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August 2003

MEDICARE HOME HEALTH PAYMENT

Nonroutine Medical Supply Data Needed to Assess Payment Adjustments

GAO-03-878

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Highlights

Highlights of GAO-03-878, a report to congressional committees

Why GAO Did This Study

Under Medicare's prospective payment system (PPS), home health agencies receive a single payment, adjusted to reflect the care needs of different types of patients, for providing up to 60 days of home health care. Some home health industry representatives have suggested that certain nonroutine medical supplies (such as wound-care dressings) should be excluded from this payment and reimbursed separately because of their high cost. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required GAO to examine home health agency payments for nonroutine medical supplies and recommend whether payment for any such supplies should be excluded from the PPS.

What GAO Recommends

GAO recommends that CMS collect and analyze the data necessary to determine whether Medicare's home health payments appropriately reflect the differences in nonroutine medical supply costs across types of patients. If any problems are identified, CMS should modify the PPS and, if necessary, seek statutory authority to exclude certain nonroutine medical supplies from the home health payment. CMS agreed with GAO's first finding and stated that it was collecting the necessary data to evaluate Medicare payments.

www.gao.gov/cgi-bin/getrpt?GAO-03-878.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Laura A. Dummit (202) 512-7119.

What GAO Found

Although Medicare's home health payment includes the average costs of nonroutine medical supplies, adjusted payments may not reflect variation in supply costs across types of patients. Further, home health agencies can be paid the same amount for treating patients with quite different supply costs. This means that under the PPS, patients who require costly supplies may have problems accessing home health care and the agencies that treat them may be financially disadvantaged. This is of particular concern for patients who have nonroutine medical supply needs that are easily identified prior to admission or who require supplies for which there are no lower-cost alternatives.

Excluding certain nonroutine medical supplies from the home health payment and reimbursing them separately would help ensure that patients have access to these supplies and that agencies are protected financially for providing them. At the same time, this would weaken the cost-control incentives of the PPS as well as increase patient out-of-pocket costs. Such a policy might be warranted, however, for nonroutine medical supplies that are high-cost, relative to the total payment, and infrequently used because the payment adjustment to account for differences in patient needs may not be adequate to compensate a home health agency for providing these supplies.

Patient care representatives suggest that an additional category of supplies should be excluded from the payment and reimbursed separately, namely those that a patient had been using prior to home health care to treat an on-going condition. Clinical experts indicated that care has been disrupted for some patients who require these kinds of supplies because some home health agencies have required patients to switch supplies or limited the supplies provided to them. Although the Centers for Medicare & Medicaid Services (CMS) has asked home health agencies to report information on nonroutine medical supply use and cost, they have not done so. Without this patient-specific supply data, CMS does not have the ability to determine whether the PPS needs to be adjusted to account for nonroutine medical supply costs or whether certain supplies should be excluded from the payment.

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Abbreviations

BBA	Balanced Budget Act of 1997
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CMS	Centers for Medicare & Medicaid Services
DME	durable medical equipment
HCFA	Health Care Financing Administration
HHA	home health agency
HHRG	home health resource group
PPS	prospective payment system

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Congressional Committees

The Balanced Budget Act of 1997 (BBA) mandated implementation of a prospective payment system (PPS) for home health agencies (HHA) that would provide a predetermined payment to cover the costs of all Medicare-covered home health visits and medical supplies delivered during home health care.[1] Under the PPS, HHAs receive a single payment, adjusted to reflect the care needs of the patient, for delivering up to 60 days of care, called a home health "episode." This episode payment is based on the historical national average cost of providing care, not on an HHA's actual costs of treating any given patient. The episode payment is intended to cover the average costs of all home health visits and medical supplies provided during the episode—including routine and nonroutine medical supplies.[2] The all-inclusive payment provides HHAs with strong incentives to control their costs of care. Strategies that HHAs can use to control episode costs include reducing the number of visits, substituting lower paid or less skilled personnel, providing fewer or less costly supplies, purchasing supplies more efficiently, or treating a less expensive mix of patients.

