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Report to Congressional Requesters

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MEDICARE HOME HEALTH AGENCIES

Closures Continue, With Little Evidence Beneficiary Access Is Impaired

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

Until 1998, home health care was one of Medicare's fastest growing benefits. Dramatically rising expenditures resulted in home health care consuming about $1 of every $12 of Medicare outlays in fiscal year 1997 compared with $1 of every $40 in 1989. This growth was primarily due to more beneficiaries receiving services and more home health visits being provided to each user. While changes in practice patterns and in the need for home health care contributed to this increased utilization, the inappropriate delivery of services as well as fraudulent billing practices also added to Medicare's spending.

Concerns about rising spending, fraud and abuse, and inadequate oversight led the Congress and the administration to implement a number of initiatives to better control Medicare's home health care costs. In particular, the Balanced Budget Act of 1997 (BBA) mandated major changes to the home health benefit.[1] To slow spending, for example, the act required the Health Care Financing Administration (HCFA), the agency responsible for administering the Medicare program, to move away from a

[1]P.L. 105-33, title IV, chapter I, 111 Stat. 251, 466.

cost-based method of payment and implement a prospective payment system (PPS) of fixed, predetermined rates for home health services. Until that system is developed, home health agencies (HHA) are using an interim payment system (IPS), which imposes limits on agencies' cost-based payments.[2] The limits give HHAs incentives to control per-visit costs and the number and mix of visits provided to users.

Since its implementation on October 1, 1997, concerns have been raised about the IPS.[3] Industry representatives have claimed that the system's cost limits are too stringent, causing some HHAs to close, which in turn has reduced access to home health services. We reported to you last September that neither agency closures through June 1998 nor the IPS had significantly affected the industry's capacity to provide services.[4] Although we found that HHA closures had accelerated, the rapid growth in the number of agencies over the past several years overshadowed the recent retrenchments. Furthermore, the number of Medicare-certified HHAs alone is a poor measure of capacity. Remaining agencies are often able to absorb the patients and staff of closing HHAs so that beneficiary access is not impaired. Since we issued that report, the industry has continued to express concern about the impact of closures on beneficiary access. In response to this sustained concern, you asked us to (1) update our September analysis on closures, paying particular attention to the distribution of closures across urban and rural counties and to the characteristics of closed agencies, and (2) assess the effect of closures on beneficiary access to home health services.[5] We analyzed HCFA data on changes in the number and characteristics of Medicare-certified HHAs through January 1, 1999. We also examined beneficiary utilization during the first quarter of 1998, the most recent data available, and compared it with similar periods in 1994 and 1996. To complement this analysis, we interviewed stakeholders during February 1999 in a sample of primarily rural counties that had experienced significant closures. These stakeholders are parties with an interest in or knowledge of these issues and included HHA managers, hospital discharge planners, advocacy groups, and others. Our work was completed in accordance with generally

[2]BBA mandated that the PPS for HHAs be implemented in fiscal year 2000. The Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (P.L. 105-277, sec. 5101(c), 112 Stat. 2681, 2681-914.) postponed implementation until fiscal year 2001.

[3]IPS implementation was phased in according to HHAs' cost reporting year. Sixty-one percent of the HHAs came under the IPS by January 1, 1998, and the remainder by September 30, 1998.

[4]Medicare Home Health Benefit: Impact of Interim Payment System and Agency Closures on Access to Services (GAO/HEHS-98-238, Sept. 9, 1998).

[5]The term "county" encompasses parishes (Louisiana), some census areas (Alaska), and certain independent cities (such as Baltimore, Md.).

accepted government auditing standards between January and April 1999. (For a detailed discussion of our scope and methodology, see app. I.)

Results in Brief

Prior to the HHA closures that have attracted widespread attention, both the number of HHAs and utilization of home health services had grown considerably. Although 14 percent of agencies closed between October 1, 1997, and January 1, 1999, beneficiaries are still served by over 9,000 HHAs, approximately the same number that were available in 1996. Forty percent of the closures were concentrated in three states that had experienced considerable growth in the number of HHAs and had utilization rates (that is, visits per user as well as users per thousand fee-for-service beneficiaries) well above the national average. Furthermore, the majority of closures occurred in urban areas that still have a large number of agencies to provide services. The pattern of HHA closures suggests a response to the IPS. The IPS revenue caps would prove particularly stringent for agencies that provided more visits per user, for smaller agencies, and for those with less ability to recruit low-cost patients. For example, agencies that closed had provided over 40 percent more services per user than agencies that remained open. Closing agencies were also about half the size of agencies that remained open, and they had been losing patients before the implementation of IPS.

Attention has been focused on the number of Medicare-certified HHAs available to provide home health care, but the more important issue is whether beneficiaries have access to Medicare-covered home health services. Evidence shows that overall home health utilization in the first 3 months of 1998 had declined since 1996, but it was about the same as a comparable period in 1994—the year that serves as the base for IPS limits. Moreover, the sizeable variation in utilization between counties with high and low use has narrowed. These changes are consistent with IPS incentives to control utilization. In counties without an HHA, both the proportion of beneficiaries served and the visits per user declined slightly during the first 3 months of 1998 compared with a similar period in 1994, but these counties' levels of utilization remained above the national average. Our interviews in 34 primarily rural counties with substantial closures indicate that beneficiaries continue to have access to services. Overall, the 130 stakeholders we interviewed in 34 counties with significant closures or declines in utilization reported few access problems. However, those interviews also suggest that as HHAs change their operations in response to the IPS, beneficiaries who are likely to be costlier than average to treat may have increased difficulty obtaining home

health care. Confusion about eligibility for services also contributed to the perception that there were access problems. Some of this reduced utilization, particularly for services that do not meet Medicare coverage criteria, could be shifted to and paid for by Medicaid.

Background

The Medicare home health benefit consists of skilled nursing, therapy, and related services furnished by a Medicare-certified HHA.[6] To qualify for services, a beneficiary must be homebound and require skilled nursing care or physical or speech therapy on a part-time or intermittent basis.[7] The services must be furnished under a plan of care prescribed and periodically reviewed by a physician. If these criteria are met, Medicare will pay for home health visits provided by

- a registered nurse or a physical, occupational, or speech therapist (or a person under their supervision);
- social workers necessary to resolve social or emotional problems that are impediments to a beneficiary's recovery; and
- a home health aide who delivers hands-on personal care.[8]

Medicare will pay for home health care as long as it is reasonable and necessary for the management of a beneficiary's illness or injury. There are no limits on the number of visits or length of coverage, and no copayments or deductibles apply. A beneficiary with no need for skilled care and who only requires custodial or personal care, however, does not qualify for the Medicare home health benefit.

Growth in Home Health Utilization

During much of the 1990s, home health care was one of Medicare's fastest growing benefits. Expenditures rose from 3.2 percent ($3.7 billion) of total Medicare spending in 1990 to 9 percent ($17.8 billion) in 1997. This translates into an average annual growth rate of 25.2 percent, compared with 8 percent for the overall program. The number of Medicare home

[6]These services include physical, speech, and occupational therapy; medical social services; and home health aide services.

[7]A beneficiary is homebound when he or she has a condition that results in a routine inability to leave home except with considerable and taxing effort, and when absences from home are infrequent or of relatively short duration, or are attributable to receiving medical treatment. "Part-time or intermittent" means that the services are needed on fewer than 7 days each week, or for fewer than 8 hours per day for periods of 21 days or less.

[8]Home health aide services include (1) personal care services, such as assistance with eating, bathing, and toileting; (2) simple surgical dressing changes; (3) assistance with some medications; (4) activities to support skilled therapy services; and (5) routine care of prosthetic and orthotic devices.

health users per 1,000 beneficiaries increased from 57 to 109 over the 1990 to 1997 period, and the average number of visits per user went from 36 to 73.[9] Concomitant with this stepped-up use was the almost doubling in the number of Medicare-certified HHAs to 10,524 in 1997.

This growth can be attributed to many factors, but the relaxation of coverage guidelines is one of the most notable. At Medicare's inception, home health care was a posthospital benefit with an annual limit on the number of visits covered for each beneficiary. The limitation on visits was removed by the Omnibus Reconciliation Act of 1980,[10] but utilization did not increase appreciably because of HCFA's relatively stringent interpretation of the coverage and eligibility criteria. A court case in 1988 challenged HCFA's interpretation, and the decision led to modification of HCFA's coverage guidelines.[11] To accommodate the court decision, the benefit was transformed from one focused on patients needing short-term care after a hospitalization to one that serves chronic, long-term-care patients as well.

Also contributing to the historical rise in spending were a payment method that provided few incentives for efficiency and lax Medicare oversight of claims for reimbursement. The substantial geographic variation in the provision of home health care suggests that at least some visits may be of marginal value. For example, in 1996, the average number of visits per user in the West South Central region (which includes Arkansas, Louisiana, Oklahoma, and Texas) was 129 compared with 47 in the Middle Atlantic region (New York, New Jersey, and Pennsylvania).[12] (See app. II.) Agencies could boost revenues by providing more services to more beneficiaries, a strategy that could actually help HHAs avoid Medicare's limits on payments per visit. Finally, Medicare oversight declined at the same time that spending mounted. The proportion of claims that were reviewed dropped sharply, from about 12 percent in 1989 to 2 percent in 1995, while the volume of claims almost tripled.[13]

[9]These numbers reflect Medicare fee-for-service beneficiaries only.

[10]P.L. 96-499, sec. 930, 94 Stat. 2599, 2631.

[11]Duggan v. Bowen, 691 F. Supp. 1487 (D.D.C. 1988).

[12]This geographic variation was evident when controlling for diagnoses. Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

[13]Our 1997 analysis of a small sample of high-dollar claims found that over 40 percent of these claims should not have been paid by the program. See Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997.)

Efforts to Control Home Health Expenditures

Beginning in 1995, the Congress and the administration implemented several initiatives to curb home health spending by constraining fraud and abuse and modifying payment methods.

Fraud and Abuse. A major anti-fraud campaign known as Operation Restore Trust (ORT) was launched in 1995 and is credited with contributing to the recent slowdown in Medicare home health spending.[14] ORT employed a number of approaches to uncovering fraud, including the use of interdisciplinary teams to review individual HHAs providing an unusually large number of Medicare services. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) also contained measures to control fraud and abuse by HHAs.[15] For example, it provided that any physician who falsely certifies a patient as eligible for home health care services is liable for a civil monetary penalty. HIPAA also provided more funding for claims review by Medicare's claims processing contractors, including the five regional home health intermediaries (RHHI) that process and pay claims and review and audit cost reports.

