain funding for medical services and less able to obtain funding for social services.

[3]Case managers identify beneficiary needs and coordinate services to meet those needs.

[4]Juanita Wood, et al., Public Policy, the Private Nonprofit Sector and Delivery of Community-Based Long Term Care Services for the Elderly, Year 02, The Aging Health Policy Center, Feb. 1985, p. v. The eight states were California, Florida, Massachusetts, Missouri, Pennsylvania, Texas, Washington, and Wisconsin.

A 1985 national study of 160 Area Agencies on Aging found that the length of service delivery and the number of service units per client increased after prospective payment was implemented. The study also found that some providers were forced to cut the number of service units per client in order to provide care over a longer period of time. Studies in Virginia and Washington State have reported similar results.[5] Overall, these trends suggest that the restraints on social service provider budgets may limit the availability of long-term custodial care for the frail and elderly if providers focus on meeting the needs of a more acutely ill population. Even for patients who receive home care services, the studies suggest that their health and social service needs may not be adequately met because of their poor health.

Further studies are needed to determine, among other things, whether

- home health agencies are capable of meeting the skilled care needs of patients who are discharged earlier, and in poorer health, under prospective payment and
- increased demand for home care services will tax the ability of social service agencies to meet the home care needs of the chronically ill elderly.

Policy Options for Addressing Unmet Need

After the factors contributing to unmet home care needs are evaluated, various policy options probably need to be considered to deal with the future home care needs of the growing elderly population. Among the options that could be considered are (1) expanding Medicare home health coverage, (2) encouraging the development of private long-term care insurance, (3) providing tax incentives to family and friends to provide more care, (4) supporting community-based home care services through increased block grant funding, and (5) expanding the availability of home and community-based services through Medicaid.

Conclusions

In 1982, about 5 percent of the chronically ill elderly indicated that they did not receive all the help they needed with their activities of daily living. Without such assistance, these individuals are, in our opinion, at increased risk of institutionalization. Medicare, however, is not intended to meet the personal care needs of the elderly unless there is also a need

[5]See "Community Services Hit Heavy by DRGs" from the National Association of Area Agencies on Aging, The Coordinator, Oct. 1985, p. 29.

for skilled nursing care on a part-time or intermittent basis. Other programs, such as Medicaid's home and community-based services, appear to be a more appropriate means of meeting the home care needs of the chronically ill elderly who do not have the resources to pay for the needed services. The Medicaid home and community-based services program is not widely available at this time, and further study is needed to evaluate this and other policy options for meeting the home care needs of the growing elderly population.

Recommendation

We recommend that the Secretary of HHS do further studies to evaluate factors contributing to unmet need for home care assistance and options for meeting the future home care needs of the elderly.

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

Official Business
Penalty for Private Use $300

Address Correction Requested

First-Class Mail
Postage & Fees Paid
GAO
Permit No. G100

Methodology for Analysis of Home Health Users

Using the 1982 National Long-Term Care Survey and 1982 Medicare hospital, home health, and skilled nursing facility billing records, we developed two data bases for analyzing the characteristics of Medicare home health users. One data base contained a national sample of Medicare home health users with a limited number of personal and health care data elements. The second, a subset of the first, included only those home health users identified as chronically ill. We developed user profiles of this subgroup which represented about half of all home health beneficiaries.

The National Long-Term Care Survey

In 1982, the Bureau of the Census, under contract to HHS, conducted a national survey of elderly Medicare beneficiaries to determine the personal characteristics of the chronically ill elderly living in the community. A random sample of approximately 36,000 elderly Medicare beneficiaries or their representatives were initially contacted by telephone or personal visit to determine if they had chronic impairments of 3 months or longer. They became the basis for our national data base of home health users. About 5,600 persons[1] were identified as having long-term care needs after all components of the survey were completed. They formed the basis for our data base of chronically ill home health users. In 1984, the Bureau of the Census followed up on these 5,600 persons to determine changes in their health status. These data were not available when we completed our analysis. (For more information on the survey, see the 1982 National Long-Term Care Survey/National Survey of Informal Caregivers Methods and Procedures. Office of the Secretary of HHS (undated)).