Under the PPS, each Medicare home health patient is assigned to a payment group based on certain clinical and service-use characteristics, and the episode payment is adjusted to account for differences in the average resource needs of the patients in each payment group. Even with these payment adjustments, the Centers for Medicare & Medicaid Services (CMS) and home health industry representatives have raised concerns about compensating for nonroutine medical supplies under the home health PPS.[3] Industry representatives have questioned whether the episode

[1]Pub. L. No. 105-33, § 4603(a), 111 Stat. 251, 467-470 (codified at 42 U.S.C §1395fff (2000)).

[2]Routine medical supplies—such as swabs, cotton balls, and adhesive tape—are those used during the usual course of a large share of home health visits. Nonroutine medical supplies are used to treat a specific patient's illness or injury and include items such as wound care dressings, catheters, intravenous supplies, and the supplies used to care for an ostomy (a surgically created opening in the body for the discharge of body wastes), such as drainage bags, pouches, and skin barriers.

[3]CMS, the agency responsible for administering the Medicare program, was known as the Health Care Financing Administration (HCFA) until July 1, 2001. This report refers to the agency as HCFA when referring to actions before the name change and as CMS when referring to actions taken since the name change.

payments include all the costs of nonroutine medical supplies and whether episode payments for different types of patients are adjusted appropriately to reflect their nonroutine medical supply costs. CMS officials have acknowledged that payments may be too low for certain types of patients who require nonroutine medical supplies, such as those requiring wound-care supplies.

Some home health industry representatives have suggested that certain nonroutine medical supplies, such as wound-care supplies' be excluded from the episode payment and paid for separately by Medicare. This is because with the all-inclusive payment under the PPS, patients requiring costly nonroutine medical supplies or HHAs serving a disproportionate number of such patients could be disadvantaged. Paying for expensive supplies separately could diminish concerns about access to care for patients requiring these nonroutine medical supplies and protect HHAs that treat them. This may be particularly appropriate for high-cost, infrequently provided nonroutine medical supplies because Medicare's payment is based on the average cost of treating all patients within a group. On the other hand, paying for specified supplies separately would dampen the incentives for HHAs to deliver services efficiently since HHAs would receive additional payments if they selected supplies that were excluded from the episode payment, even if lower-cost, clinically appropriate alternatives were available.[4] And, under Medicare payment rules, affected patients would pay more for supplies that were excluded from the episode payment.[5] CMS is currently assessing whether the home health PPS requires revisions. However, the agency has concluded it does not have the authority to exclude any supply costs from the episode payments.

In this context, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required GAO to examine the provision of nonroutine medical supplies by home health agencies and recommend whether payment for such supplies should be excluded from the episode payment and paid for separately.[6] In consultation with the committees of jurisdiction, we have examined whether (1) total HHA episode payments

[4]Furthermore, Medicare spending would increase unless the average episode payment was reduced by the cost of these supplies.

[5]Beneficiary spending would increase especially for those patients who require nonroutine medical supplies that are not otherwise covered under Medicare.

[6]Pub. L. No. 106-554, App. F § 505; 114 Stat. 2763, 2763A-531.

adequately account for nonroutine medical supply costs and (2) any nonroutine medical supplies should be excluded from the episode payment and paid for separately by Medicare.

To conduct this work, we reviewed the provisions of BBA and the Health Care Financing Administration's (HCFA) interim and final rules on the home health PPS to evaluate the design of the payment groups and adjustments. We conducted structured interviews with nine clinical experts about the use of nonroutine medical supplies by home health patients. The experts included home health nurses (including specialists in wound, ostomy, and continence care), physical therapists, university-based researchers, and home health agency managers. We also conducted structured interviews with representatives from the National Association for Homecare, the Visiting Nurse Association of America, the American Home Care Association, the American Association for Homecare, the United Ostomy Association, and representatives from the Wound, Ostomy, and Continence Nurses Society. We did not directly determine if episode payments adequately accounted for the costs of these supplies because data were not available. We conducted our work from December 2000 through August 2003 in accordance with generally accepted government auditing standards. During this period, CMS expected to receive patient-specific data on the cost and utilization of specific nonroutine medical supplies, but did not.