Several changes to the participation rules designed to screen out problem providers were initiated in 1997. These included heightened reporting requirements for owners and increased standards for providers. The administration imposed a capitalization requirement for home health providers enrolling on or after January 1, 1998, and required that an HHA serve at least 10 patients before seeking Medicare certification. This contrasts with the previous requirement that only a single patient had to have been served. HCFA also clarified that HHA branches must generally be located sufficiently close to the parent agency—approximately 1-1/2-hours driving time—so that administration, supervision, and services are provided in a manner that makes it unnecessary for the branch to be independently certified as an autonomous organization.[16]

Payment Limits. Before the BBA, HHAs were paid on the basis of their costs, up to preestablished limits. The limits were set for each type of visit but

[14]In 1997, the rate of increase for home health care expenditures was lower than in previous years. Although final data are not yet available for 1998, HCFA expects expenditures to actually decrease for 1998 compared with 1997.

[15]P.L. 104-191, title II, 110 Stat. 1936.

[16]HHAs are characterized as either parents, subunits, or branches. A parent develops and maintains administrative controls of subunits and branches and also delivers services. A subunit is a semiautonomous organization serving patients in a geographic area different from the parent and must independently meet the conditions of participation and be certified. A branch is not an autonomous unit, but shares administration, supervision, and services with the parent and does not have to be independently certified.

were applied in the aggregate; that is, costs above the limit for one type of visit would still be paid if costs were sufficiently below the limit for other types of visits. In order to slow spending, the BBA mandated key changes to Medicare's method of paying for home health services. Most importantly, HCFA is required to establish a PPS by October 2000—a fixed, predetermined payment per unit of service, adjusted for patient characteristics that affect the cost of care. Until that time, HHAs are paid under the IPS. The IPS lowered the visit payment limit and subjects HHAs to a Medicare revenue cap that is based on an aggregate per-beneficiary amount.[17] For agencies that had a full 12-month cost report for the fiscal year ending October 1, 1994, the aggregate "per-beneficiary" amount is calculated as 98 percent of a blend of 75 percent of its own fiscal year 1994 per-beneficiary payments and 25 percent of the comparable regional average.[18] For new agencies—those that had not participated in Medicare for a full year by October 1994–the per-beneficiary amount is based on the national median of these amounts for established agencies. Thus, utilization and spending are constrained to 1994 patterns. Finally, the BBA will further constrain payments with the PPS. PPS rates will be set so that Medicare expenditures are equivalent to what would have been spent under the IPS, with limits reduced by 15 percent from those in effect on September 30, 2000.

Through the application of the payment limits, the IPS attempts to control the costs and amount of services provided to beneficiaries. The per-visit limit controls the cost per visit. The aggregate revenue cap reins in the growth in the number of visits provided to beneficiaries and constrains the average cost of the services provided to users. Agencies can use several methods to keep costs below the revenue cap. These include balancing their mix of low- and high-cost patients, reducing their costs overall, increasing the proportion of low-cost patients they treat, or some combination of these activities. These limits will prove more of a constraint for agencies that have provided more visits or have higher costs than the average. Low-volume agencies with few low-cost patients or with costly treatment patterns may also find the limits particularly stringent.

[17]Under the IPS, the per-visit limit was based on 105 percent of the national median per-visit cost. The IPS was revised by section 5101(b) of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (P.L. 105-277, 112 Stat. 2681, 2681-914), which increased the per-visit limit to 106 percent of the national median cost.

[18]The Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (P.L. 105-277, sec. 5101(a), 112 Stat. 2681, 2681-913) made several changes to the revenue cap. For HHAs with per-beneficiary amounts less than the national median, limits were increased by one-third of the difference between their amount and the national median. The cap for new HHAs (as classified by the BBA) was increased from 98 percent to 100 percent of the national median. Further, HHAs that opened after October 1, 1998, have per-beneficiary limits equal to 75 percent of the wage-adjusted national median, reduced by 2 percent.

Pattern of HHA Closures Suggests Response to New Financial Incentives

Substantial growth in the number of HHAs between 1990 and 1997 has been followed by the closure of about 14 percent of HHAs between October 1997 and January 1999. Agencies that closed shared many of the characteristics of agencies that opened in the 1990s—they were disproportionately urban, freestanding, and for profit.[19] However, agencies that closed also tended to be newer, treated a smaller number of beneficiaries, and provided more services per user than agencies that remained open. Such agencies are the types of HHAs that would have difficulty adjusting to the revenue caps in the IPS, suggesting that the system is reducing the number of high-utilization, low-volume HHAs. The recent spate of closures has been concentrated in a few states that had the most growth in HHAs and that had utilization experience above the national average. All of the closures occurred in 555 counties—about 23 percent of the counties that had an HHA. The majority of counties with HHAs experienced no net reduction in the number of agencies, and the number of counties with one or two agencies remained fairly constant.

Following a Decade of High Industry Growth, HHA Closures Have Accelerated

The home health industry experienced tremendous growth from 1990 through 1997. During this period, the number of Medicare-certified HHAs almost doubled to 10,524. The expansion was concentrated in particular geographic areas and among certain types of HHAs. Most notably, freestanding and urban agencies doubled, while the number of proprietary agencies tripled. (See table 1 and app. II.)

[19]HHAs may be either freestanding (not part of a facility) or facility based, that is, operated as part of an acute-care hospital, a rehabilitation facility, or a skilled nursing facility. Ownership of HHAs is classified as government, voluntary (not for profit), or proprietary (for profit.)

Table 1: Medicare-Certified HHAs, 1990 and 1997

	Number of HHAs, Oct. 1, 1990	Number of HHAs, Oct. 1, 1997	Percentage growth, 1990-97
All HHAs	5,642	10,524	87
Type			
Freestanding	3,675 (65%)	7,607 (72%)	107
Facility based	1,967 (35%)	2,917 (28%)	48
Control			
Proprietary (for profit)	2,038 (36%)	6,119 (58%)	200
Government and voluntary (not for profit)	3,604 (64%)	4,405 (42%)	22
Location			
Urban	3,442 (61%)	7,038 (67%)	105
Rural	2,200 (39%)	3,486 (33%)	59

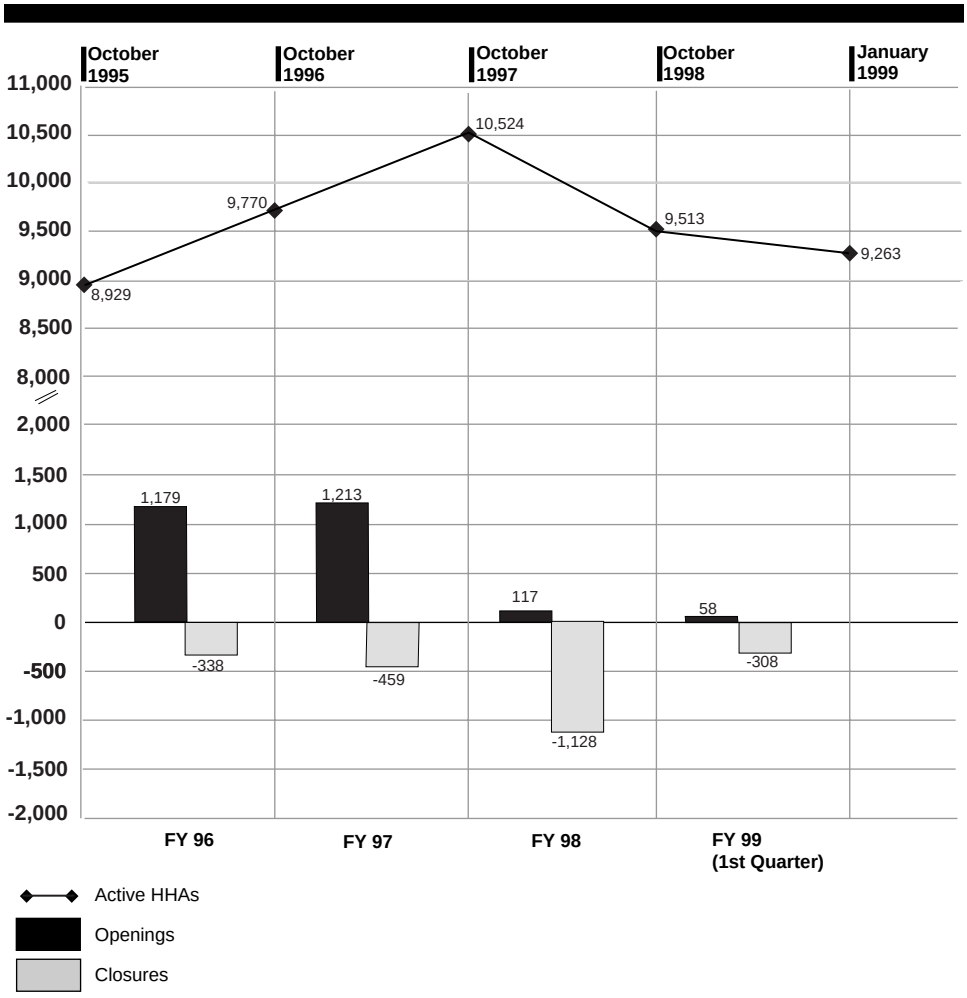
Source: GAO analysis of HCFA's On-Line Survey, Certification, and Reporting system (OSCAR) data.

Between October 1, 1997, and January 1, 1999, 1,436 Medicare-certified HHAs stopped serving Medicare beneficiaries.[20] However, because of growth in the industry since 1990, there were still 9,263 Medicare-certified HHAs in January 1999—500 fewer agencies than in October 1996. While HHAs closed in the past, closures were not as numerous and were obscured by the number of new entrants.[21] In contrast, recent closures are now being accompanied by relatively few openings. (See fig. 1.)

[20]Throughout this report we use the term "closure" to identify HHAs that either no longer participate in the Medicare program or have merged with another Medicare-certified agency.

[21]For example, a total of 797 Medicare-certified HHAs closed in fiscal years 1996 and 1997, while the number of certified agencies increased by 2,392.

Figure 1: Change in Number of Medicare-Certified HHAs, October 1, 1995 Through January 1, 1999



Source: GAO analysis of HCFA's OSCAR data.

