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Report to Congressional Requesters

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MEDICARE HOME HEALTH BENEFIT

Impact of Interim Payment System and Agency Closures on Access to Services

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Health, Education, and
Human Services Division

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The Honorable William V. Roth, Jr.
Chairman
The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Thomas J. Bliley, Jr.
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

The Honorable William M. Thomas
Chairman
The Honorable Fortney H. (Pete) Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Until 1996, Medicare spending for home health care had been rising dramatically, consuming about $1 in every $11 of Medicare outlays in 1996, compared with $1 in every $40 in 1989. To control this rapid cost growth, the Balanced Budget Act of 1997 (BBA) (P.L. 105-33) required the Health Care Financing Administration (HCFA), the agency responsible for administering the Medicare program, to implement a prospective payment system that sets fixed, predetermined payments for home health services. Until that system can be developed, agencies will be under an interim payment system, which imposes limits on agencies' cost-based payments.[1] The limits provide incentives to control per-visit costs and the number and mix of visits for each user.

[1]Although BBA mandates that the prospective payment system for home health care be effective in fiscal year 2000, HCFA announced in a July 1998 hearing that implementation would be delayed because of the resources needed to make year-2000 computer system adjustments.

Concerns have been raised about Medicare's home health interim payment system since its implementation on October 1, 1997.[2] Industry representatives have claimed that the system's new cost limits have caused some home health agencies to close or some beneficiaries, particularly those with high-cost needs, to have difficulty obtaining care. In response to these concerns, you asked us to (1) identify the potential impact of the interim payment system on home health agencies; (2) determine the number, distribution, and effect of recent home health agency closures; and (3) assess whether the interim payment system could be affecting beneficiaries' access to services, particularly for beneficiaries who are expensive to serve.

To complete this study, we conducted interviews in seven states, most of which had a high number of closures in 1998. These states are Connecticut, Indiana, Louisiana, Missouri, New Mexico, New York, and Texas. We interviewed discharge planners in 82 hospitals and representatives from 21 local aging organizations about their experiences in arranging for home health services for Medicare beneficiaries in the past year. We also analyzed data from HCFA on home health agency openings, voluntary closures, involuntary closures (that is, those agencies no longer permitted to bill Medicare because of failure to meet the program's quality or financial requirements), and utilization by state. These data were derived from HCFA's administrative systems for tracking provider participation and service utilization from payment records. In this instance, we did not independently assess the accuracy of these data.[3] With this exception, this work was completed in accordance with generally accepted government auditing standards between August 17 and August 31, 1998. (For a detailed discussion of our scope and methodology, see app. I.)

Results in Brief

Our work suggests that neither agency closures nor the interim payment system, with less than a year's implementation experience, has significantly affected the capacity of the home health industry to provide services or beneficiary access to care. However, our interviews with professionals who arrange for home health services for Medicare beneficiaries indicate that access to services may be more difficult for

[2]The date agencies become subject to the interim payment system depends on the starting date of their cost reporting year. About half of the agencies were subject to the interim payment system as of January 1, 1998, and the rest will have become subject by September 30, 1998.

[3]HCFA's data on home health agency closures may not be up to date due to a lag in agencies' reporting of their Medicare-certified status.

beneficiaries with particular needs that make them likelier to be expensive to serve, such as those receiving multiple weekly visits over an extended period.

Specifically, we noted that pressures to lower costs arising from the design of the interim payment system's aggregate per-beneficiary cost limit will differ across home health agencies. The effect on an individual agency will depend on several factors, including an agency's base-year costs, changes in the provision of services since the base year, how recently it entered the market, and its regional location. Agencies responding to pressure may avoid accepting beneficiaries that are more expensive to serve or may reduce the quantity of services beneficiaries receive. The latter may have less impact on patients in those areas where the number of services provided has been very high.

We also found that, despite the 554 voluntary agency closures and 206 involuntary closures nationwide from October 1997 through June 30, 1998, growth in the industry has been such that there were still more agencies to treat Medicare beneficiaries in August 1998 than in October 1996. Half of the voluntary closures nationwide were concentrated in four states. Three of these states had experienced growth in the number of agencies well above the national average of 33 percent, and the fourth had experienced a 20-percent net increase in agencies before the recent spate of closures.

Most of the hospital discharge planners and local aging organization representatives we interviewed had not noticed a change over the past year in the willingness or ability of home health agencies in their areas to serve Medicare beneficiaries. They did report, however, that beneficiaries who were likely to be expensive in terms of the type and amount of visits needed were more difficult to place than other patients.

Background

Home health care is an important Medicare benefit enabling beneficiaries with acute needs, such as recovery from joint replacements, and chronic conditions, such as congestive heart failure, to receive care in their homes rather than in other settings, such as nursing homes and hospitals.[4] The dramatic increase in Medicare spending for home health care since 1989 has generated intense scrutiny of Medicare's payment methods and oversight of this benefit. The slowdown in spending growth in 1996 has not

[4]To qualify for home health care, a beneficiary must be confined to his or her residence (that is, be "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.

diminished these efforts, however, because of the substantial share of Medicare outlays that remains attributable to the home health benefit.