Results in Brief

Although the costs of all nonroutine medical supplies were used in establishing the average home health episode payment, adjusted payments may not reflect all the variation in the costs of nonroutine medical supplies for different types of patients. HCFA did not have data on the cost or use of specific nonroutine medical supplies to develop the payment groups or the payment adjustments. HCFA accounted for differences in supply costs across types of patients based on the average cost of staff time of the visits associated with the patient group. As a result, the episode payments appropriately reflect supply costs only when they vary with the cost of staff time. In addition, the payment groups may not adequately distinguish among types of patients based on their need for, and the costs of, nonroutine medical supplies. Because each payment group can include patients with widely varying clinical conditions, there may be some types of patients within a payment group who have above-average costs due to their needs for these supplies.

There are certain nonroutine medical supplies that should be considered for exclusion from the episode payment because of their high cost and infrequent use and others that should be considered because of continuity of care concerns. Payments based on average costs may not adequately account for high-cost, infrequently provided medical supplies. As a result, some HHAs may be unwilling to provide these supplies or will be financially disadvantaged if they treat patients with these needs. The clinical experts we consulted suggested that continuity of care would be another reason for excluding certain nonroutine medical supplies from the PPS episode payment. They noted that care had been disrupted for some patients who had been managing a chronic condition with supplies prior to receiving home health care. Industry representatives and wound-care nurses we interviewed stated that this disruption has occurred because some HHAs have required patients to switch supplies while receiving home health care or have limited the supplies provided to patients. However, CMS lacks data on the cost and frequency of use of individual supply items to modify the payment groups and adjustments and to determine whether certain nonroutine medical supply exclusions merit consideration.

We are recommending that in evaluating refinements to the PPS, the Administrator of CMS should collect and analyze patient-specific data on the cost and utilization of individual nonroutine medical supplies to determine whether the payment groups and adjustments appropriately reflect the differences in supply costs. The Administrator should also gather and evaluate evidence on whether there have been systematic disruptions in the care for some patients under the PPS. If these analyses indicate problems with the current PPS, the Administrator of CMS should modify the payment groups and adjustments to better account for these supply costs or minimize care disruptions. If such refinements cannot resolve identified problems, the Administrator should seek the necessary legislative changes to exclude selected nonroutine medical supplies from the episode payment.

CMS provided written comments on a draft of this report and concurred with the first finding. CMS stated that it was collecting the data needed to determine whether the home health payments reflect nonroutine medical supply cost differences across types of patients. The agency did not address our recommendation to evaluate whether there have been disruptions in care.

Background

Medicare's home health care benefit enables certain beneficiaries with post-acute-care needs (such as recovery from joint replacement) and chronic conditions (such as congestive heart failure) to receive care in their homes. To qualify for home health care, beneficiaries must be homebound;[7] require intermittent skilled nursing, or physical or speech therapy or occupational therapy on a continuing basis; be under the care of a physician; and have their home health care services furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions continue to be met, Medicare will pay for an unlimited number of episodes of care that can include skilled nursing care; physical, occupational, and speech therapy; medical social service; and home health aide visits.[8]

Medicare Coverage of Medical Supplies

When a beneficiary begins receiving Medicare-covered home health care, all medical supplies except for durable medical equipment (DME) used by the patient are covered as part of the home health care.[9] Beneficiaries using home health care are not required to pay any deductibles or copayments for these services and supplies.

For beneficiaries who are not receiving Medicare-covered home health care, Medicare part B (supplementary medical insurance) covers certain medical supplies for those not hospitalized or not in another inpatient setting.[10] Beneficiaries are responsible for a 20-percent copayment for all supplies and services. Medical supplies covered under part B are limited to the devices used to replace bladder and bowel function (such as catheters, ostomy bags, and irrigation and flushing equipment); supplies required for

[7]Beneficiaries are homebound when they have a condition that results in a normal inability to leave home except with considerable and taxing effort; absences from home must be infrequent or of relatively short duration or attributable to receiving medical treatment.