Closures have occurred disproportionately in the very segments of the home health industry that experienced the greatest growth during the 1990s. (See table 2.) For example, the number of proprietary agencies tripled between 1990 and 1997, representing 84 percent of the new agencies. They also made up 83 percent of the closures from October 1997 through January 1, 1999. Similarly, freestanding agencies increased 107 percent from 1990 to 1997 to constitute 81 percent of the new

agencies. In the period that followed, they represented 86 percent of the closures. Although three-quarters of the agencies that closed between October 1, 1997, and January 1, 1999, were located in urban areas, urban beneficiaries continued to be served by 6,088 HHAs.

Table 2: Comparison of Active and Closed HHAs, October 1, 1997, Through January 1, 1999

	Share of industry growth, 1990-97	Active HHAs on Oct. 1, 1997	HHAs closed between Oct. 1, 1997, and Jan. 1, 1999
All agencies	100%	Number = 10,524	Number = 1,436
Type			
Freestanding	81%	72%	86%
Facility based	19%	28%	14%
Control			
Proprietary	84%	58%	83%
Government and voluntary	16%	42%	17%
Location			
Urban	74%	67%	74%
Rural	26%	33%	26%
Tenure in Medicare			
New (under 5 years)	75%	48%	64%
Established (5+ years)	25%	52%	36%

Source: GAO analysis of HCFA's OSCAR data.

Most of the HHAs that stopped serving Medicare beneficiaries had been in operation for fewer than 5 years. Moreover, agencies that closed were much smaller—serving less than half the number of beneficiaries—and getting smaller. Finally, they were providing more visits to each user than remaining agencies. Compared with the average of 479 beneficiaries served by their counterparts that remained open, closed agencies served only 216 beneficiaries while providing 44 percent more visits per beneficiary (see table 3). Furthermore, closed agencies had experienced an 8-percent decline in the number of beneficiaries served compared with the previous year.

Table 3: Volume and Utilization Rates of Active and Closed Home Health Agencies, Calendar Years 1996 and 1997

	Average number of beneficiaries		Visits per beneficiary	
Agencies	**1996**	**1997**	**1996**	**1997**
Active agencies on or before Jan. 1, 1996, and still in business	487	479	66	64
Agencies closed during calendar year 1998	235	216	95	92

Source: GAO analysis of HCFA's Standard Analytical File, claims data for home health services, 1996 and 1997.

The profile of closed agencies is consistent with the incentives created by the IPS to control the volume of services provided to beneficiaries. The revenue cap is applied to an agency's total Medicare payments; it does not limit payments for any specific beneficiary. HHAs need to average costs over all beneficiaries to stay within the cap. Low-volume agencies may have less ability to stay below their caps: a few high-cost patients can affect them more because they have a smaller pool of beneficiaries over which to average their costs. Similarly, agencies that provide a higher number of visits per user would face the IPS constraints because of their higher average costs. Agencies that typically provide greater than the average number of services per user will need to change their service patterns or mix of beneficiaries. These changes could be challenging for small agencies that may have less flexibility or experience in managing service use.

Finally, new agencies may face tighter payment restrictions than their established counterparts because their payment limits are based on average national utilization rather than their own experience. Agencies that opened after October 1994, and provide more services per beneficiary, may be constrained under the IPS, particularly if they are located in a region where utilization exceeds the national average.

Closures Are Concentrated in Three High-Utilization, High-Growth States

About 40 percent of agency closures since October 1997 were in three states—Louisiana, Oklahoma, and Texas.[22] These states had 2,286 HHAs in January 1999—about 25 percent of the remaining agencies nationwide—to

[22]In contrast, some states such as Alabama, Kentucky, New Jersey, and Washington had fewer than four closures between October 1997 and January 1999. No closures occurred in Georgia. Each of these states had HHAs serving more Medicare fee-for-service beneficiaries than the national average—that is, they had fewer HHAs per Medicare fee-for-service beneficiary. (App. III contains the number of active and closed HHAs and the number of Medicare fee-for-service enrollees per remaining HHA by state.)

serve 9 percent of Medicare's fee-for-service beneficiaries. In each of these states, the number of HHAs per Medicare beneficiary far exceeded the national average of one agency per 3,509 beneficiaries.[23] For example, Texas had about three agencies serving that number of beneficiaries.

Utilization in these three states was not only higher than the national average in 1994 but grew considerably between then and the implementation of the IPS. For example, in each of these states, visits per user rose between 1994 and 1997 at rates more than double the national average (ranging from 28 percent to almost 45 percent, compared with the 10.5-percent increase nationwide). Furthermore, by 1997, HHAs in these states served 20 percent more users per 1,000 fee-for-service beneficiaries and provided twice the number of visits per user compared with the national average. (See table 4.)

Table 4: Decline in HHAs and Utilization in Three High-Use States

	Number of Medicare-certified HHAs, Jan. 1, 1999	HHA closures as a percentage of active agencies as of Oct. 1, 1997	People served per 1,000 Medicare fee-for-service enrollees			Visits per user		
			1994	1997	Percentage change	1994	1997	Percentage change
Nationwide	9,263	–14.0	94.2	109.2	15.9	66.0	72.9	10.5
Louisiana	407	–21.6	138.6	157.3	13.5	125.8	161.0	28.0
Oklahoma	299	–23.2	108.9	131.9	21.1	105.7	147.0	39.1
Texas	1,580	–20.1	106.9	133.7	25.1	97.4	141.0	44.8

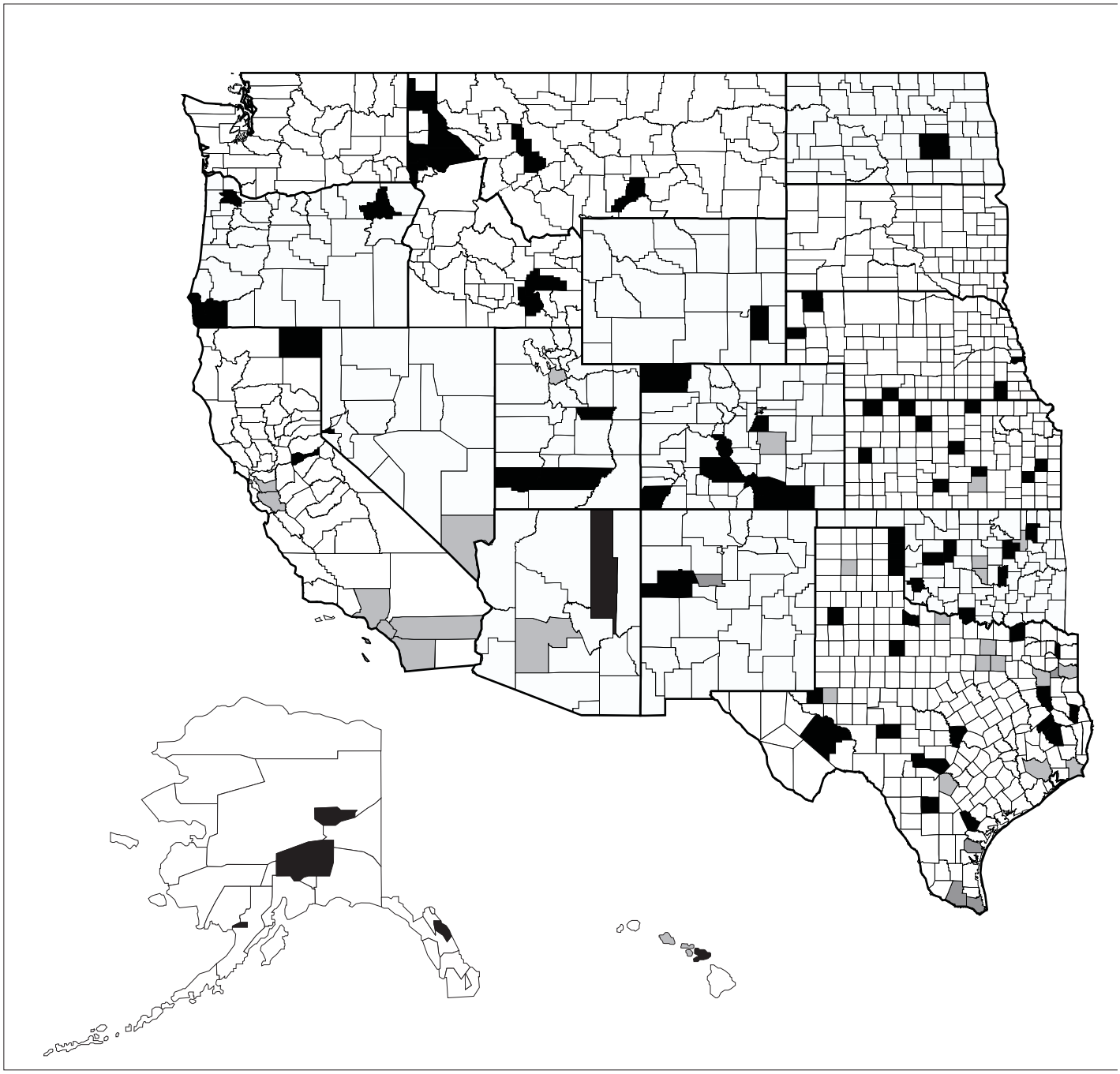
Sources: GAO analysis of HCFA's OSCAR data and Medicare enrollment data.