More than half of all home health agencies are freestanding; the rest are based in such institutions as hospitals, skilled nursing facilities, and rehabilitation hospitals. Agencies are also classified into one of three ownership categories: proprietary (private, for-profit); voluntary (private, nonprofit), such as Visiting Nurse Associations and Easter Seal Societies; and government (operated by a state or local government). Agency practices and home health users can differ across agencies and geographic regions. For example, in 1996, we reported that proprietary agencies provided significantly more visits than nonprofits for beneficiaries with the same primary diagnoses.[5]

Until Recently, Spending Growth for Medicare's Home Health Benefit Was Rapid

Between 1989 and 1996, Medicare spending for home health services rose from $2.5 billion to $16.8 billion. Concurrently, the number of home health agencies certified to care for Medicare beneficiaries swelled from about 5,700 in 1989 to more than 10,000 in 1997. Several factors account for spending growth. Since the program's inception, Medicare's coverage requirements for home health services have relaxed considerably. This has made the home health benefit available to more beneficiaries, for less acute conditions than originally permissible, and for longer periods of time. In fact, states' Medicaid programs, as payers for long-term and home-based care, began taking advantage of Medicare's liberalized guidelines to help cover the costs of long-term care for beneficiaries eligible for both Medicare and Medicaid.[6]

With the relaxed coverage requirements and states' Medicare maximization policies, Medicare's home health benefit gradually has been transformed from one that focused on patients needing short-term care after hospitalization to one that serves chronic, long-term-care patients as well. Advances in medical technology and the practice of discharging patients earlier from hospitals have also increased the number of beneficiaries seeking home health care. Finally, some of this rise in spending has been due to fraudulent or abusive practices, such as

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

[6]A recent example is the implementation in 1996 of Minnesota's Medicare Maximization Initiative, a program designed to teach providers how to use Medicare for home health services, supplies, and equipment for recipients who are dually eligible.

delivering unnecessary services and billing for visits that were not provided.

To control rapidly rising home health expenditures while ensuring the appropriate provision of services, BBA mandated a prospective payment system intended to reward efficient providers and financially penalize inefficient ones. In recognition of the time needed to develop such a system, coupled with the need to control spending growth immediately, BBA prescribed an interim system to pay for home health services until the prospective system was ready. The interim system builds on the payment limits already in place by making them more stringent. These new limits, based on agencies' own prior cost experience and average costs of agencies either regionally or nationally, create more pressure for certain agencies than others to lower their costs.

Key Features of the Interim Payment System

Previously, agencies were paid their actual costs up to a cap based on 112 percent of the national average cost per visit,[7] adjusted for local wage levels and each agency's number and mix of visits. The BBA reduced the basis of the limit to 105 percent of the national median per-visit cost.[8] In addition, the law added a new factor to the payment cap calculation—an average annual per-beneficiary limit. The average annual per-beneficiary limit is expected to constrain payments to more agencies by a larger average amount than even the reduced per-visit limit.

The per-beneficiary limit is based on the average payment for all home health services for each beneficiary who received care during an agency's fiscal year ending before October 1, 1994. For an agency that had participated in Medicare for a full year before this date—that is, an "established" agency—the limit is calculated as 98 percent of the sum of 75 percent of the agency's average per-beneficiary payment and 25 percent of the regional average per-beneficiary payment. An agency that had not participated in Medicare for a full year by October 1994 is considered "new." A new agency is subject to a per-beneficiary limit based on the national median of the per-beneficiary limits for established agencies, which is $3,356.69.[9]

[7]The previous and current national per-visit cost averages are those for freestanding agencies.

[8]The BBA required HCFA, in computing the limits, to make no adjustment for inflation for the period July 1, 1994, to July 1, 1996.

[9]This limit, when applied to each new agency, will be adjusted for local wage differences.

Basing the limits for established agencies on a blend of agency-specific and regional average annual per-beneficiary payments accounts for the significant service use differences across agencies and geographic regions. The agency-specific component accounts for variation in the mix of patients treated across agencies and, at the same time, reflects variations in agency efficiency. The regional component constrains the limit for agencies with costs that are higher than their counterparts in the region while raising the limit for the relatively lower-cost agencies. The regional amounts range from $2,548.29 in the Middle Atlantic region (New Jersey, New York, and Pennsylvania) to $5,910.55 in the East South Central region (Alabama, Kentucky, Mississippi, and Tennessee).[10] The use of a regional component rather than the national average provides less disruption to payments for established agencies and smooths the transition to a national prospective payment system.

The per-visit limits and the new per-beneficiary limits serve as a cap on an agency's total annual Medicare payments. An agency, therefore, does not need to keep the cost of each visit below the per-visit limit or manage the services provided to each beneficiary to keep costs below the per-beneficiary limit. Rather, agencies can balance high-cost visits with low-cost ones and still be paid their costs. Similarly, an agency can treat a mix of more intensive and less intensive beneficiaries and still receive Medicare payments for each service provided.

