United States General Accounting Office

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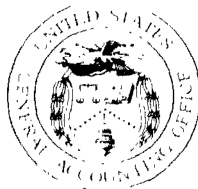
Report to the Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives

January 1992

MEDICARE

Rationale for Higher Payment for Hospital-Based Home Health Agencies



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

Human Resources Division

B-245370

January 31, 1992

The Honorable Edward R. Roybal
Chairman, Subcommittee on Health
and Long-Term Care
Select Committee on Aging
House of Representatives

Dear Mr. Chairman:

This report responds to your request that we study Medicare's policy of paying hospital-based home health agencies (HHAs) more than it pays freestanding HHAs.[1] Medicare pays HHAs their reasonable costs, subject to predetermined limits, for providing beneficiaries with prescribed skilled nursing or other health-care services in the home. Although the limits are based on freestanding HHA costs, hospital-based HHAs are allowed even higher payments because historically they have reported higher costs than freestanding agencies. Commonly referred to as the hospital add-on, the difference can be as much as 16 percent above the limits for freestanding HHAs.

The add-on is a matter of controversy within the home health industry. Representatives of freestanding agencies feel it is unfair because hospitals can be paid more for providing the same service freestanding HHAs provide for a lower payment. But hospital-based HHAs believe their higher costs justify the add-on.

You asked that we assess the rationale and justification for the hospital add-on. Our scope and methodology are described in appendix I.

Results in Brief

Allowing hospitals additional reimbursement for home health services is consistent with Medicare payment principles and federal legislation. The add-on is designed to pay a hospital for legitimate costs allocated to its HHA if those costs cause its total HHA costs to exceed predetermined Medicare cost limits. Nonetheless, the effect of this policy is to pay some hospitals more than freestanding HHAs for the same services. Several factors indicate that the add-on may not be necessary to assure beneficiary access to home health care. Specifically,

[1]HHAs can be provider-based (part of another Medicare provider, such as a hospital, skilled nursing facility, or rehabilitation facility) or freestanding. Most provider-based HHAs are part of a hospital and are referred to in this report as hospital-based HHAs.

- the number of freestanding HHAs has doubled over the last decade, indicating that needed services may be available and possibly reducing or eliminating the need for the add-on;
- about one-third of the hospital-based HHAs would be unaffected if the add-on was eliminated, because their costs are lower than the freestanding limits; and
- authority exists for payment of additional reimbursement to a hospital-based HHA with costs above the freestanding limits if it is the only source of home health care in the community.

Background

Medicare is a federal health insurance program that helps most Americans age 65 or over and certain disabled people under 65 pay for their health care costs. The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), administers Medicare.

From 1979 through 1990, Medicare spending for home health care increased from $592 million to $3.5 billion, making it one of the fastest growing components of Medicare costs. At the same time, the number of HHAs providing Medicare services nearly doubled (see table 1). Most of the growth occurred among for-profit freestanding and hospital-based HHAs. In contrast, the more traditional nonprofit providers—visiting nurse associations (VNAs) and government agencies—decreased in number and share of the HHA market.

Table 1: Growth in Home Health Agencies Providing Medicare Services (1979-90)

	1979		1990	
HHA type	**Number**	**Percent**	**Number**	**Percent**
Provider-based:				
Hospitals	349	12.2%	1,508	26.4%
Other	17	0.6	110	1.9
Freestanding:				
For-profit	165	5.8	1,918	33.5
Private nonprofit	443	15.5	710	12.4
Government	1,274	44.6	952	16.6
VNA	511	17.9	478	8.4
Other	99	3.4	45	0.8
Total	**2,858**	**100.0%**	**5,721**	**100.0%**

A variety of factors account for the increase in the demand for home health services and the number of providers. Among them are an increasingly

aging population, expanded Medicare home health benefits, and changes in Medicare hospital payment policies that encourage earlier discharge from hospitals.