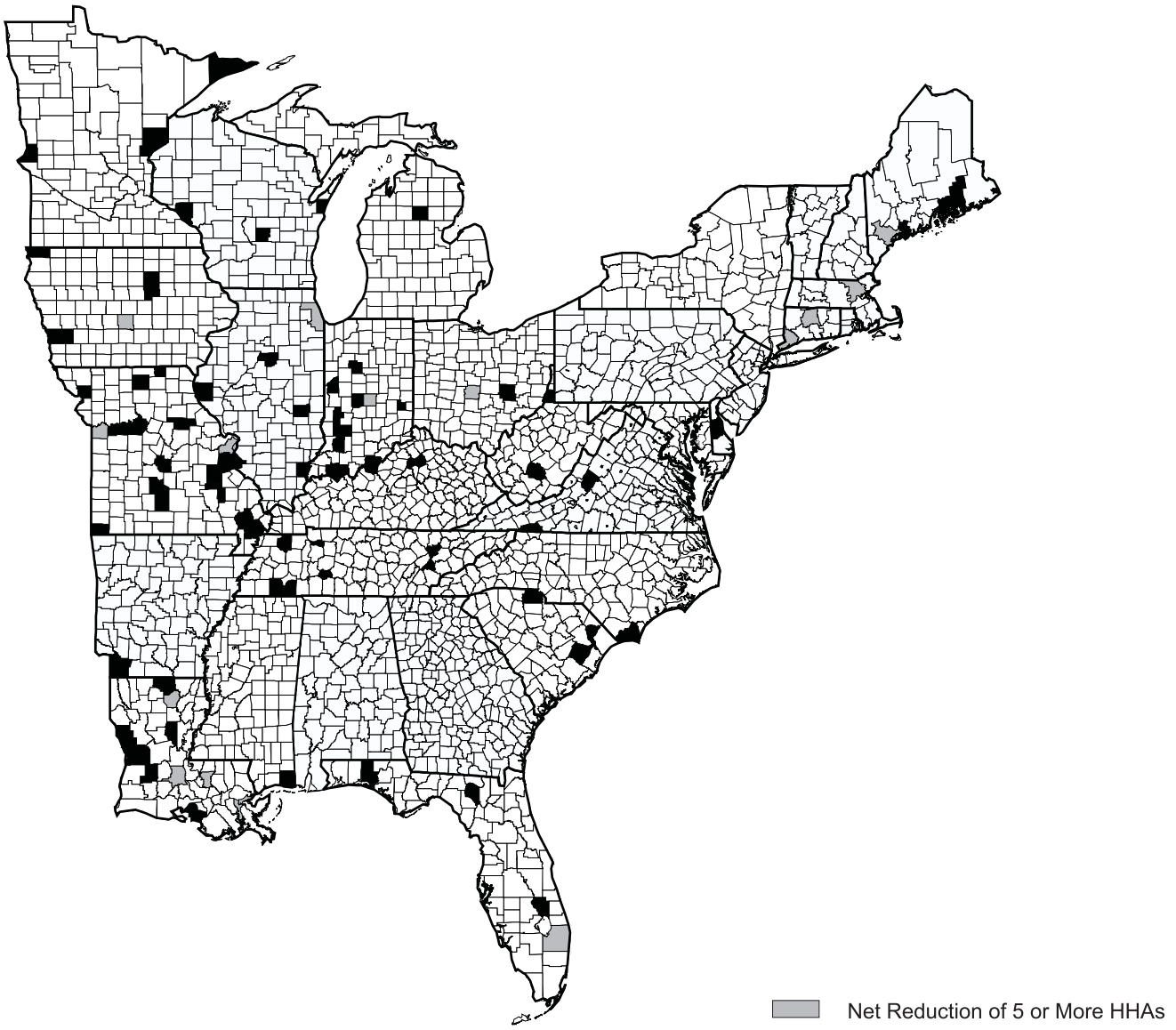
Majority of Closures Occurred in Urban Counties

HHA closures were concentrated in 23 percent of the counties (555) that had agencies as of October 1, 1997. Even fewer counties experienced significant reductions—that is, five or more agencies (primarily urban counties) or 50 percent or more of their agencies (primarily rural counties). The 205 counties are widely scattered across the country (see fig. 2). Because of the concentration of closures, the majority of counties (77 percent) that had agencies experienced no reduction in the number of HHAs. Furthermore, only a 4-percent increase occurred in the number of counties with only one or two agencies. (See app. IV.)

[23]We report the number of Medicare fee-for-service enrollees because HCFA data on service use exclude those enrolled in managed care plans.

Figure 2: Counties With Significant Reductions in HHAs Between October 1, 1997, and January 1, 1999





(Figure notes on next page)

Note: Counties that lost five or more HHAs tended to be urban, while those losing 50 percent or more were predominately rural. Three counties that met both criteria were classified in the latter category.

Source: GAO analysis of HCFA's OSCAR data for October 1, 1997, through January 1, 1999.

Closures in urban areas accounted for 74 percent of the reduction in HHAs. Nevertheless, because of the concentration of HHAs in urban areas, beneficiaries still generally have a choice of agencies. California's experience is illustrative. Between October 1, 1997, and January 1, 1999, California lost 145 HHAs, primarily in seven urban counties—Los Angeles, San Diego, San Francisco, and four adjacent counties (see app. V). However, even after these closures, the seven counties still had 450 Medicare-certified HHAs. The California home health association told us that, in reality, much of what appeared to be closures were actually mergers or consolidations of HHAs, and capacity may not have actually decreased. California's experience is not unique. For example, about 68 percent of the net reduction in HHAs in Texas occurred in 14 primarily urban counties.

Medicare Beneficiaries Continue to Receive Home Health Care Services

Although attention has been focused on the number of HHAs that have closed, a more important issue is whether beneficiaries have access to home health care services. Our analysis of the limited utilization data available for 1998 (the first 3 months) indicates that a slightly larger share of beneficiaries received home health services and users received about the same number of services as in 1994, the base year for the IPS. Utilization, both in terms of beneficiaries served and visits per user were below the peak levels reached in 1996. In addition, a large variation continued in utilization rates across areas, but the range narrowed. Indeed, utilization in low-use counties actually increased above 1994 levels. Together these patterns suggest that the IPS design is producing the desired result—controlling utilization and reducing its extreme variation. Unfortunately, it is not possible to tell from the aggregate picture whether only visits of marginal value or those that were inappropriate were forgone.

Our interviews with officials at seven state survey agencies responsible for certifying HHAs that serve Medicare beneficiaries and operating beneficiary hotlines suggest that closures are a market correction. Moreover, survey agency hotlines in these same states have received few beneficiary

complaints. In 34 primarily rural counties of these seven states—counties that have experienced significant HHA closures—most hospital discharge planners reported having little difficulty placing beneficiaries compared with previous years. Similarly, most HHA managers told us that they were unaware of access problems in their counties. In response to IPS and other initiatives, however, HHAs told us that they are changing how they operate. Some of these changes may create future access barriers for beneficiaries who need intensive or long-term skilled care.

Utilization Has Returned to 1994 Levels

There has been a substantial decline in utilization nationwide since 1996, and visits per beneficiary have now returned to about the same level as 1994, the base year for the IPS revenue caps. Home health use had been growing steadily since 1988, so 1994 represents a relatively high level of use, though not the peak.[24] The decline in visits per user between 1996 and 1998 is consistent with IPS incentives and does not necessarily imply a beneficiary access problem. Furthermore, variation in utilization between high- and low-use counties has narrowed.

The percentage of fee-for-service beneficiaries receiving home health care nationwide increased 22 percent between 1994 and 1996 and then declined 13 percent between 1996 and 1998. Despite this recent decline, the proportion of beneficiaries receiving services was 7 percent higher in 1998 than in 1994 (see table 5). Visits per user followed a similar pattern of growth and decline, but by 1998 they were essentially at the 1994 levels—30.8 and 30.5 visits, respectively. We cannot determine whether the reductions involved visits that were of marginal value, were for services that did not meet home health coverage criteria, or were indeed valuable services. These patterns are consistent, however, with the IPS incentives to constrain the costs of care for each beneficiary, but not necessarily the number of users.[25]

The difference in visits per user between high- and low- utilization counties narrowed over this period, but it is still substantial. From 1994 to 1998, high-utilization counties showed a small decrease in both the percentage of fee-for-service beneficiaries served (a decline of 1.5 percent) and the number of visits per beneficiary (a 2.2-percent decline). In contrast, HHAs in low-utilization counties served more beneficiaries

[24]Medicare Payment Advisory Commission, Report to Congress: Context for a Changing Medicare Program (Washington, D.C.: Medicare Payment Advisory Commission, June 1998), p. 108.

[25]While the IPS does not create incentives to control the number of home health users, the various fraud and abuse initiatives may have the effect of reducing the number.

(11 percent more) and provided more visits per beneficiary (15.9 percent more) over this same time period. In 1998, visits per beneficiary still varied widely, from an average of 19 visits in low-utilization counties to over 44 in high-utilization counties. The difference, however, has narrowed. The precise reasons for this historical variation are not known, but there is no reason to assume that it was warranted. The drop in visits per user in high-utilization areas suggests that practice patterns are changing in response to the IPS incentives.

Table 5: Changes in Utilization of Home Health Services Among Low-, Middle-, and High-Utilization Counties, First Quarters of 1994, 1996, and 1998

		Percentage of fee-for-service beneficiaries served			Visits per person served			
	Number of counties	First quarter 1994	First quarter 1996	First quarter 1998	First quarter 1994	First quarter 1996	First quarter 1998	Percentage change, 1994-98
Nationwide[a]	3,141	4.6	5.6	4.9	30.8	35.1	30.5	–1.0
Low-utilization counties[b]	624	3.5	4.3	3.9	16.4	20.0	19.0	15.9
Middle counties	1,870	4.3	5.2	4.7	27.5	31.1	27.5	0
High-utilization counties[b]	624	6.8	8.2	6.7	45.4	52.0	44.4	–2.2

[a]Includes 23 counties where beneficiaries received no services in 1994.

[b]Low-utilization counties are those with the lowest 20-percent utilization for the first 3 months of 1994 while high-utilization counties have the highest 20-percent utilization for the same time period. The middle counties are the remaining 60 percent.

Source: GAO analysis of HCFA's Standard Analytical File, claims data for home health services, 1994, 1996, and 1998.

State Representatives Generally Viewed HHA Capacity as Adequate

We interviewed officials at state survey agencies in seven states about potential closure-related access problems and beneficiary complaints. Each of these states had counties that experienced significant reductions—that is, five or more agencies or 50 percent or more of their agencies. In general, few access problems were identified. The small number of complaints received by state hotlines appears to suggest that most beneficiaries were not having difficulty accessing Medicare home health care, despite significant HHA closures in certain counties.

Most of the state survey agency representatives we interviewed told us that adequate capacity exists despite HHA closures. Only Texas representatives were unable to comment. A representative of Oregon's state survey agency said that areas with closures still have sufficient

options for beneficiaries to obtain home health services, as did a representative from Indiana. California's representative was not aware of any beneficiary access problems resulting from closures. A few state survey agencies went so far as to characterize closures as a market correction in response to an oversupply of HHAs. For example, Colorado's survey agency told us that, with the exception of the home health association, most stakeholders believed there had been too many HHAs chasing too few eligible beneficiaries. Missouri's state survey agency pointed out that there were no access problems before the sharp increase in HHAs in the last 3 years and that, despite the closures, Missouri now has the same number of HHAs that it had 3 years ago. A survey of state association members appears to support the Missouri state survey agency's perspective: eighty percent of members responded that capacity was still sufficient in areas that had experienced closures.

State survey agencies are required to operate hotlines that field beneficiary complaints. Hotlines in the seven states have received few complaints about access to Medicare home health care. Officials we interviewed in five of the seven states had a total of four complaints. In three states—Indiana, Missouri, and Oregon—no complaints were registered by consumers about Medicare home health care. California's state survey agency had one confirmed complaint about premature discharge from a Medicare-certified HHA. Colorado's state survey agency generally attributed three complaints about home health to "BBA changes."