Impact of Interim Payment System, Based on Averages, Differs Across Agencies

Several factors—including an agency's base-year costs, changes in service provision since the base year, the recency of its entry into the market, and its regional location—partially determine the effect of the interim payment system's per-beneficiary limit on any given agency. Agencies that will be under more pressure than others to lower their costs include the following:

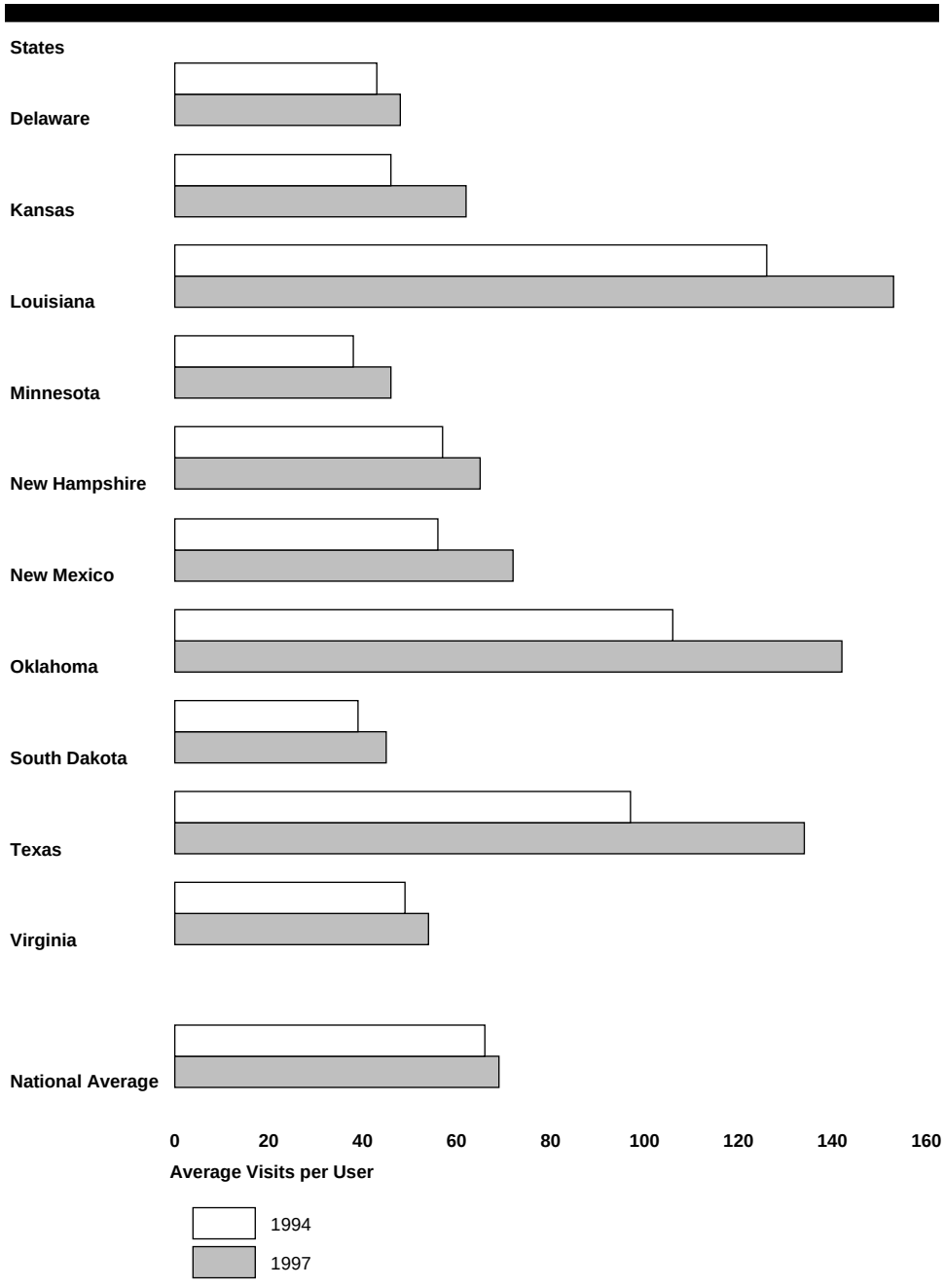
- Those with base-year costs higher than other agencies in their region. The annual average per-beneficiary limit will be below base-year costs for established agencies that had higher costs than others in their region. This limit is designed to encourage inefficient, high-cost agencies to reduce costs. However, differences in efficiency of providing care is not the only reason that costs vary across agencies; certain other factors producing agency differences may be beyond an agency's control. For example, state Medicaid policies may cause such variation, because Medicaid-covered services may be substituted for Medicare home health visits. Serving an

[10]These are the regional levels before adjusting for local wage differences.

urban versus a rural population; the numbers of other providers, including home health agencies, available in a market; and other factors may contribute as well. How much of an agency's higher costs are due to such factors, as opposed to its relative efficiency, is not known. Holding agencies accountable for higher-than-average costs without regard to this distinction may unduly penalize some.