[8]Home health aide visits include personal care services, such as assistance with eating, bathing, and toileting; simple surgical dressing changes; assistance with certain medications; activities to support skilled therapy services; and routine care of prosthetic and orthotic devices.

[9]DME is equipment that can withstand repeated use, is generally used to serve a medical purpose, is not useful to a person without illness or injury, and can be used in the home (such as respirators, crutches, oxygen, and inhalators).

[10]Participation in part B is voluntary (about 95 percent of beneficiaries participate) and part B is partly financed by monthly premiums paid by enrollees.

parenteral and enteral nutrition feeding[11] (such as catheters, filters, and nutrient solutions) and tracheostomy[12] care; and surgical wound dressings, if they are required for treatment of a wound caused by a surgical procedure or after the debridement[13] of a wound. Such supplies must be ordered by a physician and be medically necessary. Medicare has coverage guidelines regarding the maximum number of each supply that is normally medically necessary per month (for example, the number of catheters or ostomy bags).[14]

Prospective Payment for HHAs

On October 1, 2000, HCFA implemented the PPS for home health care. BBA stipulated that PPS payments cover all home health care services and supplies used to treat a beneficiary, including medical supplies, that were paid for on a reasonable cost basis at the time of enactment.[15] Because DME was paid for on the basis of a fee schedule, it was not required to be included in the PPS and is paid for separately. The law also required HHAs to "consolidate" the billing and be paid for all Medicare-covered home health services and supplies provided to patients receiving home health care, even when they are furnished by an outside supplier under contract to the HHA.[16] This all-inclusive payment gives HHAs an incentive to control the total costs of care provided during the episode, including the use of supplies. Under the home health PPS, HHAs that deliver care for less than the payment can profit. Conversely, HHAs will lose financially when their service costs are higher than the payment.

Because patients who receive Medicare-covered home health care require differing amounts of care, a basic episode payment is adjusted based on the classification of each patient into one of 80 payment groups, called

[11]Parenteral nutrition is a method of delivering nutrition and other substances directly into a vein. Enteral nutrition includes oral feeding, sip feeding, and tube feeding.

[12]A tracheostomy is a surgically created opening in the neck into the windpipe to provide an airway and to allow removal of secretions from the lungs.

[13]Debridement is the removal of dead, infected, or foreign material from a wound.

[14]The medical necessity for using more than the number of supplies indicated in the coverage policies has to be documented in the patient's medical record.

[15]BBA § 4603(a), 111 Stat. 467.

[16]BBA § 4603(c)(2)(B), 111 Stat. 470-471. DME was excluded from the consolidated billing requirement by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, App. F, § 305; 113 Stat. 1501, 1501A-361, 62.

home health resource groups (HHRG).[17] The classification is based on three dimensions of the patient—clinical condition, functional status, and expected use of services—that affect the total cost of the episode.[18] Patients with similar total episode costs are grouped together: the use of nonroutine medical supplies contributes to, but does not determine, the payment group for any type of patient. The payment for each payment group is adjusted to reflect the average cost of providing services to patients in that group (as determined by the average time of the skilled nursing, home health aide, therapy, and other visits for the patients in the group) relative to the average cost of patients across all 80 payment groups.[19] In fiscal year 2002, after adjusting for inflation, the basic episode payment was $2,274, with the payment adjusters resulting in payments for patients in the different HHRGs ranging from $1,197 to $6,393 per episode.

The accuracy of the adjusted payments in reflecting the cost variation across patients depends on how well the payment groups distinguish among types of patients (and their episode costs) and how well the payment adjusters account for differences in total episode costs across the different payment groups. Shortcomings in either will result in some patients or payment groups being more financially attractive than others for HHAs to treat. We have reported that in the first 6 months of 2001 there was considerable variation in the relationship between payments and

[17]There are four clinical severity categories (ranging from minimal to high severity), five functional classifications (ranging from requiring little assistance with daily activities to requiring a high level of assistance) and four levels of service use (ranging from low to high expected resource use), for a total of 80 possible combinations.