State officials in Florida were not always able to distinguish access complaints received by the hotline from other types of complaints about home health care. Florida's state survey agency reported 14 confirmed complaints about inappropriate discharges from HHAs. However, these were not necessarily problems with Medicare coverage, because the agencies in question also served other clients. In Texas, because of the broad categories used to classify complaints, officials were unable to distinguish complaints related to home health access.

We inquired about whether reductions in Medicare utilization are actually a transfer to other payers, particularly Medicaid. Beneficiaries who are eligible for both Medicare and Medicaid services, for example, may receive more Medicaid-funded services as Medicare home health expenditures are constrained. Medicaid officials from two study states told us that they believed their programs were experiencing such shifts; other states expected, but had not yet seen, an impact. Some state officials we talked with had not collected data to substantiate these trends.

Beneficiaries in More Vulnerable Rural Counties Also Not Experiencing HHA Access Problems

Closures in rural areas can be a major concern because of the small number of HHAs located there and the potential for closures to drastically reduce capacity. Although rural counties lost only about 9 percent of their agencies, 32 rural counties lost their only HHA and an additional 97 lost 50 percent or more of their agencies.[26] Our interviews in 34 primarily rural counties, however, generated little evidence that access had been impaired by closures. In those counties that lost their only HHA, hospital discharge planner supervisors as well as managers of nearby HHAs told us that access is not a problem because services are available from HHAs in neighboring counties or from branch offices located in the county. The results from our analysis of utilization data for counties that had no HHA are consistent with the information collected from the stakeholders we interviewed in seven counties with no HHA.

Our interviews underscore the limitations of using the presence or absence of an HHA as an access indicator. Six of the 34 primarily rural counties in our sample had recently lost their only HHA, according to HCFA tracking data. A seventh county had never had an HHA. Hospital representatives and HHA managers in all seven counties told us that beneficiaries had access to services from either a branch[27] or an agency in an adjacent county. HCFA data on closures track parent agencies and not the branch agencies that served many of these counties. The following information describes the counties identified in HCFA tracking data as having no HHAs and the reported availability of HHAs according to information we received during interviews.

- Wright County, Missouri: Three HHAs had offices located in the county, and at least three more from outside the county were serving county beneficiaries.
- Montezuma County, Colorado: Two HHAs had offices located in the county, and one to two were serving beneficiaries from outside the county.
- Modoc County, California; Hamilton County, Florida; and Clay County, Indiana: Each county had one HHA office located in the county.
- Columbia County, Oregon: No HHA was located in the county, but five HHAs were serving beneficiaries from outside the county.
- Trinity County, Texas: No HHA located in the county, but four HHAs in adjacent counties serve beneficiaries.

[26]Rural counties account for 2,290 of the 3,141 counties in the United States.

[27]In a few instances, we were told that the agency was a parent agency not reflected in the HCFA tracking data. We did not attempt to verify these assertions.

We also examined utilization data for 715 primarily rural counties identified as having no HHA between October 1997 and January 1999.[28] About 1.7 million fee-for-service Medicare beneficiaries (or 5.4 percent of all fee-for-service beneficiaries) lived in those counties. Beneficiaries in all but 16 of these counties used home health services in 1998. Although counties with no HHA experienced a larger decline in visits than the national average, a higher proportion of beneficiaries continued to be served and to be provided slightly more services than the national average. (See tables 5 and 6.)

Table 6: Changes in Utilization of Home Health Services in Counties Without an HHA, First Quarters of 1994, 1996, and 1998

		Percentage of fee-for-service beneficiaries served			Visits per person served			
	Number of counties	First quarter 1994	First quarter 1996	First quarter 1998	First quarter 1994	First quarter 1996	First quarter 1998	Percentage change (1996-98)
Nationwide	3,141	4.6	5.6	4.9	30.8	35.1	30.5	–1.0
Counties that had no HHAs during the Oct. 1, 1997-Jan. 1, 1999, period	715	5.5	6.5	5.4	33.3	36.1	31.1	–6.6

Source: GAO analysis of HCFA's Standard Analytical File, claims data for home health services, 1994, 1996, and 1998.

According to hospital discharge supervisors and HHA managers in the majority of the other 27 counties in our sample, most beneficiaries eligible for Medicare home health care are not experiencing difficulty accessing services. The majority of hospital representatives told us that they were not having difficulty finding home health care for Medicare beneficiaries compared with their experience before the IPS. Hospitals in two of the three California counties and one of the seven Missouri counties reported recent problems placing Medicare beneficiaries in home health care. Two of these three hospitals operated their own HHA. In addition, in all but 3 of the 27 counties, HHAs reported no access problems. Of the six HHAs in three counties reporting access difficulties, four were in an urban county and cited problems for patients with diabetes or wounds. The remaining two HHAs were in rural counties and cited rural issues, such as distance or the lack of informal caregivers nearby.

[28]On October 1, 1997, 732 counties lacked HHAs. By January 1, 1999, new HHAs had opened in 17 of those counties. In addition, 42 other counties lost all of their agencies; consequently, by January 1, 1999, a total of 757 counties had no HHAs.

Changes in the Way HHAs Operate Could Create Future Access Problems for High-Cost Beneficiaries

According to HHAs, IPS and other federal initiatives or requirements have changed the way HHAs operate. (See app. VII.) Managers of HHAs we interviewed told us that they are trying to lower their operating costs by cutting staff, reducing supply and overhead costs, and providing more education to staff about the implications of the revenue caps. However, other operational changes are more focused on beneficiary receipt of services and may reduce visits or admissions, particularly for beneficiaries with an intense or long-term need for skilled nursing services. Four national advocacy groups told us that they have received complaints about access to home health services from such beneficiaries, but these complaints are hard to evaluate.

Although most HHAs told us that they have not officially changed their admission or discharge policies, they have made operational changes. In admitting beneficiaries, they (1) screen them more carefully to determine eligibility and the amount of care needed (2) assess whether the HHA has the capacity to provide that care, and (3) monitor patients' needs during treatment to ensure that they are discharged when appropriate. Frequent comments from HHAs that they compare patient need and agency capacity may reflect that HHAs are trying to manage their average costs per beneficiary to stay within the revenue caps. This balancing act could entail ensuring that they have enough short-term patients to adequately reduce average costs to compensate for any higher-cost patients served. Indeed, 10 HHAs volunteered that they balance their low- and high-cost patients to stay within their revenue limits. HHAs also told us that they educate beneficiaries or families in self-care sooner and make a greater effort to use community resources, including Medicaid services.

While many HHAs indicated that they continue to accept all Medicare-eligible beneficiaries, they acknowledged that they are more careful about accepting expensive, long-term patients. This comment may indicate a potential access problem for these types of beneficiaries. HHAs most frequently mentioned wound patients and diabetics unable to administer insulin themselves as types of beneficiaries they are careful about accepting or reluctant to accept. Most HHAs told us they continue to treat patients who need more services than originally estimated and continue to treat long-term patients for whom they cannot find another alternative, such as care provided informally by family or neighbors.

Four of the five national advocacy groups we interviewed have received access complaints focused on individuals with chronic illnesses or conditions such as Alzheimer's disease, multiple sclerosis, and

quadriplegia. Similarly, the Area Agencies on Aging we interviewed reported that beneficiaries in need of long-term care were having difficulty obtaining Medicare-covered home health care. These access complaints, however, may reflect uncertainty about who is eligible for the Medicare home health care benefit. It is not clear that the types of individuals cited by advocacy groups actually required skilled care and therefore were eligible for Medicare home health. Some advocacy groups we interviewed believed that home health care should be a long-term-care benefit available to any beneficiary with chronic conditions, regardless of the specific eligibility criteria in the statute. In the past, some beneficiaries who received home health services were not really eligible for Medicare coverage, and others are no longer eligible because of recent changes in the benefit. In five of the seven states we studied, one or more HHAs reported that referrals from closing agencies included beneficiaries who were ineligible for Medicare home health care. In one state, an HHA manager told us that only 4 of 78 referrals were eligible. Thus, reported access problems may actually reflect appropriate targeting of services, given Medicare's coverage criteria.

Conclusions

Although approximately 14 percent of HHAs have closed and the number of visits provided to Medicare beneficiaries has declined since 1997, we found little evidence that appropriate access to Medicare's home health benefit has been impaired. The substantial increases in the number of HHA beneficiaries using this benefit and visits per user over the past several years have outstripped the recent reductions. As a result, the number of remaining agencies as of January 1, 1999, and utilization as of March 1998 mirror patterns in 1994, the year designated as the basis of the IPS HHA revenue caps. Our interviews with key stakeholders in areas most affected by the HHA closures confirmed the overall impression that the recent spate of HHA closures has not impaired beneficiary access. Moreover, information we gathered indicates that beneficiaries who are not eligible for Medicare home health care because they do not need skilled care may have been the likeliest candidates for service reductions.

The changes in the number of HHAs and home health utilization are consistent with the incentives of the IPS. That the majority of closures occurred in areas with many HHAs and were smaller agencies indicates that beneficiaries still have access to services. The declines in visits per beneficiary signal HHAs' response to the IPS incentives to reduce the average costs of caring for their patients. Following years of substantial increases in home health visits, the IPS has curbed the growth in home

health spending. Whether services will be reduced to inappropriately low levels or access will be limited for beneficiaries who are likely to require more visits than the average is not known, but we found little evidence that this is occurring now. Furthermore, the pending implementation of the PPS, which will adjust payments to account for costlier patients, could ameliorate any future access problems. However, it is critical that the payments under the PPS be adequate and appropriately account for variation in patient resource needs. Thus, we will continue to monitor beneficiary access to home health care through the IPS and, as payments are changed, under the PPS.

Agency and Industry Comments

In its comments on a draft of this report, HCFA agreed with our findings that HHA closures have continued with little evidence of impaired beneficiary access. HCFA also provided technical comments, which we incorporated in the final report as appropriate. HCFA's written comments are included as appendix VIII.