How Medicare Reimburses HHAs

Under authority originally provided through section 223 of the Social Security Amendments of 1972 (P.L. 92-603), HCFA has established upper limits on the amount Medicare will pay HHAs. Based on the cost experience of freestanding HHAs, these limits are set by type of home health visit (such as skilled nursing or home health aide). They are applied in the aggregate; that is, costs above the limit for one type of visit can offset costs below the limit for another type. Separate limits are set for urban and rural HHAs because costs tend to differ between them, and the limits for each HHA are adjusted to reflect local wage rates.

In addition, hospital-based HHAs are allowed an add-on in recognition that such organizations historically have reported higher costs than the free-standing agencies upon which the rates are based (see p.4). Depending on the type of visit, the add-on ranges about 13-16 percent above the free-standing limits (see table 2). HCFA estimates that the add-on cost Medicare about $33 million in 1991.

Table 2: Freestanding Cost Limits and Hospital-Based Add-On for Urban HHAs (June 30, 1991)

	Cost limit[a]			
Type of visit	Freestanding HHA	Hospital-based HHA	Diff. (add-on)	Percent diff.
Skilled nursing care	$69.33	$79.30	$9.97	14.4%
Physical therapy	67.06	75.48	8.42	12.6
Speech therapy	72.72	81.99	9.27	12.7
Occupational therapy	69.08	78.02	8.94	12.9
Medical social service	100.24	115.91	15.67	15.6
Home health aide	40.65	45.85	5.20	12.8

[a]National average rates that are adjusted for local wage rates.

Cost-allocation Rules Result in Higher Reported Costs for Hospital-based HHAs

Hospital-based HHAs generally report higher costs than freestanding HHAs, in part because the Medicare cost-allocation system requires that a portion of hospital overhead be allocated to the HHA. To ensure proper matching of revenue and expenses, Medicare requires that hospital cost centers,[2] such as the HHA, include both direct expenses and their proportionate share of overhead costs of the overall hospital. Consequently, a hospital-based HHA is allocated some additional overhead costs not typical of those incurred by freestanding HHAs and, therefore, not recognized by the freestanding cost limits.

When HCFA first established cost limits for home health services in 1979, no distinction was made between freestanding and provider-based agencies. However, a HCFA analysis found that the percentage of provider-based HHAs exceeding the cost limits was higher than the percentage of freestanding HHAs. These higher costs, HCFA concluded, were due largely to the allocation of hospital overhead expenses to the home health cost center as required by Medicare cost-allocation rules. Consequently, in 1980 separate cost limits were established for freestanding and provider-based HHAs.

The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) required HCFA to establish single-payment limits for all health services, based on the costs of freestanding HHAs only. The Conference Committee Report accompanying the statute, however, indicated that adjustments to recognize legitimate cost differences of hospital-based HHAs, such as the effects of Medicare cost-allocation requirements, were allowable.[3]

To replace the separate provider-based limits, HCFA established an add-on for hospital-based HHAs. Analyzing a sample of hospital cost reports to determine what costs should be recognized, HCFA concluded that about 26 percent of hospital-based HHA costs were for overhead allocated from the hospital in conformance with Medicare cost-allocation rules. Half of the overhead costs, such as depreciation, building operation and maintenance, and housekeeping, were similar to the overhead costs a freestanding HHA incurs, HCFA found.

The other half, according to HCFA, consisted of a portion of hospital administrative and general (A&G) expenses. These costs represent a variety of

[2]A cost center is an organizational unit within an institution, such as a department, where direct and indirect costs are accumulated for accounting and reimbursement purposes.

[3]The Omnibus Budget Reconciliation Act of 1986 required HCFA to include an adjustment to hospital-based HHA cost limits to recognize the administrative and general costs of hospital-based HHAs.

activities directed toward overall management and operation of the hospital, such as the salaries of hospital administrators. As part of the hospital complex, such hospital departments as the HHA receive some benefit from A&G costs, hospital-based officials contend. Because the relationship between A&G costs and benefits to a particular department is not precisely measurable, the extent of the benefit is estimated by allocating the costs proportionately throughout the complex. This approach is frequently used for allocating costs when the relationship between costs and services provided is difficult to determine.

