

February 2004

# MEDICARE HOME HEALTH

## Payments to Most Freestanding Home Health Agencies More Than Covered Their Costs



G A O

Accountability \* Integrity \* Reliability



Highlights of [GAO-04-359](#), a report to congressional requesters

## Why GAO Did This Study

Under Medicare's home health prospective payment system (PPS), home health agencies (HHA) are paid a fixed amount, adjusted for differences in individual patients' expected care needs, for providing an episode (up to 60 days) of care. For this payment, HHAs provide therapy, skilled nursing, medical social service, and aide visits to patients in their homes. GAO previously reported that PPS payments to HHAs were significantly above Medicare costs. GAO recommended that the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, modify the PPS to mitigate extreme financial gains and losses.

HHA representatives have raised concerns that Medicare's PPS financially disadvantages certain urban and rural HHAs. GAO was asked to examine (1) whether Medicare payments cover HHAs' costs and (2) what factors distinguished financially weak HHAs from financially strong performers under Medicare. To address these issues, GAO used Medicare cost reports and claims data for freestanding HHAs. GAO analyzed Medicare margins—the difference between Medicare payments and Medicare costs, divided by Medicare payments.

[www.gao.gov/cgi-bin/getrpt?GAO-04-359](http://www.gao.gov/cgi-bin/getrpt?GAO-04-359).

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

# MEDICARE HOME HEALTH

## Payments to Most Freestanding Home Health Agencies More Than Covered Their Costs

### What GAO Found

The total amount that Medicare paid freestanding HHAs as a group more than covered the overall costs of caring for their Medicare home health patients. In 2001, the aggregate Medicare margin for home health services provided by freestanding HHAs was 16.2 percent; in 2002, the aggregate margin rose to 17.8 percent. Medicare payments also more than covered costs for both HHAs that served exclusively rural patients and those that served exclusively urban patients. Moreover, more than four-fifths of individual HHAs had positive Medicare margins; two-thirds had margins of 10 percent or higher; and over one-fifth had high margins of more than 30 percent.

Per-visit costs distinguished the financially weak-performing HHAs (those with negative margins) from those that did well under Medicare. The cost of a home health visit for financially weak-performing HHAs was over 70 percent more than the cost for those with high margins. Two-thirds of the difference was attributable to overhead costs. Negative-margin HHAs spent more than twice as much on overhead and almost 40 percent more on direct patient care—the cost of nurses, therapists, medical social workers, and aides. However, compared to the patients of high-margin HHAs, those served by the negative-margin HHAs needed slightly less intensive care, as measured by Medicare's system of classifying patients according to their expected care needs. GAO also found that similarly sized HHAs in the same urban or rural areas had both negative and highly positive margins. This suggests that factors other than geographically linked special circumstances contributed to an HHA's weak financial performance.

In commenting on a draft of the report, CMS noted that research on case-mix payment adjustment issues was ongoing. However, CMS has not committed to a date for implementing a more accurate case-mix adjustment. GAO remains concerned that inadequacies in payment adjusters, identified in previous GAO reports, could lead to underpayments for some types of patients and overpayments for others. CMS also raised concerns about the implementation of risk sharing, which GAO had recommended in previous reports and discusses in this report. GAO continues to believe that the sharing of financial risk between Medicare and the HHAs could protect beneficiaries from impaired access, insulate agencies from extreme financial losses, and shield Medicare from burgeoning expenditures.

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**Abbreviations**

AAHomecare	American Association for Homecare
BBA	Balanced Budget Act of 1997
CMS	Centers for Medicare & Medicaid Services
HHA	home health agency
HHRG	home health resource group
IPS	interim payment system
NAHCH	National Association for Home Care & Hospice
PPS	prospective payment system
VNA	visiting nurse association
VNAA	Visiting Nurse Associations of America
VNSNY	Visiting Nurse Service of New York

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United States General Accounting Office  
Washington, D.C. 20548

February 27, 2004

The Honorable Charles B. Rangel  
Ranking Minority Member  
Committee on Ways and Means  
House of Representatives

The Honorable Pete Stark  
Ranking Minority Member  
Subcommittee on Health  
Committee on Ways and Means  
House of Representatives

The Honorable Carolyn B. Maloney  
House of Representatives

Under Medicare's home health prospective payment system (PPS)—implemented in October 2000—home health agencies (HHA) are paid a fixed amount, adjusted for differences in individual patients' expected care needs, for providing an episode (up to 60 days) of care. Payments are also adjusted to account for geographic differences in HHAs' costs. For this payment, HHAs provide therapy, skilled nursing, medical social service, and aide visits to patients in their homes. HHAs face the risk of loss if their costs exceed their payments, while those that can furnish care for less than the fixed rate retain the difference. To earn profits or avoid losses, HHAs can control the number of visits, per-visit costs, or both.

Representatives of HHAs have raised concerns about Medicare's method of paying for home health services. Specifically, there are concerns that Medicare's home health PPS financially disadvantages some HHAs that face special costs and circumstances due to where they provide services. For example, one contention is that the Medicare payment does not account for high transportation costs and low patient volume of HHAs serving rural patients. Another contention is that the payment does not account for the cost of security guards and escorts that some HHAs incur to protect nurses, aides, and other personnel who see patients in high-risk, particularly urban, areas. In your request that we study the security guard issue, you asked whether these HHAs should be entitled to an additional payment. In the absence of systematic data on transportation and security guard costs, however, we could not directly assess the need for an additional payment. As agreed with your staff, we examined for the first 2 years of the PPS (1) whether Medicare payments covered HHAs' costs, and

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(2) what factors distinguished financially weak HHAs from financially strong performers under Medicare.