We also obtained oral comments on a draft of this report from home health care industry representatives, including the American Association of Homes and Services for the Aging, American Federation of Home Care Providers, American Hospital Association, Home Health Services and Staffing Association, National Association for Home Care, and Visiting Nurses Association of America. In general, industry representatives agreed with our finding that beneficiaries who are likely to be costlier than average to treat are most at risk under the IPS. They stressed the need to quickly implement a PPS that adjusts payments to account for costlier patients to ameliorate any future access problems. Industry representatives did not dispute our findings on changes in home health utilization but pointed out that the only available utilization data since implementation of the IPS is already a year old and may not reflect more recent experience. Furthermore, they stated that it is not possible to determine if 1994 utilization levels were appropriate or inappropriate. Although the most recent data only account for the first 3 months of 1998, we did conduct interviews in February 1999 to complement the analysis and found little evidence of impaired beneficiary access. As soon as more complete data for 1998 are available, we plan to update our utilization analysis. We agree that available data do not permit the establishment of a baseline of appropriate use of home health care, especially in light of the fraud and abuse identified in the program. Finally, industry representatives suggested that the few complaints by beneficiaries may reflect a lack of awareness of Medicare home health coverage and their right to appeal

decisions. We agree that there is confusion about eligibility for the home health benefit. However, many HHA managers told us that they are helping to better educate beneficiaries and their families about qualifying for services.

We will send copies of this report to the Honorable Donna E. Shalala, Secretary of Health and Human Services; the Honorable Nancy-Ann Min DeParle, Administrator of HCFA; appropriate congressional committees; and other interested parties. We will also make copies available to others upon request.

If you or your staffs have any questions, please call me or Laura Dummit, Associate Director, at (202) 512-7114. Other major contributors to this report include Carol Carter, Roger Hultgren, Sally Kaplan, Walter Ochinko, Carmen Rivera-Lowitt, and Shari Sitron.

William J. Scanlon
Director, Health Financing and
Public Health Issues

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Abbreviations

BBA	Balanced Budget Act of 1997
HCFA	Health Care Financing Administration
HCIS	HCFA's Customer Information System
HHA	home health agency
HIPAA	Health Insurance Portability and Accountability Act of 1996
IPS	interim payment system
OASIS	Outcome and Assessment Information Set
ORT	Operation Restore Trust
OSCAR	On-Line Survey, Certification, and Reporting system
PPS	prospective payment system
RHHI	regional home health intermediary

Scope and Methodology

We analyzed data from the Health Care Financing Administration's (HCFA) On-Line Survey, Certification, and Reporting system (OSCAR) on the growth in HHAs since 1990, the characteristics of agencies that opened and closed during this period, and the number of closed and active agencies through January 1, 1999. To assess the effect of closures on beneficiary access, we analyzed the limited data available on beneficiary utilization since the implementation of the interim payment system (IPS) and conducted in-depth interviews with stakeholders in areas that had a substantial number of HHA closures since October 1997.

We compared utilization in the first 3 months of 1998 with comparable periods in 1994 and 1996 using HCFA's Standard Analytical File (version G). We selected 1994 as a point of comparison because the IPS revenue caps were based on the cost and utilization experience from that year. We looked at how many beneficiaries received services (the percentage of fee-for-service beneficiaries served) and how many services they received (the number of visits per user.) It is important to note that many Medicare home health care users receive services for considerable periods so visits per user based on 3 months of data significantly understate the actual use for the average user. Moreover, agencies may not have responded to the revenue cap until they had more information on their own long-term users. Finally, since IPS was phased in, not all agencies were under the new payment system during the first 3 months of 1998. Sixty-one percent of agencies were under the IPS by January 1, 1998. HCFA is concerned that changes in billing requirements that took effect later in the year may have affected data for the first quarter of 1998 as well.[29] In addition, these data do not reflect the full effect of closures reported here because the majority occurred after March 1998. Nonetheless, these are the most complete current utilization data available and we believe they provide an accurate picture of use at that time.

We used OSCAR data to identify counties that had lost 40 percent or more of their Medicare-certified HHAs between October 1, 1997, and January 1, 1999. We further focused on county-level analyses in seven states that had counties that met these closure criteria and that varied along several dimensions, including geographic area, home health utilization experience, and approaches to controlling the number of agencies providing services (see table I.1). Our sample consisted primarily of rural counties because the number of HHAs in urban counties remained high even in those counties with many closures. To examine the potential impact of HHA

[29]Although changes in billing requirements went into effect after the first quarter of 1998, HCFA expressed concern that these data could be affected.

closures on beneficiaries' utilization of services, we used data from HCFA's Customer Information System (HCIS) to select an additional six counties. These 6 counties were among the 100 counties nationwide with the greatest percentage decline in visits per user from 1996 to 1998 and with Medicare populations of more than 50 and less than 10,000. Table I.2 lists the 34 counties and the number of HHAs in these counties.

We conducted structured interviews with stakeholders in a sample of seven states (California, Colorado, Florida, Indiana, Missouri, Oregon, and Texas). These interviews were conducted in a sample of 34 counties—28 were primarily rural counties that had experienced a substantial reduction in the number of HHAs (one of these counties had never had an HHA). We augmented this sample with six counties in which home health visits had declined notably between the first 3 months of 1996 and a comparable period in 1998.

In each sample state, we interviewed officials at (1) state Medicaid agencies; (2) state home health associations; (3) state agencies responsible for the survey and certification of HHAs serving Medicare beneficiaries and for maintaining hotlines that collect data on beneficiary complaints; and (4) beneficiary advocacy groups such as local Area Agencies on Aging and chapters of the American Association of Retired Persons. In each county, we interviewed hospital discharge planner supervisors and HHA managers. Overall, we interviewed representatives of 54 HHAs, 40 hospitals, and 42 advocacy groups.[30] At the national level, we also spoke with officials at six home health associations and five advocacy groups.

Finally, because representatives of the home health industry question the accuracy of the OSCAR data, we attempted to verify the number of closures in our state sample with personnel from state survey and certification offices and health care providers. However, we were told in most cases that the state survey and certification data were no more up to date than the OSCAR data we were using.

[30]We interviewed representatives from 54 HHAs, because when we made contacts in the counties selected, we found operating HHAs or branches of HHAs in some counties where OSCAR data told us there were no HHAs.

Table I.1: Characteristics of States in Interview Sample

	Characteristics					
State	**Region**	**Average visits per user, 1997**	**How new agency revenue limits compare with those for established agencies**	**Ratio of Medicare beneficiaries per HHA to national average**	**ORT[a] state?**	**Does state restrict number of HHAs?**
California	West	Low	Above	Average	Yes	No
Colorado	West	Medium	About the same	Low	Yes	No
Florida	South	Medium	Below	High	Yes	Yes
Indiana	Midwest	Medium	About the same	Average	No	No
Missouri	Midwest	Low	Above	Average	Yes	No
Oregon	West	Low	Above	High	No	No
Texas	South	High	Below	Low	Yes	No

[a]Operation Restore Trust (ORT) is HCFA's antifraud campaign.

Sources: GAO analyses of data from various sources, including HCFA's OSCAR; Medicare beneficiary enrollment data; Department of Health and Human Services, ORT; and the National Association for Home Care.

Table 1.2: Counties Selected for In-Depth Analyses

State	Counties selected	Number of HHAs on Jan. 1, 1999
California	Amador	1
	Modoc	0
	San Mateo	6
Colorado	Chaffee	1
	Douglas	1
	Huerfano	2
	Las Animas	1
	Montezuma	0
Florida	Gulf	2
	Hamilton	0
	Okeechobee	1
	Suwannee	1
	Walton	1
Indiana	Clay	0
	Daviess	1
	Fayette	1
	Greene	1
	Noble	1
Missouri	Howard	1
	Iron	1
	Jefferson	2
	Laclede	1
	St. Francois	3
	Washington	1
	Wright	0
Oregon	Columbia	0
	Curry	1
	Lane	5
	Washington	3
Texas	Jasper	5
	Polk	1
	Potter	5
	Trinity	0
	Winkler	1

Source: GAO's analysis of HCFA's January 1999 OSCAR data.

Use of Home Health Services by State, Calendar Years 1994 and 1997

State	Medicare home health users per 1,000 fee-for-service enrollees			Visits per person served		
	1994	1997	Percentage change	1994	1997	Percentage change
Alabama	119.4	128.1	7.3%	113.4	120.7	6.4%
Alaska	61.8	71.0	14.9	43.4	45.7	5.3
Arizona	66.7	79.3	18.9	56.2	58.8	4.6
Arkansas	98.9	106.5	7.7	76.0	77.2	1.6
California	100.1	109.5	9.4	46.1	48.7	5.6
Colorado	93.7	104.1	11.1	59.8	67.4	12.7
Connecticut	107.4	128.4	19.6	72.9	81.2	11.4
Delaware	90.8	93.4	2.9	43.4	49.8	14.7
District of Columbia	77.7	94.8	22.0	42.1	52.9	25.7
Florida	118.0	124.6	5.6	75.9	74.7	–1.6
Georgia	109.2	109.5	0.3	102.1	98.9	–3.1
Hawaii	39.0	47.8	22.6	41.0	38.8	–5.4
Idaho	84.1	99.8	18.7	54.2	59.9	10.5
Illinois	91.7	107.1	16.8	51.9	50.3	–3.1
Indiana	80.4	95.6	18.9	72.5	71.7	–1.1
Iowa	70.3	83.3	18.5	46.4	49.0	5.6
Kansas	71.0	88.4	24.5	55.8	63.5	13.8
Kentucky	92.1	116.4	26.4	64.8	73.7	13.7
Louisiana	138.6	157.3	13.5	125.8	161.0	28.0
Maine	96.2	119.6	24.3	64.1	68.2	6.4
Maryland	78.3	92.0	17.5	37.1	37.4	0.8
Massachusetts	127.9	152.2	19.0	87.0	96.5	10.9
Michigan	87.8	104.0	18.5	44.7	50.1	12.1
Minnesota	55.7	72.2	29.6	37.8	47.1	24.6
Mississippi	140.8	153.3	8.9	113.5	119.7	5.5
Missouri	107.2	120.2	12.1	49.5	53.5	8.1
Montana	70.9	87.0	22.7	51.6	52.2	1.2
Nebraska	66.3	84.9	28.1	40.9	45.2	10.5
Nevada	72.8	87.2	19.8	68.1	63.2	–7.2
New Hampshire	105.8	122.1	15.4	56.8	63.6	12.0
New Jersey	77.4	96.6	24.8	39.7	43.2	8.8
New Mexico	79.1	99.0	25.2	56.0	74.4	32.9
New York	75.8	93.9	23.9	44.6	52.6	17.9
North Carolina	86.3	104.9	21.6	57.3	54.8	–4.4
North Dakota	69.6	81.6	17.2	41.5	43.4	4.6

(continued)

State	Medicare home health users per 1,000 fee-for-service enrollees			Visits per person served		
	1994	1997	Percentage change	1994	1997	Percentage change
Ohio	79.5	96.4	21.3	50.7	50.4	–0.6
Oklahoma	108.9	131.9	21.1	105.7	147.0	39.1
Oregon	79.7	94.4	18.4	39.7	33.7	–15.1
Pennsylvania	104.3	125.1	19.9	43.0	47.0	9.3
Rhode Island	109.9	143.6	30.7	60.7	71.6	18.0
South Carolina	84.6	99.4	17.5	66.8	63.2	–5.4
South Dakota	61.2	78.3	27.9	39.2	48.4	23.5
Tennessee	134.4	132.4	–1.5	116.4	108.7	–6.6
Texas	106.9	133.7	25.1	97.4	141.0	44.8
Utah	102.9	103.4	0.5	98.4	115.1	17.0
Vermont	134.0	144.4	7.8	61.4	68.1	10.9
Virginia	79.6	96.9	21.7	49.0	57.1	16.5
Washington	72.7	80.9	11.3	38.4	32.4	–15.6
West Virginia	86.9	106.0	22.0	51.0	59.9	17.5
Wisconsin	59.7	68.8	15.2	41.6	43.1	3.6
Wyoming	89.0	92.5	3.9	77.0	71.7	–6.9
Nationwide	94.2	109.2	15.9%	66.0	72.9	10.5%

Source: HCFA, Office of Information Services. Data are from the Medicare Decision Support System and data developed by the Office of Strategic Planning for calendar years 1994 and 1997.