[18]The clinical condition is generally based on a primary orthopedic, neurologic, or diabetic diagnosis; the need for intravenous, parenteral, or enteral therapies; and the presence of vision impairment, pain, wounds or lesions (including pressure ulcers, stasis ulcers, and surgical wounds), dyspnea, urinary incontinence, bowel incontinence, bowel ostomy; and behavioral problems (such as significant memory loss, impaired decision making, physical aggression, disruptive or socially inappropriate behavior, and delusional or paranoid behavior). The use of nonroutine medical supplies will be reflected in the clinical dimension of a patient's assessment. The functional status is based on the patient's need for assistance with activities of daily living, including dressing, bathing, toileting, transferring (for example, moving from bed to chair), and locomotion. The expected use of services is based on the patient's use of home health therapy services during the episode and the use of other health services (such as nursing home or rehabilitation hospital services) prior to receiving home health care.

[19]For each visit, the minutes spent by each type of clinician (such as home health aides, nurses, and therapists) is multiplied by the average wage rate for the discipline of the clinician. These per-visit costs are totaled for all visits within an episode to obtain the cost for the episode.

costs across payment groups.[20] For example, the episode payments for 10 payment groups averaged about 1 percent above the average estimated episode cost, while for 10 other payment groups payments averaged almost twice the average episode cost. On average, episode payments were about 35 percent higher than the average estimated episode cost.

Home health episode payments based on average costs may not be adequate for HHAs serving a disproportionate number of patients with high-cost nonroutine medical supply needs when a payment group includes few such patients. This is because if there are few high-cost patients in a payment group, their costs do not substantially increase the average cost for the group. In contrast, frequently provided high-cost services and supplies would boost average episode costs and, therefore, the payments based on them.

Refinements to the PPS

HCFA's efforts to refine the PPS, including a better accounting for nonroutine medical supply costs, began even before the PPS was implemented. For example, the agency considered excluding the costs of nonroutine medical supplies from the episode amount and paying for supplies covered under part B separately.[21] HCFA concluded that it did not have the authority to exclude nonroutine medical supplies given the BBA requirement that all medical supplies be included in the episode payment. The agency also modified the HHRG patient classification system to better reflect the costs of high-cost patients with severe wounds, such as burns, after concerns were raised during the comment period on the proposed rule about the payments for these patients. Even with the revisions, HCFA officials acknowledged that the HHRGs may not adequately differentiate among home health patients, particularly those who need wound-care supplies, and that additional modifications might be needed. The agency plans to examine the payment groups and the payment adjusters using information on total episode costs, the visits provided during each episode, and patient diagnoses. CMS will use these analyses in

[20]U. S. General Accounting Office, *Medicare Home Health Care: Payments to Home Health Agencies Are Considerably Higher Than Costs*, GAO-02-663 (Washington, D.C.: May 6, 2002).

[21]This same reasoning was used to exclude from the PPS daily payment for skilled nursing facilities certain high-cost and infrequently provided services that could not be easily overprovided. See U. S. General Accounting Office, *Skilled Nursing Facilities: Services Excluded From Medicare's Daily Rate Need to be Reevaluated*, GAO-01-816 (Washington, D.C.: Aug. 22, 2001).

determining if there are inadequacies in the payment groups or adjustments that require modifications to the PPS.

Episode Payments May Not Reflect Variation in Nonroutine Medical Supply Costs across Patients

HCFA used the total costs associated with furnishing home health care, including the costs of nonroutine medical supplies, to establish the average episode payment. HCFA estimated average total episode costs based on 1997 audited costs of a representative sample of HHAs and updated these costs for inflation each year through 2000—the beginning of the home health PPS. HCFA added an amount (based on 1998 data) to the episode payment rate to account for the separate payments that had been made to external suppliers for nonroutine medical supplies furnished directly to patients receiving home health care. HCFA estimated that the costs of all nonroutine medical supplies averaged about 2 percent of episode costs (or about $50 per episode).

