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MEDICARE

**Interim Payment System for
Home Health Agencies**

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Medicare: Interim Payment System for Home Health Agencies

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the recent changes in Medicare's payment policies for home health agencies and the need to ensure that the level of payments and their distribution are appropriate. Medicare spending for home health care has risen dramatically in recent years. By 1996, this benefit consumed 9.3 percent of Medicare expenditures, up from 2.5 percent in 1989. Changes in the law and program guidelines have contributed to the rapid growth in the number of beneficiaries using home health care and in the average number of visits per user. These changes have not only resulted in accelerating costs but also a marked shift from an acute-care, short-term benefit toward a more chronic-care, longer-term benefit as a result of changes in patient mix and treatment patterns. The increased use of home health care has not been matched by a commensurate rise in spending for claims review and program monitoring. As a result, some of the visits provided and people served may not meet Medicare's coverage criteria.

In response to this rapid cost growth and concerns about program abuses, the Balanced Budget Act of 1997 (BBA) included a number of provisions on home health payment and provider requirements. Specifically, the law requires implementation of a prospective payment system (PPS) for home health agencies in fiscal year 2000. Until then, an interim payment system that incorporates limits, based on historical spending levels, that are applied to cost-based payments will be used to constrain program outlays. The interim limits will differ for each provider to reflect the substantial variation in home health spending across agencies and geographic areas. BBA also prohibits certain billing practices determined to be abusive, strengthens participation requirements for agencies, and authorizes the Secretary of Health and Human Services to develop guidelines on the frequency and duration of home health services to use in determining whether visits should be covered.

My comments today focus on the rise in Medicare spending for home health services and the reasons for this growth, the objectives of the home health interim payment system enacted by BBA, and concerns about the level and distribution of home health payments. The information presented is based primarily on our analysis of BBA and on our previous work on Medicare's home health benefit. (A list of related GAO products is at the end of this statement.)

In summary, a well-designed PPS will provide the Medicare program with the best means to rationally control home health spending. Until such a system is implemented, the interim payment system will help constrain the growth in outlays. However, concerns have been raised about the interim payment system. Specifically, the industry has expressed doubts about whether payments will be adequate and whether the payment limits will appropriately account for differences in patient mix and treatment patterns across agencies. Another concern is that inefficient providers will have unduly high limits because the limits are based on historic payments that reflect inappropriate practices.

Previous analyses by us and the Department of Health and Human Services' (HHS) Office of Inspector General have demonstrated that Medicare has been billed for home health visits that may not have been needed, were not consistent with Medicare policies, or were not even delivered. Thus, concerns about the overall adequacy of payments under the interim system may be unwarranted, since the limits were based on historic costs, a portion of which were inappropriate. Whether the payments to individual agencies will reflect legitimate differences across agencies is more difficult to determine. Costs vary widely across agencies, which reflects differences in patient mix and levels of efficiency. In protecting legitimate cost differences across agencies, the interim system may unavoidably reward some inefficient agencies. Furthermore, the interim system may also be too restrictive for agencies with costs that legitimately increase more rapidly over time. Because the interim payment system will be used for a longer period than originally intended, we believe it is even more important to better take account of appropriate variation in agency costs.

Background

To qualify for Medicare home health care, a beneficiary must be confined to his or her residence (that is, "homebound"); require intermittent skilled nursing, physical therapy, or speech therapy; be under the care of a physician; and have the services furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions are met, Medicare will pay for part-time or intermittent skilled nursing; physical, occupational, and speech therapy; medical social service; and home health aide visits. Beneficiaries do not pay any coinsurance or deductibles for these services.

The Health Care Financing Administration (HCFA), the agency within HHS responsible for administering Medicare, uses six regional claims

processing contractors (which are insurance companies) to process and pay home health claims. These contractors pay the claims submitted by home health agencies on the basis of the costs they incur, subject to predetermined payment limits. They are also responsible for ensuring that Medicare does not pay claims when beneficiaries do not meet Medicare's coverage criteria, when services claimed are not reasonable or necessary, or when the volume of services exceeds the level called for in an approved plan of treatment. They carry out these responsibilities through medical reviews of claims, performed either before or after a claim is paid, and occasionally through site visits to the agencies.

Reasons for Home Health Cost Growth

Congressional changes to home health payment policies, enacted in BBA, were made in response to dramatic growth in the cost and use of the benefit. From 1989 to 1996, expenditures for home health care increased from \$2.5 billion to \$18.1 billion—an average annual increase of 33 percent. Home health payments in 1996 represented 9.3 percent of Medicare outlays.