Medicare-Certified HHAs and Medicare Fee-for-Service Enrollees per HHA, by State, for Selected Periods

State	Number of Medicare-certified HHAs		Changes, Oct. 1, 1997, to Jan. 1, 1999		Number of Medicare fee-for-service enrollees per HHA	
	Oct. 1, 1997	Jan. 1, 1999	Closures	New openings	Oct. 1, 1997	Jan. 1, 1999
Alabama	183	181	2	0	3,541	3,548
Alaska	27	18	9	0	1,181	1,874
Arizona	131	112	22	3	3,163	3,640
Arkansas	205	195	11	1	2,112	2,207
California	848	703	165	20	2,805	3,394
Colorado	200	161	42	3	1,615	1,934
Connecticut	116	101	17	2	4,016	4,159
Delaware	21	18	3	0	4,736	6,004
District of Columbia	21	22	1	2	3,409	3,247
Florida	398	365	47	14	5,271	5,654
Georgia	97	103	0	6	9,009	8,461
Hawaii	28	21	7	0	3,953	5,247
Idaho	77	62	16	1	1,982	2,436
Illinois	393	362	35	4	3,873	4,149
Indiana	292	248	49	5	2,852	3,367
Iowa	211	195	19	3	2,234	2,412
Kansas	221	187	34	0	1,702	1,992
Kentucky	111	116	2	7	5,375	5,178
Louisiana	519	407	112	0	1,040	1,255
Maine	52	46	9	3	4,125	4,708
Maryland	81	78	3	0	6,894	7,235
Massachusetts	199	183	18	2	3,950	4,097
Michigan	230	223	11	4	5,993	6,104
Minnesota	266	262	9	5	2,053	2,184
Mississippi	70	69	1	0	5,992	6,115
Missouri	273	221	56	4	2,866	3,443
Montana	62	60	4	2	2,194	2,266
Nebraska	83	76	8	1	2,962	3,213
Nevada	54	41	14	1	2,827	3,817
New Hampshire	46	43	3	0	3,420	3,576
New Jersey	57	55	3	1	18,780	18,795
New Mexico	118	95	23	0	1,586	2,000
New York	227	223	5	1	10,276	10,218
North Carolina	162	174	6	18	6,708	6,287

(continued)

State	Number of Medicare-certified HHAs		Changes, Oct. 1, 1997, to Jan. 1, 1999		Number of Medicare fee-for-service enrollees per HHA	
	Oct. 1, 1997	Jan. 1, 1999	Closures	New openings	Oct. 1, 1997	Jan. 1, 1999
North Dakota	35	35	1	1	2,989	2,989
Ohio	465	426	43	4	3,302	3,409
Oklahoma	388	299	90	1	1,226	1,570
Oregon	91	74	18	1	3,418	4,237
Pennsylvania	381	370	22	11	4,438	4,292
Rhode Island	30	29	5	4	4,830	4,089
South Carolina	82	77	5	0	6,656	7,335
South Dakota	57	53	5	1	2,121	2,292
Tennessee	232	206	26	0	3,486	3,889
Texas	1,948	1,580	392	24	1,001	1,209
Utah	89	72	19	2	1,945	2,753
Vermont	13	13	0	0	6,682	6,737
Virginia	233	226	15	8	3,585	3,722
Washington	68	66	3	1	8,154	8,406
West Virginia	92	91	4	3	3,442	3,514
Wisconsin	176	164	13	1	4,344	4,637
Wyoming	65	56	9	0	966	1,144
Nationwide	**10,524**	**9,263**	**1,436**	**175**	**3,133**	**3,509**

Note: The count of HHAs includes only those agencies with Medicare provider numbers. Therefore, it includes parents or home offices and subunits but does not include branch offices. Numbers of Medicare fee-for-service enrollees per HHA are based on Medicare enrollment data as of September 1997 and December 1998 and the number of HHAs within the states as of October 1, 1997, and January 1, 1999.

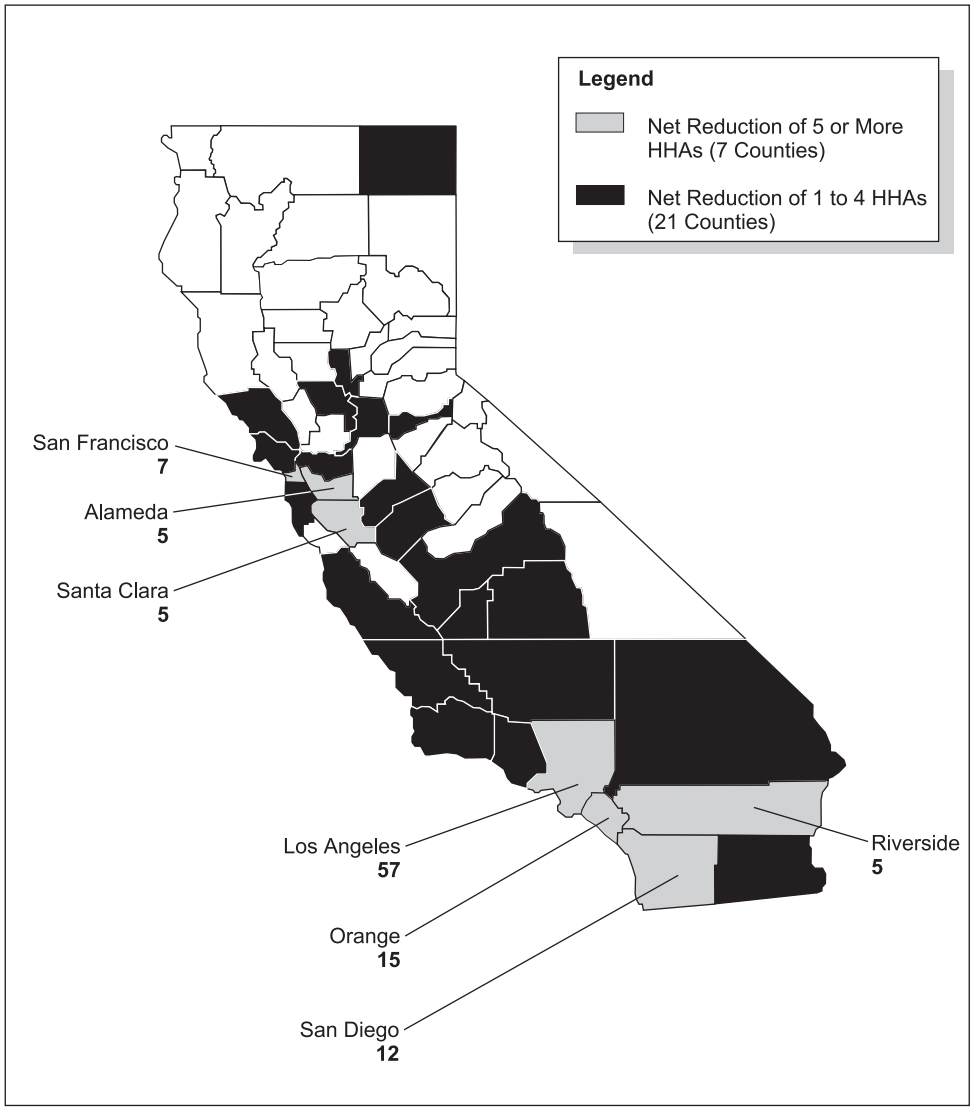
Sources: GAO analysis of HCFA's OSCAR data and Medicare enrollment data for 1997 and 1999.

Counties With Medicare-Certified HHAs, October 1, 1997, and January 1, 1999

Number of HHAs per county	Number of counties with HHAs		Percentage of counties, Jan. 1, 1999	Percentage change in number of counties, Oct. 1997 to Jan. 1999
	Oct. 1, 1997	Jan. 1, 1999		
0	732	757	24%	3%
1	956	1,005	32	5
2	548	558	18	2
3	304	288	9	–5
4	153	147	5	–4
5	98	91	3	–7
6	60	52	2	–13
7	52	47	1	–10
8	31	26	1	–16
9	32	20	1	–38
10	16	11	0	–31
11-15	60	52	2	–13
16-20	26	23	1	–12
21-50	56	54	2	–4
51-100	11	6	0	–45
101-150	2	1	0	–50
151-200	1	0	0	–100
Over 200	3	3	0	0
Total no. of counties	3,141	3,141	100.0%	
Number of HHAs	10,524	9,263		

Source: GAO analysis of HCFA's OSCAR data for October 1, 1997, through January 1, 1999.