Medicare Bill Data

Although the National Long-Term Care Survey collected data on payment sources, we anticipated relatively poor reliability of self-reported home health care payment data. This expectation was based on findings from the National Medical Care Expenditure Survey conducted by the National Center for Health Services Research, which found that over 40 percent of all elderly reported that their home health care provided by "other sources" was free. It was believed that Medicare and Medicaid were likely payors of this "free" care.[2] Because there is no copayment or deductible for Medicare home health and the provider bills Medicare

[1]The 1984 survey also included some additional persons not included in the 1982 survey.

[2]M. L. Berk and A. Bernstein, "Use of Home Health Services: Some Findings from the National Medical Care Expenditure Survey," Home Health Services Quarterly, Vol. 6(1), Spring 1985, p. 21.

directly, many elderly may not know the specific payment source for services they receive in their homes.

As a result, we used data from HCFA's Infrequent Users Retrieval Output file, which is part of the Beneficiary Bill History Retrieval System, to analyze the National Long-Term Care Survey respondents' use of home health, hospital, and skilled nursing facility services. This file, which is updated annually, brings together summaries of separate hospital, skilled nursing facility, home health and other part A bills for all Medicare beneficiaries beginning in 1978. We extracted the bill histories for all 36,000 persons contacted in the National Long-Term Care Survey and created a file of summary payment variables for those with a hospital, skilled nursing facility, or home health bill in 1982.

Creation of Home Health Beneficiary Types

To develop a better picture of the medical conditions and physical limitations of home health care beneficiaries, we employed a patient classification methodology, known as Grade of Membership analysis, to categorize types of individuals by clinical diagnostic information. The methodology considers several characteristics of individuals simultaneously to produce types of home health users who are differentiated by their probability of having a set of related medical conditions and physical impairments. These types of home health beneficiaries do not describe specific individuals. Instead, they represent a type of user that can be examined in relationship to utilization patterns and other service needs. Unlike diagnosis-related groups, which define medical conditions based on their ability to predict costs or length of stay, Grade of Membership classifies individuals by their multiple clinical characteristics. This methodology is particularly relevant to the chronically ill elderly, who tend to have more than one interacting condition.

The following are the 48 variables we used to construct types of home health users.[3] Regarding medical conditions, we considered the presence of the following at the time of the survey:

- Rheumatism or arthritis.
- Paralysis.
- Other permanent numbness or stiffness.

[3]For more information on the Grade of Membership methodology, see M. Woodbury, et al., "Mathematical Typology: A Grade of Membership Technique for Obtaining Disease Definition," Computers and Biomedical Research (11), June 1978, pp. 277-298; and M. A. Woodbury and K. G. Manton, "A New Procedure for Analysis of Medical Classification," Meth. Inform. Med., Vol. 21, No. 4, 1982, pp. 210-220.

- Multiple sclerosis.
- Cerebral palsy.
- Epilepsy.
- Parkinson's disease.
- Glaucoma.
- Diabetes.
- Cancer.
- Frequent constipation.
- Frequent trouble sleeping.
- Frequent severe headaches.
- Obesity.
- Arteriosclerosis.
- Mental retardation.
- Senility.

We also considered the presence of the following in the last 12 months:

- Heart attack.
- Other heart problem.
- Hypertension.
- Stroke.
- Circulation trouble in arms or legs.
- Pneumonia.
- Bronchitis.
- Flu.
- Emphysema.
- Asthma.
- Broken hip.
- Other broken bones.

Regarding physician limitations, we considered whether the person needed assistance in the following activities at the time of the survey:

- Bathing.
- Eating.
- Getting into/out of bed.
- Getting around inside.
- Dressing.
- Toileting.
- Heavy housework.
- Light housework.
- Laundry.
- Cooking.

- Grocery shopping.
- Getting around outside.
- Transportation.
- Managing money.
- Taking medication.
- Using telephone.