Add-On May Not Be Necessary to Assure Access

While not an exact way of distributing costs, the hospital add-on is consistent with Medicare cost-reimbursement principles and the statutory requirements for setting cost limits. However, it results in hospitals receiving more than freestanding agencies for the same services. Further, given the increase in the number of freestanding agencies (see table 1), the add-on may not be necessary to assure beneficiary access to home health care. The increase in freestanding HHAs suggests that services will be available if needed.

About one-third of hospital-based HHAs report costs below the limits for freestanding HHAs, HCFA data indicates. Elimination of the add-on would not adversely affect these hospital-based HHAs. Also, if a hospital-based HHA with costs above the freestanding limits is the only HHA available to beneficiaries in an area, it can be excepted from the cost limits under the "extraordinary circumstances" exception.[4] It appears the only beneficiaries who would be affected adversely would be those in an area in which hospital-based HHAs ceased participation because of the elimination of the add-on and other HHAs in the area were unable or unwilling to expand services sufficiently to meet the need.

HHS Comments and Our Evaluation

HHS commented on a draft of our report in a letter dated December 6, 1991 (see app. II). While agreeing with the results of our review, HHS expressed the belief that, in certain instances, hospital-based HHAs can offer more services and a continuum of care that is unavailable from freestanding HHAs. As a result, HHS believes that access to certain quality services may be reduced where hospital-based HHAs are affected adversely by elimination of the add-on.

[4]An exception is an upward adjustment of the cost limits for a provider with costs above the limits due to certain circumstances specified in the law. "Extraordinary circumstances" is the provision under which an HHA can apply for an exception if it is the only source of home health care in its community.

As we have reported, the add-on was designed to compensate hospitals for increased A&G expenses they incur in the operation of a HHA (see p.4). It was not designed to pay for more services that certain hospital-based HHAs potentially could provide nor to compensate them for offering a continuum of care. Further, about one-third of the hospital-based HHAs do not receive the benefit of the add-on. This does not indicate, however, that they provide lower-quality services or that they have less capability to be part of a continuum of care than HHAs receiving the add-on.

To assess the impact of reducing the number of hospital-based HHAS, HHS thought it would be helpful to include the number of visits furnished by hospital-based and freestanding HHAs. In addition, HHS stated that the dramatic increase in the number of participating freestanding HHAs would appear to indicate that the "advantage" hospital-based HHAs receive from the add-on has not been as detrimental as alleged.

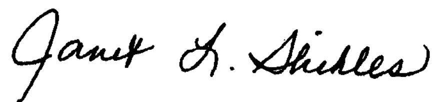
Hospital-based HHAs furnish about 22 percent of all HHA visits. We believe it would be erroneous to assume, however, that this is the size of the gap that would be created if the add-on were eliminated. We are not aware of any evidence that the availability of the add-on is significant enough to be the deciding factor in the operation of a HHA. As we indicate on p. 5, it appears that the only beneficiaries adversely affected are those in an area where the hospital closed its HHA and other HHAs in the area were unable or unwilling to expand their services to the level needed. Further, the rapid growth of existing HHAs would seem to indicate that a freestanding HHA would be started to meet the demand if necessary. While HHS said that the increased number of freestanding HHAs would appear to indicate that the add-on has not been detrimental to them, we believe the issue is whether the government should pay hospital-based HHAs more than freestanding agencies for the same services.

The draft report we provided for HHS' advance review and comment discussed a HCFA demonstration of prospective payment for HHAs. As part of that demonstration, HCFA intended to determine how cost differences, such as those between hospital-based and freestanding agencies, should be accommodated. HHS commented, however, that the demonstration will be extremely limited for this issue due to the greater reluctance of hospital-based HHAs to participate. Although HCFA intended to recruit approximately 20 hospital-based agencies, only 3 agreed to participate. As a result, we have deleted our discussion of the demonstration.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties, and make it available to others on request.

Please call me on (202) 275-5451 if you or your staff have any questions about this report. Major contributors are listed in appendix III.