- Those with higher growth in visits per beneficiary than the average. The more an established agency increased the number of visits provided per beneficiary since the base year, the more pressure the average annual per-beneficiary limit will create to reduce costs. Between 1994 and 1997, the number of visits per beneficiary rose, on average, by about 4.5 percent, although many agencies had increases that greatly exceeded the average (see app. II). Indeed, in 10 states, the average number of visits increased by more than 10 percent (see fig. 1). For some, this high growth boosted utilization that already greatly exceeded the national average. This was the case in Louisiana, Oklahoma, and Texas. In other states with large increases—like Delaware, Kansas, Minnesota, New Hampshire, South Dakota, and Virginia—use levels had been below the national average previously and remained so after recent increases. Nevertheless, the average annual per-beneficiary limits will constrain payments to agencies with significant increases in costs from the base year in both groups of states, regardless of whether utilization is above or below the national average.

Figure 1: Average Medicare Home Health Visits per User, Selected States, 1994 and 1997



Source: HCFA.

- New agencies in states with historically high payments. New agencies' average annual per-beneficiary limits are based on the national median of the limits across established agencies.[11] Consequently, new agencies will have lower limits than established ones with high base-year costs. In 19 states, the limit for new agencies falls below these states' median limits for the established agencies. Thus, new agencies in these states may be at a disadvantage owing only to their location and tenure. HCFA estimates that, for example, for an average new agency in Oklahoma, the per-beneficiary limit is $2,711, or about 45 percent less than the median limit for established agencies.[12] In contrast, an agency in Minnesota benefits from being new, as its limit exceeds the median for established agencies by over 50 percent. (See app. III, which shows amounts of agencies' per-beneficiary limits.)

Recent Closures Dwarfed by Longer-Run Industry Growth

More agencies closed in the 9 months ending June 30, 1998, than in recent years.[13] However, there has been such rapid growth recently in the industry that there were still more agencies available to treat Medicare beneficiaries in August 1998 than in October 1996. Since the interim payment system's implementation in October 1997 through June 30, 1998, 554 home health agencies closed voluntarily nationwide. An additional 206 closed involuntarily, according to HCFA's data, because they failed to meet Medicare's quality-of-care or financial standards. Despite the number of closures during this time, 45 agencies were able to open nationwide (that is, become certified to serve Medicare beneficiaries). Agency closures are not unusual in the home health industry. For example, during each of the previous 3 years, there were, on average, 285 voluntary and 62 involuntary agency closures. During this period, an average of 1,227 agencies opened for Medicare business each year.[14] (See fig. 2.)

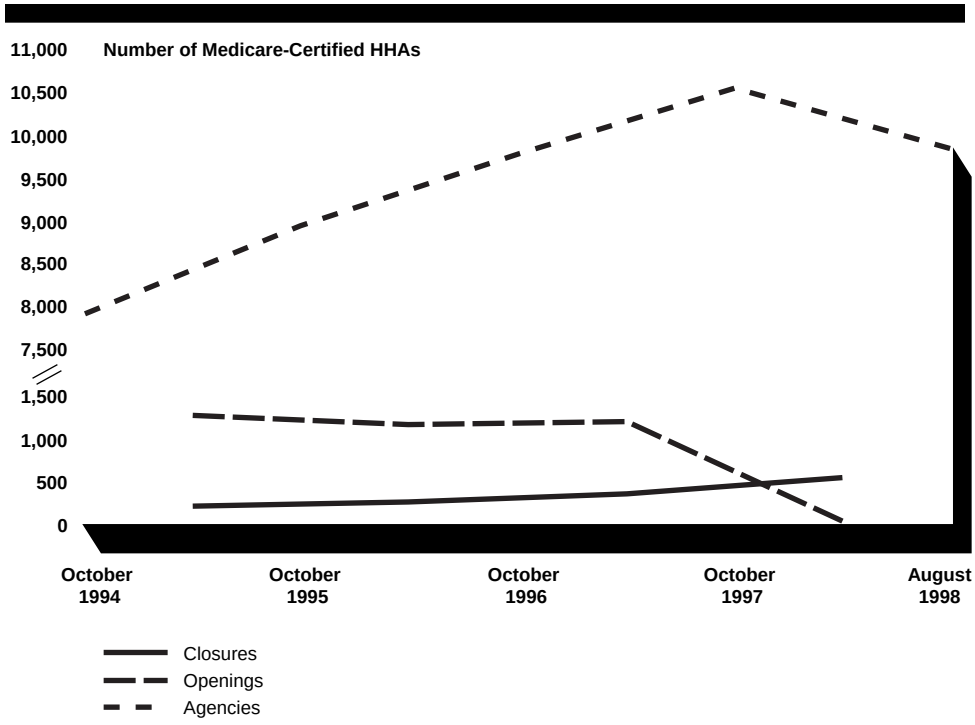
[11]The national limit assigned to new agencies will be adjusted for area wage differences, which accounts for the variation in this amount across states.

[12]HCFA data on the average per-beneficiary limit for new agencies are only illustrative because HCFA had to approximate the impact of the wage adjustment and did not have complete data on all new agencies.

[13]In this report, "closed" means that the home health agency was no longer certified by Medicare. Some may continue to operate, serving other patients.