The growth in spending was due primarily to an increase in users and in visits per user, rather than rising payments per visit. The payment per visit has been held in check by existing Medicare payment limits. In 1989, 50 Medicare beneficiaries per 1,000 enrollees received home health care. The average user in that year received 27 visits. By 1996, 99 beneficiaries per 1,000 used home health care and received an average of 76 visits. The payment per visit went from \$54 to \$62 over this period.

Changes in Medicare eligibility and coverage rules played an important role in the increased use of this benefit. At Medicare's inception in 1965, home health care was primarily a posthospitalization benefit, and there was an annual limit on the visits covered for each beneficiary. These restrictions were eliminated by the Omnibus Reconciliation Act of 1980 (P.L. 96-499). This did not lead to a surge in spending growth, however, because the manner in which HCFA interpreted coverage and eligibility criteria limited the number of home health users and covered visits. In the late 1980s, however, HCFA's coverage criteria were struck down by a U.S. district court. As a result, it became easier for beneficiaries to receive these services. In addition, other court decisions made it more difficult for HCFA's claims processing contractors to deny certain services.

The combination of these changes essentially transformed the home health benefit from one focused on patients needing short-term care after

a hospitalization to one that serves chronic, long-term-care patients as well. We found that from 1989 to 1993, the proportion of home health users receiving more than 30 visits a year increased from 24 percent to 43 percent and those receiving more than 90 visits tripled, from 6 percent to 18 percent. Moreover, about a third of beneficiaries receiving home health care in 1992 did not have a recent prior hospitalization.

The importance of long-term users to Medicare home health spending has continued to increase. The majority of visits in 1996 (59 percent) were for the 15 percent of users who received 150 visits or more. Almost one-third of this high-user group received over 300 visits in the year. About half of home health users received fewer than 30 visits, which accounted for 9 percent of total home health visits in that year.

Concurrent with this dramatic growth in service use has been a rapid rise in the number of home health agencies. By 1994 there were almost 8,000 home health agencies, about 40 percent more than in 1989. And by 1996, there were almost 10,000 Medicare-certified agencies. For-profit providers contributed disproportionately to this growth so that by 1994 they represented 48.5 percent of the total, up from 35.3 percent in 1989.

Recent evidence demonstrates that some home health services have been provided to beneficiaries who did not meet Medicare's coverage criteria, and in some instances the services were not provided at all. We have reported on a number of examples of noncovered services that were billed to Medicare. Of particular concern is whether beneficiaries actually are homebound when they receive these services. Operation Restore Trust, a joint effort by federal and several state agencies, found very high rates of noncompliance with Medicare's coverage conditions. It documented abuses of the homebound criteria, instances in which services were billed for but never provided, visits that were not authorized by a physician, and visits to beneficiaries who otherwise did not qualify.

Home health spending growth has slowed markedly in recent years. Between 1995 and 1996, outlays rose 8 percent, compared with the average annual growth rate in the early 1990s of 33 percent. Preliminary estimates indicate that expenditures actually declined from 1996 to 1997. This was due to an overall reduction in visits provided. The number of beneficiaries receiving home health care fell enough to more than offset a slight increase in the number of visits per user.

There is no definitive explanation for this downturn. Some speculate that the sentinel effect of Operation Restore Trust and pending payment constraints may have changed agency behavior. Other possibilities include increased use of managed care and the maturation of the home health industry. Without a better understanding of the contributing factors and, more importantly, without additional experience, it is not clear whether the reduced use is a trend that will continue or merely a temporary aberration.

Objectives of the Interim Payment System

BBA mandated a prospective payment system for home health services beginning in fiscal year 2000. The PPS would establish a fixed, predetermined payment per unit of service, adjusted for patient characteristics that affect the cost of care (termed “case mix”). The Congress supports a PPS for home health agencies, as well as for other facilities, because it has the potential to improve provider incentives to control costs while delivering appropriate services. Under a well-designed system, efficient providers would be financially rewarded. Conversely, inefficient ones would need to better control their costs to remain viable. If a PPS is not properly implemented, Medicare will not save money, cost-control incentives will at best be weak, and access to and quality of care could suffer.