The adjusted payment associated with each payment group may not reflect the variation in the cost of the supplies used across the payment groups. When HCFA determined the payment adjustments for the payment groups, it did not have data on the cost or use of specific nonroutine medical supplies for different types of home health patients. Instead of considering the costs of nonroutine medical supplies in varying the payments across each of the payment groups, the agency used the average cost of staff time associated with the average number of visits.[22] For some types of patients, such as those needing wound-care supplies and dressing changes, increasing payments in proportion to the cost of staff time is likely to result in an appropriate adjustment to total payments if wound-care supply costs are proportionately higher for patients receiving more costly staff time. However, some types of patients who have above-average nonroutine medical supply costs may not require more costly staff time. For example, staff may not need to spend extra time with patients who, prior to receiving home health care, managed their own ostomy care and will continue to do so. As a result, payments could be too low for these types of patients.

In addition, the payment groups may not adequately distinguish among types of patients and their need for, and costs of, nonroutine medical supplies. Each payment group can include patients with widely varying

[22]The time therapists, nurses, and aides spent with patients were used to calculate the payment adjustment.

clinical characteristics and nonroutine medical supply use. For example, the moderate clinical severity groups can include patients with diabetes and bowel ostomies, patients with stasis ulcers that are not healing, and patients with Parkinson's disease—all of whom would be assigned to the same group even though their nonroutine medical supply costs could be quite different. These patients could be assigned to the same payment group, depending on their functional and service use characteristics. Although patients within a payment group have similar total episode costs, there could be subgroups of patients within a group who have above-average episode costs because of their nonroutine medical supply needs. Thus, patients requiring costly nonroutine medical supplies could have more difficulty gaining access to care, particularly since these patients are easy to identify prior to admission.

As part of CMS's review of the current PPS, the agency says it will try to evaluate whether the payment groups and adjustments appropriately account for variation in nonroutine medical supply costs across types of patients. CMS has noted that if supply costs vary significantly for different types of patients, the agency may modify the payment groups to account for supply cost differences as well as staffing.

However, CMS continues to lack patient-specific data on the use and cost of specific nonroutine medical supplies needed to assess the variation in nonroutine medical supply costs across patients. Although the agency asked HHAs to provide patient-specific information on the use of and charges for wound-care supplies, HHAs have not done so, which will hamper CMS's ability to better account for these costs in the episode payments.[23] Unless CMS renews its pursuit of these data and successfully obtains them, its refinements will continue to rely on aggregate nonroutine medical supply cost information to refine the payment groups even though these data are unlikely to be adequate to reflect the variation in supply costs across patients.

[23]When implementing the PPS, HCFA asked HHAs to include the number of wound-care supplies used and the associated charges on their claims so that future refinements could be made. HHA industry representatives said the HHA computer systems could not gather these data.

Certain Nonroutine Medical Supplies May Warrant Exclusion from Episode Payment

Patients requiring nonroutine medical supplies are classified into many different payment groups, so the payment for any given group, which is based on the group's average cost, may not account for unusually high nonroutine medical supply costs. For example, patients with multiple pressure ulcers, who may need extensive supplies, could be grouped into any one of 40 payment groups, depending on the severity of the ulcers and the patients' other clinical, functional, and service use characteristics. Similarly, the Wound, Ostomy, and Incontinence Nurses Society found that the few patients with ostomies were grouped into a wide range of payment groups.[24] Due to this wide dispersion, there may not be enough patients requiring nonroutine medical supplies assigned to any given payment group to sufficiently increase the group's average cost to reflect these patients' above-average costs.

Even patients with similar clinical characteristics who are classified into the same payment group may have widely varying nonroutine medical supply costs. The United Ostomy Association estimated that the supply costs for patients with ostomies vary fivefold.[25] Likewise, using the 2002 Medicare fee schedule as a proxy for supply costs, there is even more variation across the different types of surgical dressings.[26] The costs of nonroutine medical supplies provided during an episode for wound-care patients could be considerably higher than the average, depending on the types of dressings provided, the price the HHA has to pay for them, and the number of dressing changes made during an episode. For example, an HHA providing 24 dressing changes during a patient's episode, with each dressing costing $7, would incur $168 of nonroutine medical supply costs,

[24]Patients with bowel ostomies represented about 2 percent of all episodes. Of those, about 42 percent of the episodes of patients with ostomies were grouped into the "low" clinical severity payment groups, 42 percent into the "medium" groups, and 15 percent were in the "high" groups. Each of the three groups includes 20 HHRGs.