[14]Some of these openings may reflect agency branches' converting to become separate providers.

Figure 2: Change in Number of Medicare-Certified Home Health Agencies, Fiscal Years 1995-97 and as of August 1998



Note: HHA = home health agency.

Source: HCFA's On-Line Survey, Certification, and Reporting System.

Half of all recent voluntary closures nationwide were concentrated in four states (California, Louisiana, Oklahoma, and Texas). In the first three, the voluntary closures were somewhat less than 30 percent of the almost 500 agencies added between 1994 and 1997. In Texas, voluntary closures equaled only 11 percent of the almost 1,200 agencies added during this period. In eight states, there were no closures over this period. (See app. IV for data on openings and closures for selected years.)

Agencies that closed voluntarily differed from the remaining agencies in two key ways. First, they were on average smaller, as measured by the number of beneficiaries served. The closed agencies treated an average of 166 beneficiaries, compared with an average of 385 beneficiaries for the agencies that remained open. The agencies that closed also provided on average more visits per beneficiary—90.2 compared with 65.2. These

findings are consistent with expectations that less efficient agencies may have the most difficulty adjusting to the new payment limits.

The industry has reported that over 1,000 agencies have closed since January 1998, with almost half of the closures in Texas. However, what is counted as a closure depends on some definitional issues. The discrepancy between the industry's and HCFA's figures likely results from the industry's inclusion of branch offices in the count of agency closures. However, home health agency branch offices are not independent providers under Medicare rules.[15]

Agencies may be choosing to close branch offices for reasons unrelated to the interim payment system's cost limits. Previously, it may have been financially advantageous for an agency to use a parent office, located in an urban area with high wage costs, for Medicare billing purposes, but to actually provide services out of a branch office in a low-wage area. Branches may also have been used to circumvent Medicare quality standards, because HCFA does not require branch offices to be surveyed or certified for compliance with Medicare requirements.[16] In 1997, HCFA issued a program memorandum that consolidated and clarified the guidance used to categorize an agency as a branch. In August 1998, it reissued this guidance defining home health agency parent, branch, and subunit organizations.[17] Except under certain circumstances, a branch has to be within 1-1/2 hours of its parent agency or it has to be restructured as a subunit—in other words, certified as a Medicare provider. In addition, the BBA now requires payments to be based on where the service was provided rather than the location of the billing office. The restructuring and site-of-service billing requirements may have reduced the financial benefit of maintaining a branch office, thus prompting branch closures.

Other factors unrelated to Medicare payment changes may have contributed to the recent spate of closures as well. For example, surety bond and other requirements to shore up program controls contributed to a number of agencies dropping out of Florida's Medicaid program. Medicare's intention to adopt surety bond requirements may have already

[15]Branches within home health agencies are part of and under the administrative control of the parent home health agency. They are not independently certified by Medicare as a provider, nor are they required to file a Medicare cost report.

[16]For a detailed discussion of this problem, see Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies (GAO/HEHS-98-29, Dec. 16, 1997).

[17]Subunits are a constituent of a "parent" home health agency. They are assigned provider numbers and are therefore counted as independent agencies in HCFA's tabulations of home health agency data.

screened out additional agencies that would not have been able to comply.[18]

As to whether closures, regardless of the way they are measured, have affected capacity, it is important to note that some closures reflect the merger of two agencies and not the actual loss of capacity. In addition, since home health agencies require little physical capital, it is possible for another agency to quickly absorb the staff and patients of a closing agency. Thus, capacity may not necessarily be affected.

Access Problems, If Any, Likely Limited to Costly Beneficiaries

Overall, Medicare beneficiaries' ability to obtain home health services does not appear to have changed significantly since the implementation of the interim payment system in October 1997. We interviewed hospital discharge planners in seven states because they are professionals who help Medicare patients leaving the hospital find agencies that will provide them with home health services. We also spoke with representatives of local aging organizations in these states for an additional perspective on access for all beneficiaries, regardless of whether they started using home health immediately after a hospital stay. We chose states that had experienced a disproportionate number of closures and that manifested diverse service use patterns.[19] More than half the hospital discharge planners and many representatives of local aging organizations we interviewed indicated that they had not noticed a change in the willingness or ability of their area's home health agencies to take Medicare beneficiaries. However, home health industry representatives, commenting on our draft report, suggested that these responses may understate the full effect of the interim payment system in the future.

Respondents who did notice a change often referred to issues unrelated to interim payment system reforms. For example, in each state studied, one or more individuals interviewed noted that home health agencies were more attentive than previously to ensuring that beneficiaries meet such coverage criteria as the need for skilled care and the requirements for being considered homebound. This could be a reaction to the increased scrutiny since 1995—by Medicare program officials, the Department of Health and Human Services' Inspector General, and other federal and state enforcement officials—of home health claims and agency billing practices.

[18]BBA required Medicare-participating home health agencies to have a surety bond effective January 1, 1998. Because of industry concerns, however, this requirement was suspended until at least February 15, 1999.

[19]See app. IV.