Sincerely yours,



Janet L. Shikles
Director, Health Financing
and Policy Issues

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Abbreviations

A&G	administrative and general
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHA	home health agency
HHS	Department of Health and Human Services
VNA	Visiting Nurse Association

Scope and Methodology

To assess the rationale for the add-on and determine whether its continuation is warranted, we visited HCFA headquarters in Baltimore and its regional office in Chicago, two freestanding HHAs in the Kansas City area, and one freestanding and three hospital-based HHAs in the Chicago area. In addition, we met with representatives of the Visiting Nurse Association of America, the American Hospital Association, the American Federation of Home Health Agencies, and the National Association for Home Care. We also discussed the relationship between the add-on and the way hospitals are paid for inpatient services with representatives of the Prospective Payment Assessment Commission.

To better understand how hospital A&G costs are allocated to their HHAs, we reviewed selected HHA cost reports at Blue Cross and Blue Shield of Illinois, a Medicare contractor responsible for paying HHA claims. To identify articles and studies concerning Medicare payments to HHAs, we reviewed prior GAO reports and conducted literature searches. In addition to examining laws, regulations, and other guidance on Medicare's payment system for HHAs, we analyzed HCFA data on home health costs, utilization, and types of providers.

We did not verify the accuracy of HCFA data. With this exception, we conducted our work between November 1990 and September 1991 in accordance with generally accepted government auditing standards.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

DEC 6 1991

Ms. Janet L. Shikles
Director, Health Financing
and Policy Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Shikles:

Enclosed are the Department's comments on your draft report, "Medicare: Rationale for Higher Payment for Hospital-Based Home Health Agencies." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Medicare: Rationale for Higher Payment for Hospital-Based Home Health Agencies"

GAO prepared this report at the request of the Chairman, Subcommittee on Health and Long-Term Care, House Select Committee on Aging. Specifically, GAO was asked to study Medicare's policy of paying hospital-based home health agencies (HHAs) more than it pays freestanding HHAs. Medicare payments to HHAs are subject to certain predetermined limits. However, because hospital-based HHAs have historically reported higher costs than freestanding ones, Medicare allows them higher limits. The difference is commonly referred to as the hospital add-on.

Now on p. 5.

The report, on page 10, states, "Further, given the increase in the number of freestanding agencies, the add-on may not be necessary for assuring beneficiary access to home health care. The increase in freestanding HHAs seems to indicate that services will be available if needed." The GAO report concludes that the add-on, however, results in Medicare paying hospitals more for the same services that freestanding agencies provide and may not be necessary to maintain beneficiaries' access to home health care.

While we agree with the results of the GAO review, we believe that in certain instances hospital-based HHAs can offer more services to the beneficiaries and offer a continuum of care not available from freestanding HHAs. Therefore, where hospital-based HHA's are adversely affected by eliminating the add-on, beneficiary access to certain quality services may be reduced.

In assessing the impact of reducing the number of participating hospital-based HHAs, it may be helpful to include in the report a breakdown of the number of visits currently furnished by hospital-based HHAs versus freestanding HHAs. Additionally, based on the dramatic increase in the number of participating freestanding HHAs, it would appear that the "advantage" that hospital-based HHAs receive from the add-on has not been as detrimental as alleged by the providers.

Discussed on p. 6.

Page 2

Finally, the report recognizes that HCFA is conducting a demonstration of prospective payment for HHAs. On page 11, the report states, "As part of the demonstration, HCFA will also attempt to determine how cost differences between HHAs, such as those between hospital-based and freestanding agencies, should be accommodated." GAO is correct that analysis of potential differences in costs and service patterns between hospital-based and other HHAs has been an objective of this project. Our intention was to recruit approximately 20 hospital-based HHAs to participate. Unfortunately, hospital-based agencies were much more reluctant to participate in this initiative than freestanding HHAs, and only three hospital-based agencies agreed to participate in the demonstration. Consequently, the capability of our evaluation contractor to analyze hospital-based HHA costs under this project will be extremely limited.

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