Recognizing the difficulty of designing such a system, coupled with the need to immediately control spending, BBA imposed an interim payment system on home health agencies until a PPS could be developed. The interim system builds on the cost limits already in place by making them more stringent. Previously, agencies were paid the lower of their actual costs or a limit based on 112 percent of the average cost per visit, adjusted for the number and mix of visits they provided. BBA changed the calculation of this per-visit limit so that it is based on 105 percent of the median per-visit cost. A new annual per-beneficiary limit was added as well. It is the average payment for all home health services for each beneficiary who received care. The limit is calculated as a blend of 75 percent of the agency’s updated, per-beneficiary payment and 25 percent of the comparable average regional amount. The base year for these calculations is the facility’s cost reporting year that ended in federal fiscal year 1994.

This interim payment method provides incentives to control per-visit costs and the number and mix of visits for each user. For agencies with per-visit costs considerably below the limits, however, there is no incentive to

provide visits more efficiently. The objective of the per-beneficiary limit was to rein in the growth in the number of visits provided to each user. However, most of this rapid growth would be reflected in the data used to establish the limits, so the limits may be inappropriately generous. Moreover, per-beneficiary limits give home health agencies an incentive to increase their caseloads, particularly with less expensive patients. Given lax home health claims review, this may even occur by adding beneficiaries who do not meet Medicare coverage criteria.

It is important to keep in mind that the existing per-visit limits as well as the new per-beneficiary limits are applied to aggregate agency costs. Thus, an agency does not need to keep the cost of each visit below the limit or to restrict the visits provided to each beneficiary to base-year levels. Rather, agencies can balance high-cost visits with low-cost ones to stay below the limits. Similarly, an agency could treat a mix of more intensive and less intensive beneficiaries and still not bump up against the per-beneficiary limits.

Achieving the Appropriate Level and Distribution of Payments

Even with this ability to average costs across visits and beneficiaries, the industry has voiced concerns that the per-beneficiary limits in the interim system are too stringent and that reliance on agency-specific and regional costs to establish the limits rewards providers who are inefficient and thus have historically high payments. For efficient providers, the limits may be too low if changes in their patient mix or other external factors have significantly increased their costs above the base-year amounts. Concern about the overall stringency of the limits may be unwarranted because of the lack of historical payment controls. Assessing whether the per-beneficiary limits are appropriate for each agency, however, is a more difficult undertaking.

The lack of sufficient program controls over the past decade may have made it likely that a portion of the recent increase in home health spending stemmed from inappropriate use of the benefit or abusive practices. For this reason, in aggregate, payments under the interim system may be adequate. The rapid growth in spending since 1989 has been accompanied by decreased, rather than increased, funding for program safeguard activities. By 1995, fewer than 3.2 percent of all claims were reviewed to determine whether the beneficiary actually qualified for the services, needed them, or even received what was being billed to Medicare. In a study last year, we selected a sample of high-dollar claims that had been paid without any review. After they were examined by an

intermediary at our request, it turned out that a large proportion of them should not have been paid. More recently, the Office of Inspector General in its annual audit of HCFA estimated that 12.5 percent of Medicare home health spending in fiscal year 1997 was inappropriate because the services were not medically necessary or lacked supporting documentation.

Each agency's per-beneficiary limit should reflect the types and number of services needed by its patients. Because service needs vary, the use of agency-specific and regional average payments in the calculation of the per-beneficiary limit is intended to account for differences in resource needs of patients across agencies. Though historic average payments are a readily available measure, they are admittedly a crude case-mix adjuster because they will reflect differences from multiple causes. Agencies with higher costs as a result of inefficient practices will have higher per-beneficiary limits than efficient ones. Conversely, if an agency had a history of managing its costs and controlling its visits to each patient, its per-beneficiary limit will be constrained. Unfortunately, examining costs alone cannot reveal whether an agency serves more needy patients or operates inefficiently. Practically, therefore, inefficient agencies may be unintentionally rewarded in order to protect those serving a more complex mix of patients.

The marked variations in home health use across geographic areas and agency types raise questions about differences in efficiency, which would inappropriately boost per-beneficiary limits in some areas. In 1995, users received an average of 132 visits in the West South Central region, in contrast with 52 visits in the Middle Atlantic region. These extremes are more likely due to differences in practice styles and efficiency among agencies rather than patient mix. We demonstrated in an earlier study that even when controlling for patient diagnosis, substantial variation in the number of visits per beneficiary remained. For example, we found that beneficiaries with a primary diagnosis of diabetes received an average of 67 home health visits in Utah compared with 22 visits in South Dakota. This three-fold variation in service use is unlikely to be due to case-mix differences that were not reflected in the beneficiaries' primary diagnosis.