Other respondents affirming a change in agency behavior presented issues that more plausibly reflected agencies' concerns about the interim payment system. Discharge planners and representatives of organizations for the aged noted agencies' caution in taking beneficiaries who needed expensive care or frequent visits. Under the interim payment system, an imbalance of patients receiving expensive visits or multiple visits for a longer-than-average period of time could raise an agency's average per-beneficiary spending above the new aggregate per-beneficiary limit. Alternatively, a greater proportion of patients needing only a limited number of visits facilitates an agency's adjustment to the new limit.

Although those interviewed did not cite an overall change in agency behavior, about two-thirds of the discharge planners and more than a third of the representatives of organizations for the aged reported having had difficulty obtaining home health services for specific types of Medicare patients in the last year. We could not determine whether this reflected greater difficulty than in previous years. The respondents reported that patients with intensive skilled nursing needs and patients needing a significant number of visits over a long period of time (rather than patients, for example, with short-term rehabilitation needs) were the most difficult to place in home health services. The issue was that these patients might use services that could result in higher costs for an agency. However, respondents also indicated difficulties that were related to coverage restrictions and shortages of nurses and other skilled professionals proficient in delivering high-technology services—problems very likely unrelated to the interim payment system's implementation.

Conclusions

As home health care has become a larger share of total Medicare spending, legislative and regulatory efforts to constrain inappropriate growth and to control Medicare outlays have been stepped up. As a result, in the past year the home health industry has been subject to new policies, including surety bond requirements, changes in coverage guidelines, and the interim payment system. All of these may cause agencies to make adjustments to their business and clinical practices to meet the program integrity and budgetary needs of the Medicare program.

Agencies appear to have responded to these policy changes. There has been a moderate upswing in the number of agencies that are no longer certified to provide services to Medicare beneficiaries. Recent budget projections show that Medicare home health spending growth has slowed from recent record high levels. Our interviews indicate that some agencies

are more cautious about enrolling beneficiaries with certain needs and some are reducing their costs of caring for others.

To the extent that the agencies dropping out of the program are those that cannot meet Medicare quality or financial requirements, the industry has not been inappropriately constrained. To the extent that utilization changes represent scaling back home health visits that were of marginal clinical value, the policy changes have had their intended effect. If, however, efficient agencies cannot remain viable under the interim payment system, and high-cost beneficiaries have difficulty obtaining appropriate services, the policies then have had an unintended impact. While we found that to date there do not appear to be marked reductions in access to services, we could not distinguish between the intended and unintended effects of the policy changes.

Agency Comments

In written comments on a draft of this report, HCFA agreed with our findings, observations, and conclusions. Commenting on the various changes affecting the home health industry—in addition to the interim payment system—HCFA agreed that it is difficult to single out the effect of any particular factor. In response to the many concerns regarding the impact of BBA provisions on home health agencies, HCFA also noted that it made some administrative changes that could ease certain agencies' financial burden. HCFA also provided technical comments, which we incorporated into the final report.

We also obtained oral comments on a draft of our report from home health care industry representatives, including the National Association for Home Care, the Home Health Services and Staffing Association, and the Visiting Nurses Association of America. They believed the report should have emphasized the recency of the interim payment system's implementation. They also noted that we did not address future projections regarding closures or effects of the interim payment system. Their expectation is that closures will continue to increase and beneficiaries' access to services will be adversely affected. One commenter cited studies completed early this year about the potential effects of the interim payment system, which we did not discuss. While we agree with those studies' conclusions about the important role of home health care, our focus was primarily on experience with the interim payment system over the last 11 months. The industry representatives also provided technical comments, which we incorporated where appropriate into the final report.

As arranged with your offices, we will send copies of this report to the Secretary of Health and Human Services, the Administrator of HCFA, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request.

If you or your staff have any questions, please call me or Susan A. Flanagan at (202) 512-7114. Other major contributors to the report were Mary Ann Curran, Laura A. Dummit, Gloria N. Eldridge, Hannah F. Fein, Roger T. Hultgren, Shari B. Sitron, and Michael C. Williams.

William J. Scanlon
Director, Health Financing and
Systems Issues

Contents

Abbreviations

BBA	Balanced Budget Act of 1997
HCFA	Health Care Financing Administration
HHA	home health agency

Scope and Methodology

To complete this study, we analyzed legislation and regulations pertaining to the home health interim payment system, analyzed data from the Health Care Financing Administration (HCFA) on the number of Medicare-certified home health agencies and Medicare home health care utilization, and interviewed experts in the field of home health care referrals and service delivery.

Using Medicare program data extracts from HCFA's Health Care Information System and the On-Line Survey, Certification, and Reporting System, we analyzed the annual changes in Medicare-certified home health agencies from October 1, 1994, through June 30, 1998. HCFA-supplied data also allowed us to compare home health utilization and the number of agencies across states from 1994 to 1997. In addition, we compared characteristics of recently closed home health agencies with those that remained open. Finally, we used HCFA data to analyze the per-beneficiary limits that apply to new agencies relative to the limits for established agencies in each state.

