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Health, Education and Human Services Division

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May 28, 1997

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

Subject: Comments on H.R. 4229–A Proposal for a Home Health Prospective Payment System

Dear Mr. Chairman:

You asked us to comment on H.R. 4229, introduced in the 104th Congress, which the home health care industry has suggested could be a model for a Medicare prospective payment system (PPS) for home health services. Many of the comments in this letter are similar to issues we raised about home health PPS in general in our testimony before the Subcommittee on March 4, 1997.[1]

H.R. 4229 would require the Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA) to establish, after congressional approval, a PPS for Medicare home health care 4 years after enactment that would pay fixed rates for episodes of care. During the 4 years between enactment of the legislation and implementation of the home health PPS, H.R. 4229 would establish two transitional 2-year phases.

Home health agencies (HHA) would be paid on a per visit basis with rates for each type of visit equal to the national average Medicare payment in 1994, adjusted for geographic wage differences and updated for inflation using the Medicare home health market basket index. In phase I, the first 2 years after enactment, an annual aggregate limit on payments would be applied to each HHA equal to the 1995 national average number of visits per

[1] Medicare Post-Acute Care: Home Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment (GAO/T-HEHS-97-90, Mar. 4, 1997).

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beneficiary multiplied by a blend of agency-specific cost per visit (75 percent in the first year and 50 percent in the second year) and average regional cost per visit. In phase II, the 3rd and 4th years after enactment, the limit would be based on the number of episodes in each of 18 case mix categories and the national average Medicare payment per visit plus an amount for each visit after 120 days has passed in an episode of care. If the payments the HHA had received during the year were below the limit and its average payment per beneficiary did not exceed 125 percent of the regional average, it would receive 50 percent of the difference, up to a total of 10 percent of the aggregate limit.

The transitional payment methods would give HHAs incentives to reduce costs per visit but would provide little if any incentive for many agencies to control the number of visits furnished. Medicare's increased costs for home health have been driven much more by increased numbers of visits per beneficiary and more beneficiaries being served than by growth in cost per visit. While Medicare's total home health costs increased an average of 33 percent per year from 1989 to 1996, its costs per visit increased an average of only 3.6 percent per year. Moreover, what constitutes a visit has not been defined, and HHAs could gain by responding to the incentives to reduce cost per visit by actions such as merely reducing the length of visits.

Basing the limits on episodes in phase II would at best provide weak incentives to control the number of visits, the factor that has driven Medicare expenditure growth for home health. As we reported in 1996,[2] the average number of visits is skewed by a substantial portion of patients who receive extraordinarily high numbers of visits and by the significant variation in the average number of visits supplied by different HHAs. For example, in 1993, 18 percent of patients received more than 90 visits in an episode. In that year the average number of visits per beneficiary was 57, much higher than the median number of visits of 24, which illustrates the skewing. The effect is that the care received by most patients should already be well below the average number of visits used in calculating the limit and that in the aggregate, most HHAs are providing fewer visits than the limit. Thus, while over time such a payment method might provide incentives to hold down the growth in visits per episode, the short-term effects are not likely to be significant.

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[2] Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

A potential problem with an episode payment system with stronger incentives for cost control is that HHAs might respond to it by reducing the number of visits during the episode, potentially lowering the quality of care. HCFA would need a method to ensure that beneficiaries receive adequate services and that any reduction in services that can be accounted for by past overprovision of care does not result in windfall profits for HHAs. In addition, HCFA would need to be vigilant to ensure that patients meet coverage requirements, because HHAs would be rewarded for increasing their caseloads.

Another problem with the phase II proposal is that it uses the 18 case mix categories from HCFA's PPS demonstration project. HCFA has stated that these categories are not sufficiently developed for general use and explain less than 10 percent of the variation in cost across patients. In addition, HCFA does not routinely collect the data on patient activities of daily living that are necessary for this case mix system.

We also have concerns related to the data on utilization and costs of home health that would be used to establish rates in both phase I and phase II proposed in H.R. 4229. Efforts to identify fraud and abuse, such as Operation Restore Trust, indicate that substantial amounts of noncovered care are likely to be reflected in HCFA's home health care utilization data. Similar concerns exist regarding the home health cost data base. Our work, and that of the HHS Inspector General, has found examples of questionable costs in cost reports. Also, the percentage of HHAs subjected to field audits has generally decreased over the years, as has the extent of auditing done at the facilities that are audited. For these reasons, there is little assurance that HCFA's cost data reflect only reasonable costs that are related to patient care. Using these data to set payment rates and determine extra payments to HHAs could result in windfall profits for them.

Overall, considering all the factors discussed previously, we believe that it is questionable whether savings would be realized by Medicare if H.R. 4229 were adopted. Moreover, mechanisms do not exist to protect beneficiaries from potential quality of care problems that could arise from the incentives to shorten visit times and decrease the number of visits in an episode of care.

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As agreed with your office, unless you release its content earlier, we plan no further distribution of this letter for 7 days. At that time we will make

copies available to other congressional committees and Members of Congress with an interest in this matter. If you have any questions about this letter, please contact me on 202-512-7114 or Tom Dowdal, Senior Assistant Director, on 202-512-6588. Sally Kaplan, Senior Evaluator, also contributed to this letter.

Sincerely yours,

William J. Scanlon
Director, Health Financing and Systems Issues

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