[25]The United Ostomy Association based its estimates on the episode data used to develop the PPS.

[26]Under the 2002 Medicare fee schedule, payments for large dressings averaged over $9 per item for foam dressings and $174 for collagen dressings, and were between $16 and $39 per item for hydrogel and hydrocolloid dressings.

or more than three times the average supply cost.[27] If there are no lower-cost alternatives or it is not possible to reduce the number of dressings, the HHA would be limited in its ability to provide a more cost-effective mix of visits and supplies to care for this patient. Therefore, some HHAs may be unwilling to provide costly supplies or will be financially disadvantaged if they do so.

There is mixed evidence on whether there are any high-cost, infrequently provided nonroutine medical supplies. Some of clinical experts we consulted said there are no nonroutine medical supplies that are both high-cost and infrequently provided.

Our review of the Medicare fee schedules for supplies indicated that most medical supplies are relatively low cost. For beneficiaries who are not receiving home health care, Medicare's payment would be less than $20 for over 80 percent of all nonroutine medical supply items. But there are some high-priced items. For example, Medicare pays over $40 per item for certain tracheostomy, wound-care, and ostomy supplies when provided to patients not receiving home health care.

The clinical experts suggested, however, that including nonroutine medical supplies in the payment has disrupted care for some patients, which could justify excluding these supplies from the episode payment. The experts noted that the use of nonroutine medical supplies for patients who were self-managing a chronic condition prior to their entering home health care could be disrupted by the cost containment strategies adopted by some HHAs. HHA representatives and wound-care nurses told us that under the PPS some HHAs have limited their inventories of particular types of nonroutine medical supplies or reduced the number of supplies they provide to patients. Such changes required some patients who had been self-managing chronic conditions to either change the type of supply

[27]The Medicare coverage guidelines indicate that hydrogel dressings with borders are typically changed up to three times per week. With 8 weeks in an episode, up to 24 dressing changes could be included in an episode without requiring additional documentation. The Medicare fee schedule amount for medium-sized (16 to 48 square inches) hydrogel dressings without borders is at least $10, but HHAs may be able to use their volume as leverage to obtain discounted prices. In this example, we have assumed that an HHA can purchase supplies at 30 percent less than the fee schedule amount. These supply costs would be higher if more expensive dressings (such as hydrogel dressings without borders or collagen dressings) are used, if the dressings are changed more frequently (for example, hydrogel dressings without borders are typically changed daily), or if the HHA purchases the supplies at a higher price than what we assumed.

(for example, the type of ostomy appliance) or number of supplies used while receiving home health care. Such actions are most likely to have affected patients with chronic medical conditions (such as bowel ostomies and tracheotomies) that they self-manage, where switching products may have impaired their sense of security and their ability to function as normally as possible.

As part of its assessment of the effects of the home health PPS, CMS plans to examine changes in home health utilization, including the number, type, and duration of home health visits and the number of patients served. This could include an examination of whether certain types of patients, such as those requiring nonroutine medical supplies, have the same utilization now as they did prior to the PPS. But, due to the lack of information about individual supply items, these analyses cannot evaluate whether patterns of self-care have been disrupted.

Conclusions

The adequacy of Medicare's home health payment groups and adjustments to reflect the variation in episode costs across patients is critical to ensuring that patients and HHAs are not disadvantaged under the PPS. CMS is working on refinements that might include additional payment groups, different payment adjustments, or the exclusion of particular supplies from the episode payment. While there are sound reasons to retain most nonroutine medical supplies in the episode payment, excluding certain supplies may be warranted if the payment groups will not adequately account for their costs or if it has been demonstrated that patient access to care or continuity of care has been disrupted.