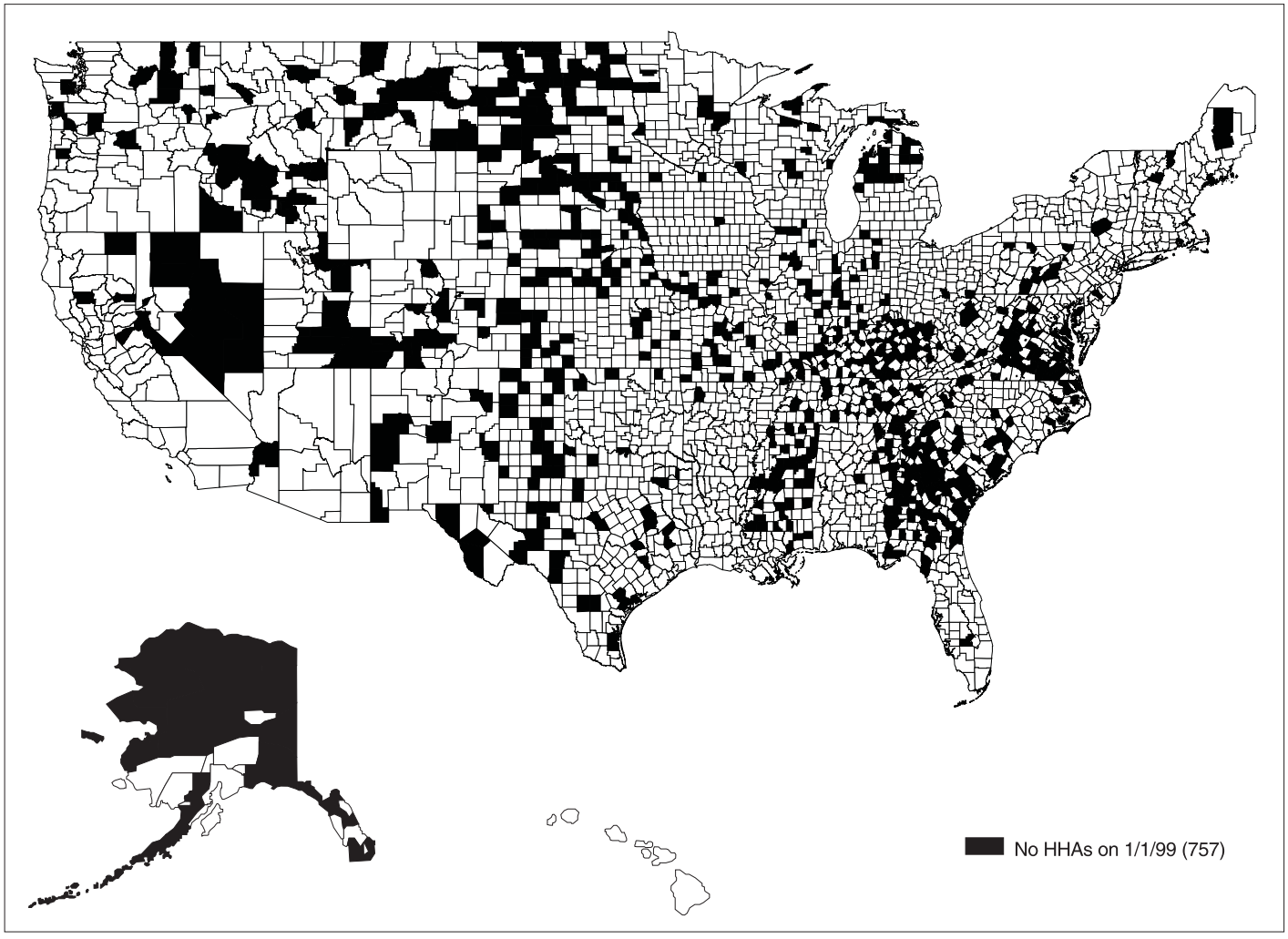
California Counties With Significant Decline in Number of HHAs Between October 1, 1997, and January 1, 1999



Note: Numbers indicate HHA closures.

Source: GAO analysis of HCFA's OSCAR data for October 1, 1997, through January 1, 1999.

Counties With No HHAs on January 1, 1999



Source: GAO analysis of HCFA's OSCAR data for October 1, 1997, through January 1, 1999.

Other Policies Have Affected HHA Costs and Revenues

During interviews with industry representatives in seven states, we were consistently told that closures are not only due to the IPS but also to policy changes that may have decreased utilization and thus affected HHA revenues or increased their operating costs. According to stakeholders, the concurrent changes increased pressure on many HHAs at the same time they were adjusting to the IPS, that is, attempting to manage their costs to their new revenue limits. We did not attempt to verify these assertions.

Factors Cited as Reducing HHA Revenues

During our interviews, we were told that two developments have affected HHAs' caseloads—a drop in physician referrals and a change in coverage of venipuncture (drawing blood).[31] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposed a civil monetary penalty on physicians falsely certifying patients as eligible for home health care.[32] In a fraud alert dated January 1999 and sent to medical societies, trade associations, and HCFA, the Office of the Inspector General, Department of Health and Human Services, reminded providers about the penalty. Another factor reportedly reducing home health care is the BBA change in Medicare home health coverage: venipuncture is no longer considered a qualifying skilled nursing service, that is, the need only for venipuncture does not qualify a beneficiary for home health services. HHAs in six of the seven states reported that patient volume had dropped significantly as a result of the change, especially in rural areas. However, there are no readily available estimates of the number of beneficiaries affected by the venipuncture change.

In addition to the impact of fewer patient referrals on revenue, we were told that the combination of increased claim reviews and changes in billing have impeded the cash flow of some HHAs. More frequent regional home health intermediary (RHHI) requests for additional documentation to support claims have created a growing backlog of unpaid bills. This increased scrutiny is a result of concern about fraud and abuse and additional funding for claims review provided by HIPAA.

Another policy change may have reduced revenues for some HHAs. The BBA changed the billing rules so that the location of the beneficiary, not the HHA

[31]Section 4615 of the Balanced Budget Act (BBA) (111 Stat. 251, 475) eliminated venipuncture as a qualifying service for home health care when it is the only skilled service provided. According to HCFA, Operation Restore Trust (ORT) had found that physicians were using this procedure as the only skilled service to enable beneficiaries to obtain home health aide services, resulting in numerous visits for individuals who would not otherwise qualify for Medicare home health.

[32]The law imposed a fine of the greater of $5,000 or 3 times the amount of Medicare payments made as a result of the false certification (P.L. 104-191, sec. 232, 110 Stat. 1936, 2015).

billing office, determined the wage adjustment applied to the Medicare payment to adjust for differences in labor costs across locations.[33] This may have reduced the incentive for HHAs to operate branches. 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.

HCFA fiscal intermediary officials maintain that delays in implementing the IPS revenue caps have increased overpayments to HHAs. As a result, more HHAs have had to reimburse Medicare for payments that were too high. Some contend that the repayment of these overpayments has placed hardships on some agencies and contributed to closures.[34] Although Medicare overpayments to HHAs are not unusual, both HCFA and RHHI representatives expected overpayments for fiscal year 1998 to be both more frequent and higher than in previous years. The category of overpayments most likely to be IPS-related has grown compared with 1996, both in the number of HHAs with overpayments and the amount owed. The extent to which the repayment of overpayments has contributed to closures, however, is not known.

Factors Cited as Increasing the Cost of Doing Business

According to our interviews, new Medicare requirements, such as surety bonds and the Outcome and Assessment Information Set (OASIS), will also place additional administrative and financial obligations on HHAs. National and state associations criticized any increased financial demands given the IPS reduction in revenues for HHAs. Although the details have not yet been announced, agencies will be obligated to purchase a surety bond in 1999.[35] We were told that the newly required OASIS, including its electronic transmission to HCFA, necessitates that agencies train employees, in some cases purchase new computer hardware, and conduct 1- to 2-hour patient

[33]Sec. 4604, 111 Stat. 251, 472.

[34]During each fiscal year, HHAs receive interim payments based on their projected per-visit cost and, in some instances, the projected volume of services for Medicare beneficiaries. At the end of the year, an HHA submits a report on its costs and the services provided, and the amount the HHA should have been paid is calculated. If the HHA has been overpaid, it must return the excess to Medicare. Otherwise, the program makes a supplemental payment to the agency to make up the difference between the earned reimbursement and the interim payments. HHAs with overpayments as a result of the IPS will have a longer period in which to repay Medicare. According to HCFA, HHAs must obtain permission from the RHHI to have 1 year to repay their overpayments resulting from the IPS without incurring interest. They can obtain an additional 2-year extension with permission from the HCFA regional office, but interest is charged on the unpaid balance at a legally required rate, currently 13.75 percent per year. HCFA executives at headquarters must approve longer extensions.

[35]Medicare Home Health Agencies: Role of Surety Bonds in Increasing Scrutiny and Reducing Overpayments (GAO/HEHS-99-23, Jan. 29, 1999).

assessments. It is not clear, however, if these requirements will represent a major new cost. First, conducting patient assessments is not a new requirement. Second, HCFA officials told us that OASIS simplifies and systematizes the collection of data on patient characteristics and conditions and, in the long run, will lower agency assessment costs per claim. Indeed, some agencies have already made the necessary investments. Finally, we were told that the change in the definition of branch offices has increased the operating costs for those agencies that no longer qualify as a branch and must operate independently as a parent agency.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAY 17 1999

FROM: Nancy-Ann Min DeParle
Administrator, HCFA

SUBJECT: General Accounting Office (GAO) Draft Report, "Access to Home Health Care: Agency Closures Have Little Effect on Medicare Beneficiaries"

TO: Laura Dummit, Associate Director,
Health Financing and Public Health Issues, GAO

We appreciate the GAO's continuing work on Medicare's home health benefit and agree with the report's conclusions that beneficiaries continue to have access to care. Medicare's home health benefit is essential for millions of elderly and disabled Americans, and we must assure access to care for those who qualify for its services.

The Administration and Congress have worked together to protect Medicare's home health benefit while slowing the rapid rise in costs. Between 1990 and 1997, home health expenditures grew at an average annual rate of 25 percent -- three times the growth rate for the program overall. During the same time period, the average number of visits per beneficiaries more than doubled, and the number of home health agencies providing services to Medicare beneficiaries grew from 5,700 to 10,500.

While some of this growth reflected legitimate medical needs, Operation Restore Trust and other program integrity efforts found that much of it stemmed from waste, fraud and abuse. In the Balanced Budget Act of 1997 (BBA), the Administration and Congress created new tools for us to address abuse while mandating reforms and closing loopholes.

Like the GAO, we are monitoring how the BBA's provisions affect beneficiaries and home health agencies. We have set up a special work group to monitor the implementation of the BBA and beneficiary access to care. While we have found a decline in the number of home health agencies, we have not found barriers to care based on the best information available to date.

We will continue to monitor the situation carefully, and we look forward to further collaboration with the GAO on this issue. Assuring access to care for Medicare beneficiaries remains one of our highest priorities.

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