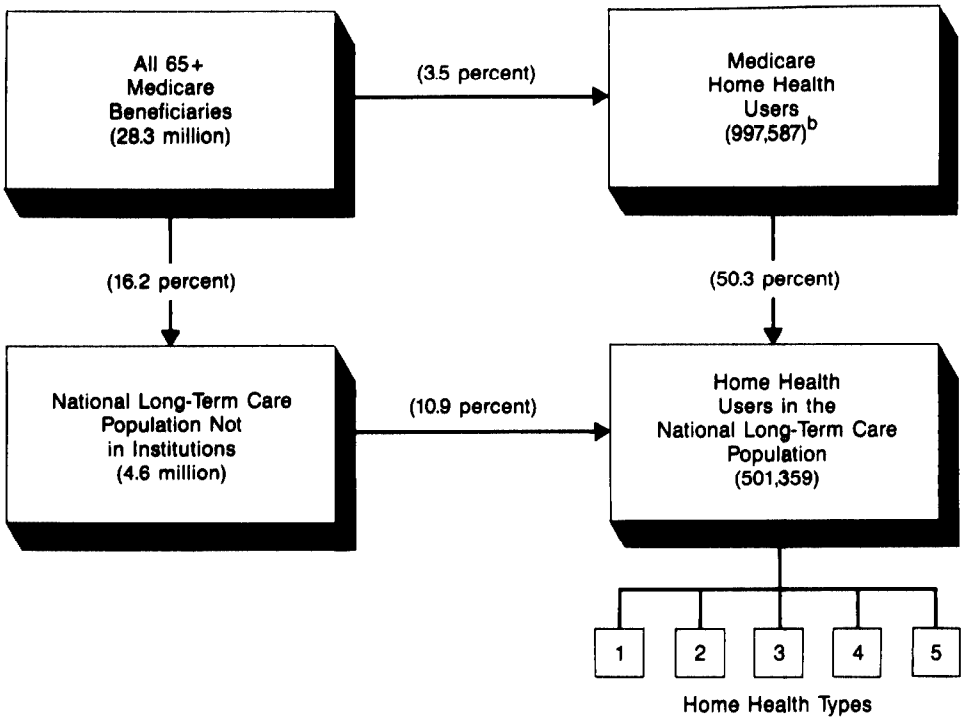
We also considered the presence of the following at the time of the survey:

- Bedfast.
- Unable to move around.
- Wheelchairfast.

Data Bases Used in the Analysis

From our matched data base of National Long-Term Care Survey respondents and their Medicare bill records, we estimated that 3.5 percent of all elderly Medicare beneficiaries used home health in 1982. About half of these users had long-term care needs and formed the data base for our Grade of Membership analysis. They represented about 11 percent of the noninstitutionalized long-term care population. Figure II.1 presents national estimates of various populations from our samples.

Figure II.1: 1982 Data Bases Used in Analysis of Home Health Users[a]



[a] All figures are estimates based on the survey weights developed by the Bureau of the Census.
[b] 14.2 percent of this group could not be analyzed due to missing data.

Limitations of Our Analysis

The different time frames covered by the two data bases limited our analysis in three ways. First, the National Long-Term Care Survey respondents may not have had a chronic condition for the entire 12 months covered by the Medicare claims data. For instance, if a respondent had a chronic condition for only the last 3 months of 1982, our analysis of the Medicare payment tape included the 9 months of home health use before the respondent had a chronic condition.

A second limitation to our analysis was that persons who reported no chronic limitations during the initial telephone contact, but later developed a chronic condition, were excluded from our analysis of chronically ill home health users. Because the 1984 follow-up survey data were not available, we do not know how often this occurred. Lastly, because our analysis of Medicare bill data was based on individuals who began receiving home health care during 1982, it includes persons who started home health care in 1982 and continued using it beyond 1982. However,

less than 0.5 percent of visits included in our analysis were provided sometime after 1982; one-fourth of these were provided in January 1983. Other persons, who began home health care before 1982 but continued using it in 1982, were excluded from our analysis.

Although we reviewed all documentation available on both data bases, we did not independently verify the work done by the Bureau of the Census in preparing the National Long-Term Care Survey data tape or by HCFA in preparing the Medicare bill tapes. We performed the match and our consultant verified our work for completeness and accuracy.[4]

[4]The matching process inadvertently excluded (1) 44 persons who used Medicare hospital, skilled nursing facility, or home health care in 1982 (0.5 percent) and (2) Medicare bills amounting to $23,549 for another 16 persons.

U.S. GOVERNMENT PRINTING OFFICE:1986-181-235/40122

Requests for copies of GAO reports should be sent to:

U.S. General Accounting Office
Post Office Box 6015
Gaithersburg, Maryland 20877

Telephone 202-275-6241

The first five copies of each report are free. Additional copies are $2.00 each.

There is a 25% discount on orders for 100 or more copies mailed to a single address.

Orders must be prepaid by cash or by check or money order made out to the Superintendent of Documents.

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

Official Business
Penalty for Private Use $300

Address Correction Requested

First-Class Mail
Postage & Fees Paid
GAO
Permit No. G100