Yet, CMS continues to lack patient-specific cost and utilization data on individual nonroutine medical supplies needed to evaluate if the payment groups could be improved or if certain supplies warrant consideration for exclusion from the PPS. Because CMS's efforts to gather these data on a voluntary basis from HHAs have not been successful, the agency needs an alternative data collection method. One approach would be to gather data on the patients treated by a representative sample of HHAs, as CMS did in establishing the average episode payment. The agency also needs to gather systematic evidence on patterns of care to assess whether any supplies warrant consideration for exclusion because care has been disrupted. Yet even if these data confirm that there are high-cost and infrequently provided nonroutine medical supplies or that care has been disrupted, congressional authority is needed to make these exclusions.

Recommendations for Executive Action

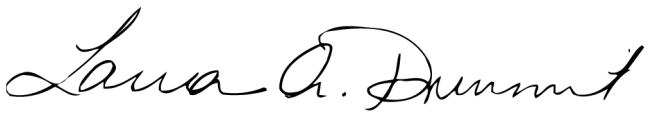
We are recommending that in evaluating refinements to the PPS, the Administrator of CMS collect and analyze patient-specific data on the cost and utilization of individual nonroutine medical supplies to determine whether the payment groups and adjustments appropriately reflect the differences in supply costs. The Administrator should also gather and evaluate evidence on whether there have been systematic disruptions in the care for some patients under the PPS. If these analyses indicate problems with the current PPS, the Administrator of CMS should modify the payment groups and adjustments to better account for these supply costs or minimize care disruptions. If such refinements cannot resolve identified problems, the Administrator should seek the necessary legislative changes to exclude selected nonroutine medical supplies from the episode payment.

Agency Comments

CMS provided written comments on a draft of this report. (See app. I.) CMS noted the importance of monitoring the impact of Medicare payment changes and improving payment systems over time. It referenced the research it is sponsoring with regard to the home health PPS. CMS agreed with the recommendation on the need to collect sufficient data to be able to evaluate the appropriateness of Medicare's payments with regard to the provision of nonroutine medical supplies to home health patients. It stated that it was collecting such data and plans to fund analyses of these data, which will guide future policy decisions. CMS did not indicate whether it will consider changes to home health payment groups and adjustments if its research indicates problems nor did it mention if it will investigate whether particular types of patients are experiencing disruptions in care. Because HHAs could identify many of the patients with costly nonroutine medical supply needs prior to admitting them for home health care, we believe it is important to explicitly consider this group of patients in designing analyses of the impact of the home health PPS and to consider changes to the payment to ameliorate any identified problems.

CMS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Administrator of the Centers for Medicare & Medicaid Services, appropriate congressional committees, and other interested parties. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov. If you or your staffs have any questions, please call me at (202) 512-7119. This report was prepared under the direction of Carol Carter.



Laura A. Dummit
Director, Health Care—Medicare Payment Issues

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Appendix I: Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUL 24 2003

TO: Laura A. Dummit
Director, Health Care—Medicare Payment Issues

FROM: Thomas A. Scully
Administrator

SUBJECT: General Accounting Office (GAO) Draft Report, "*Medicare Home Health Payment: Nonroutine Medical Supply Data Needed to Assess Payment Adjustments*" (GAO-03-878)

Thank you for the opportunity to review the General Accounting Office's (GAO) draft report entitled, "Medicare Home Health Payment: Nonroutine Medical Supply Data Needed to Assess Payment Adjustments" (GAO-03-878). We have provided both general and technical comments below.

The Centers for Medicare & Medicaid Services (CMS) recognizes the importance of monitoring the effects of payment changes and improving and refining Medicare payment systems over time. The Agency is sponsoring substantial research related to the home health prospective payment system (PPS) in this regard.

We agree with GAO's finding that existing data do not allow for an adequate evaluation of the appropriateness of Medicare payments for providing nonroutine medical supplies to home health patients. To address this information deficit, CMS is currently collecting the data needed to determine whether Medicare home health payments appropriately reflect the differences in nonroutine medical supply costs across types of patients. In the next year, as part of our ongoing efforts to monitor the implementation of the home health prospective PPS, we plan to fund further analyses of these data. We expect these analyses will be able to address issues regarding nonmedical supplies and other aspects of the home health PPS in order to help guide future policy choices in this area.

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