Despite taking account of agencies' case mix by using historical costs, per-beneficiary limits can prove problematic for some agencies if external factors cause them to begin serving a more expensive mix of patients. New agencies entering or some existing agencies leaving a local market could have such an effect on other agencies. An even more widespread impact could accompany a state's adoption of a so-called "Medicare maximization

policy.” Through these policies, states attempt to ensure that Medicare is billed instead of Medicaid, when appropriate, for home health services for patients who are eligible for both programs. If such a policy is implemented after the base year, the per-beneficiary limits would not reflect the fact that some services formerly paid by Medicaid are now being billed to Medicare. As an example, Minnesota’s implementation of a Medicare maximization policy in 1996 likely contributed to its agencies having much faster growth in visits per user since 1994 than occurred elsewhere.

Attempting to calibrate the per-beneficiary limits to reflect legitimate differences among agencies without data on the causes of those differences inevitably leads to potential underpayments and overpayments. The mandated PPS to be implemented in fiscal year 2000 would resolve this by basing payments on each patient’s needs so that total payments reflect each agency’s current patient mix. However, HCFA has announced that the PPS’s implementation will be delayed to make its computer systems Year 2000 compliant. It should also be acknowledged that the development of a PPS for home health will be a much greater challenge than prior efforts to create one for hospitals and skilled nursing facilities (SNF). In the case of SNFs, for example, a number of Medicaid programs had years of experience with case-mix-adjusted PPSS. Comparable in-depth experience for home health is lacking. Furthermore, in the case of hospitals and SNFs, the task of defining the unit of service (an admission and a day, respectively) was relatively easy. For home health, defining what should comprise the unit of service—an episode of care—may prove very difficult. At present, no consensus exists on what constitutes a needed Medicare covered visit or what a visit would entail—basic information essential to establishing an appropriate PPS.

There is the potential that the Year 2000 problem and difficulties in completing a satisfactory design could delay further PPS’s implementation. Since the per-beneficiary limits are to remain in place longer than expected, a mechanism for agency-specific adjustments to them to better account for appropriate variations in current costs will take on added importance. Potential adjustors that could be developed with available information include, for example, the proportion of Medicare patients who are also eligible for Medicaid, patient length of stay, and proportion of beneficiaries with a recent hospitalization. Research HCFA currently has under way to develop the PPS might guide this effort. Without adjustment of the per-beneficiary limits, the extent of underpayments and overpayments would likely increase with time.

Conclusions

The Congress has taken very positive steps in positioning HCFA to rein in unsustainable growth in Medicare spending for home health care. Because this benefit has been largely unchecked in recent years, it is likely that these efforts will be met with opposition. The unanticipated extension of the interim payment system creates a need for HCFA to examine whether refinements to the per-beneficiary limits to distribute payments more equitably are needed while working to develop an appropriate case-mix-adjusted PPS. The goal should be to move as quickly as possible to adjust the interim payment system so that it ensures that agencies are paid appropriately for the mix of beneficiaries they serve.

This concludes my prepared remarks. I would be happy to respond to questions from the Subcommittee at this time.

Related GAO Products

Medicare Home Health Benefit: Congressional and HCFA Actions Begin to Address Chronic Oversight Weaknesses ([GAO/T-HEHS-98-117](#), Mar. 19, 1998).

Medicare: Improper Activities by Mid-Delta Home Health ([GAO/T-OSI-98-6](#), Mar. 19, 1998, and [GAO/OSI-98-5](#), Mar. 12, 1998).

Long-Term Care: Baby Boom Generation Presents Financing Challenges ([GAO/T-HEHS-98-107](#), Mar. 9, 1998).

Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies ([GAO/HEHS-98-29](#), Dec. 16, 1997).

Medicare Home Health: Success of Balanced Budget Act Cost Controls Depends on Effective and Timely Implementation ([GAO/T-HEHS-98-41](#), Oct. 29, 1997).

Medicare Fraud and Abuse: Summary and Analysis of Reforms in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 ([GAO/HEHS-98-18R](#), Oct. 9, 1997).

Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings ([GAO/HEHS-97-108](#), June 13, 1997).

Medicare: Home Health Cost Growth and Administration's Proposal for Prospective Payment ([GAO/T-HEHS-97-92](#), Mar. 5, 1997).

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

Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements ([GAO/HEHS-95-171](#), Aug. 8, 1995).

Medicare: Allegations Against ABC Home Health Care ([GAO/OSI-95-17](#), July 19, 1995).

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