To obtain qualitative information on the impact of closures and the interim payment system, we interviewed hospital discharge planners and representatives of local organizations for the aged in seven states about their recent experience in finding home health services for Medicare beneficiaries. We used standardized protocols to elicit their opinions on whether home health closures or changes in admitting practices had affected beneficiary access to care. We also interviewed national experts on home health care, officials from Medicare's regional intermediaries (which process Medicare home health care claims), and officials of home health agencies that had recently closed a branch office.

The seven states we analyzed—Connecticut, Indiana, Louisiana, Missouri, New Mexico, New York, and Texas—reflect a range of experience regarding agency growth and geographic areas. To choose these states, we compared the number of agencies in all states in 1994 with the growth in agencies between 1994 and 1997 to ensure that we would get information from areas that had few new agencies over this period and areas with many openings. We also chose states that had relatively low absolute numbers of agencies compared with states with high numbers. One state (New York) had one agency closure since October 1, 1997.

For each study state, we randomly selected 20 acute-care general hospitals with 50 beds or more. We contacted discharge planners in 112 of these hospitals and completed interviews with 82.

We also interviewed representatives of local aging organizations in each of the seven study states. They were identified on the basis of recommendations from hospital discharge planners and representatives from the states' offices on aging. We contacted 25 local aging organizations and interviewed 21 officials in these offices.

Average Medicare Home Health Visits per User, 1994 and 1997

State	Average visits per user, 1994	Average visits per user, 1997	Percentage change
Alabama	113	109	–3.5
Alaska	45	43	–4.4
Arizona	64	55	–14.1
Arkansas	76	71	–6.6
California	46	47	2.2
Colorado	60	65	8.3
Connecticut	73	75	2.7
Delaware	43	48	11.6
District of Columbia	42	43	2.4
Florida	76	70	–7.9
Georgia	102	93	–8.8
Hawaii	41	36	–12.2
Idaho	54	56	3.7
Illinois	52	47	–9.6
Indiana	73	69	–5.5
Iowa	46	47	2.2
Kansas	46	62	34.8
Kentucky	65	68	4.6
Louisiana	126	153	21.4
Maine	64	64	0.0
Maryland	37	34	–8.1
Massachusetts	87	89	2.3
Michigan	45	48	6.7
Minnesota	38	46	21.1
Mississippi	114	111	–2.6
Missouri	50	50	0.0
Montana	52	50	–3.8
Nebraska	41	44	7.3
Nevada	68	62	–8.8
New Hampshire	57	65	14.0
New Jersey	40	41	2.5
New Mexico	56	72	28.6
New York	45	49	8.9
North Carolina	57	51	–10.5
North Dakota	42	40	–4.8
Ohio	51	48	–5.9
Oklahoma	106	142	34.0

(continued)

State	Average visits per user, 1994	Average visits per user, 1997	Percentage change
Oregon	40	32	–20.0
Pennsylvania	43	44	2.3
Rhode Island	61	65	6.6
South Carolina	67	59	–11.9
South Dakota	39	45	15.4
Tennessee	116	101	–12.9
Texas	97	134	38.1
Utah	98	107	9.2
Vermont	61	65	6.6
Virginia	49	54	10.2
Washington	38	30	–21.1
West Virginia	51	52	2.0
Wisconsin	42	41	–2.4
Wyoming	77	68	–11.7
United States	66	69	4.5

Source: HCFA.

Medicare Per-Beneficiary Limits for "New" and "Established" Home Health Agencies

State	Median aggregate per-beneficiary limit for "established" agencies[a]	Illustrative aggregate per-beneficiary limit for "new" agencies, state averages[b]	Ratio of "new" provider limits to "established" provider limits
Alabama	$4,484	$2,744	0.612
Alaska	$3,674	$3,957	1.077
Arizona	$3,529	$3,171	0.899
Arkansas	$3,715	$2,620	0.705
California	$3,160	$3,942	1.247
Colorado	$3,072	$3,187	1.037
Connecticut	$3,589	$4,037	1.125
Delaware	$3,015	$3,336	1.106
District of Columbia	$3,300	$3,595	1.089
Florida	$3,630	$3,188	0.878
Georgia	$4,070	$3,311	0.814
Hawaii	$3,304	$3,417	1.034
Idaho	$3,020	$2,921	0.967
Illinois	$2,826	$3,151	1.115
Indiana	$3,364	$3,151	0.937
Iowa	$2,047	$2,850	1.392
Kansas	$2,513	$2,966	1.180
Kentucky	$3,613	$3,109	0.861
Louisiana	$5,764	$2,978	0.517
Maine	$3,059	$3,192	1.043
Maryland	$2,900	$3,435	1.184
Massachusetts	$3,676	$3,803	1.035
Michigan	$2,868	$3,497	1.219
Minnesota	$2,186	$3,332	1.524
Mississippi	$4,977	$2,989	0.601
Missouri	$2,742	$2,976	1.085
Montana	$2,690	$3,140	1.167
Nebraska	$2,248	$3,131	1.393
Nevada	$3,988	$3,523	0.883
New Hampshire	$2,688	$3,594	1.337
New Jersey	$2,556	$3,919	1.533
New Mexico	$3,190	$2,993	0.938
New York	$2,605	$3,850	1.478
North Carolina	$3,005	$3,080	1.025

(continued)

State	Median aggregate per-beneficiary limit for "established" agencies[a]	Illustrative aggregate per-beneficiary limit for "new" agencies, state averages[b]	Ratio of "new" provider limits to "established" provider limits
North Dakota	$2,156	$2,669	1.238
Ohio	$2,615	$3,204	1.225
Oklahoma	$4,885	$2,711	0.555
Oregon	$3,025	$3,449	1.140
Pennsylvania	$2,505	$3,451	1.378
Rhode Island	$3,711	$3,631	0.978
South Carolina	$3,591	$3,089	0.860
South Dakota	$2,197	$2,749	1.251
Tennessee	$5,521	$2,979	0.540
Texas	$4,822	$3,072	0.637
Utah	$4,064	$3,282	0.808
Vermont	$2,762	Not applicable	0.000
Virginia	$3,008	$3,129	1.040
Washington	$2,888	$3,581	1.240
West Virginia	$2,755	$2,926	1.062
Wisconsin	$2,554	$3,193	1.250
Wyoming	$3,302	$2,840	0.860

Note: An established agency is one that opened before October 1, 1993; all others are new agencies.

[a]The per-beneficiary limit for established agencies is a blend of 75 percent of an agency's own per-beneficiary payment and 25 percent of the average payment in the region. When the limits are compared with an agency's costs, the regional component is adjusted for area wage differences. In this table, the regional component has not been adjusted.

[b]New agencies are given a national per-beneficiary limit based on the median of such limits for all established agencies. In this table, the national limit is adjusted for differences in wages based on the location of the agency. In calculating payments, the wage index adjustment will be based on the place of service. These numbers do not reflect all new agencies.

Source: HCFA.

Medicare-Certified Home Health Agencies, 1994 to 1997, and Voluntary Closures, Fiscal Year 1998

State	HHAs as of Oct. 1, 1994	HHAs as of Oct. 1, 1997	Percentage change (1994-97)	Voluntary closures,[a] Oct. 1, 1997-Jun. 30, 1998	HHAs as of Aug. 1, 1998
Alabama	173	183	5.8	0	183
Alaska	19	27	42.1	7	20
Arizona	100	131	31.0	13	114
Arkansas	200	206	3.0	2	202
California	617	861	39.5	74	768
Colorado	150	201	34.0	21	174
Connecticut	115	116	0.9	7	104
District of Columbia	18	22	22.2	1	21
Delaware	19	21	10.5	2	19
Florida	305	398	30.5	20	378
Georgia	81	96	18.5	0	97
Hawaii	26	28	7.7	5	22
Idaho	56	78	39.3	4	73
Illinois	314	392	24.8	17	369
Indiana	214	299	39.7	11	282
Iowa	172	211	22.7	5	205
Kansas	163	221	35.6	16	202
Kentucky	107	111	3.7	0	112
Louisiana	432	519	20.1	37	466
Maine	29	51	75.9	4	47
Maryland	74	81	9.5	3	78
Massachusetts	175	198	13.1	5	192
Michigan	179	234	30.7	3	230
Minnesota	232	265	14.2	2	261
Mississippi	76	70	–7.9	1	69
Missouri	229	272	18.8	20	247
Montana	48	62	29.2	0	61
Nebraska	65	83	27.7	0	83
Nevada	41	54	31.7	8	44
New Hampshire	39	46	17.9	0	46
New Jersey	53	57	7.5	0	58
New Mexico	80	117	46.3	11	102
New York	214	227	6.1	1	226
North Carolina	149	162	8.7	3	166
North Dakota	33	35	6.1	1	34
Ohio	352	472	34.1	21	452

(continued)

State	HHAs as of Oct. 1, 1994	HHAs as of Oct. 1, 1997	Percentage change (1994-97)	Voluntary closures,[a] Oct. 1, 1997-Jun. 30, 1998	HHAs as of Aug. 1, 1998
Oklahoma	232	389	67.7	36	336
Oregon	81	90	11.1	6	80
Pennsylvania	312	381	22.1	4	375
Rhode Island	19	30	57.9	3	28
South Carolina	66	82	24.2	1	80
South Dakota	36	56	55.6	3	52
Tennessee	234	232	–0.9	8	222
Texas	961	1,949	102.8	134	1,758
Utah	65	89	36.9	12	75
Vermont	13	13	0	0	13
Virginia	197	233	18.3	8	226
Washington	59	68	15.3	2	67
West Virginia	67	92	37.3	3	88
Wisconsin	172	181	5.2	4	176
Wyoming	57	65	14.0	5	59
United States	7,920	10,557	33.3	554	9,842

Note: HHA = home health agency.

[a]This does not include the 206 closures that were involuntary because the agencies were out of compliance with Medicare's conditions of participation.

Source: HCFA's On-Line Survey, Certification, and Reporting System data.

Related GAO Products

Medicare: Interim Payment System for Home Health Agencies (GAO/T-HEHS-98-234, Aug. 6, 1998).

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 Med-Delta Home Health (GAO/T-OSI-98-6, Mar. 19, 1998; 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).

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