In addressing these issues, we focused on freestanding HHAs, which in 2001 accounted for almost 70 percent of Medicare-certified HHAs and a similar share of Medicare payments for home health services. Our analysis did not include the remaining HHAs, which are largely hospital based,<sup>1</sup> because of the difficulty in accurately apportioning the larger institutions' costs to their Medicare-covered home health services. We analyzed HHAs' Medicare cost reports, which are the financial documents that HHAs submit annually to the Centers for Medicare & Medicaid Services (CMS), the agency that administers the Medicare program, to receive payment from Medicare. We examined these documents for cost-reporting years 2001 and 2002, the most recent years for which sufficient data were available.<sup>2</sup> We assessed the reliability of the cost report data and excluded cost reports with incomplete or questionable data. After exclusions, the number of HHA cost reports in our analysis totaled 3,061 for 2001 and 2,109 for 2002. These HHAs were generally similar to all Medicare-certified freestanding HHAs in terms of type of ownership and location.

To examine the relationship between payments and costs, we calculated 2001 and 2002 aggregate Medicare margins<sup>3</sup> for freestanding HHAs as a group—the difference between total Medicare payments and Medicare costs, divided by total Medicare payments. We also calculated 2001 Medicare margins for individual HHAs and report the median. To identify major factors associated with HHA financial performance under Medicare, we compared HHAs grouped by Medicare margin and analyzed the impact on margins of HHA characteristics, including the average cost of a home health visit and the mix of patients served. For this analysis, we used 2001 HHA cost reports and Medicare home health service claims data, which were both available for 2,179 HHAs. For details on our data and methods, see appendix I. We performed our work from October 2003 through

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<sup>1</sup>Historically, institution-based HHAs—such as those affiliated with hospitals—have reported higher per-visit costs than those of freestanding HHAs.

<sup>2</sup>A cost-reporting year reflects each HHA's fiscal year that begins during the federal fiscal year (from October 1 of one year through September 30 of the following year).

<sup>3</sup>Aggregate margins could also be termed revenue-weighted margins, because HHAs with the highest revenues have the greatest effect on the margins. In this report, margins for 2001 and 2002 refer to cost reporting years.

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February 2004 in accordance with generally accepted government auditing standards.

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## Results in Brief

In the first 2 years after the PPS started, aggregate Medicare payments to freestanding HHAs as a group more than covered their total Medicare costs of providing care to their patients. Their aggregate Medicare margin was 16.2 percent in 2001 and 17.8 percent in 2002. Medicare payments also more than covered aggregate costs for both HHAs that served exclusively rural patients and those that served exclusively urban patients. Moreover, more than four-fifths of individual HHAs had positive Medicare margins; two-thirds had margins of 10 percent or higher; and over one-fifth had high margins of more than 30 percent.

Our analysis of individual HHAs' 2001 Medicare margins found that per-visit cost was the main factor that distinguished financially weak from financially strong performers under Medicare. For the HHAs with negative margins (slightly less than one in five of freestanding HHAs), the cost of a home health visit averaged over 70 percent higher than that of HHAs with high margins (30 percent and higher). A home health visit's chief cost components are direct patient care (wages and benefits for nurses, therapists, medical social workers, and aides) and overhead. Overhead costs accounted for two-thirds of the difference in per-visit cost between the negative-margin and high-margin HHAs. Direct patient care costs—even after adjusting for differences in patients—were less important than overhead. We also found that HHAs with negative margins were located in the same area as HHAs with substantial, positive margins, suggesting that geographically linked special circumstances beyond an HHA's control were not the primary factors accounting for an HHA's poor financial performance under Medicare.

In commenting on a draft of this report, CMS noted that research on case-mix payment adjustment issues was ongoing. However, CMS has not committed to a date for implementing a more accurate case-mix adjustment. We remain concerned that inadequacies in payment adjusters that we identified in previous reports could lead to underpayments for some types of patients and overpayments for others. CMS also raised concerns about the implementation of risk sharing, which we had recommended in previous reports and discuss in this report.<sup>4</sup> We continue to believe that the sharing of financial risk between Medicare and the HHAs could protect beneficiaries from impaired access, insulate agencies from

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extreme financial losses, and shield Medicare from burgeoning expenditures.

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## Background

Medicare's home health benefit is available to patients who need care following their discharge from a hospital or who have chronic conditions, such as congestive heart failure, that require continuing but intermittent care. Medicare patients qualify for home health benefits if they generally cannot leave their home unassisted; their physician prescribes and periodically reviews their home health services; and they require intermittent skilled nursing, physical therapy, or speech therapy services. Patients who need one of these three services may also receive occupational therapy, medical social services, and home health aide services if these additional services are part of a plan of care prescribed by a physician. As long as patients remain eligible for home health care, they may receive an unlimited number of visits. Home health services are provided by a variety of organizations, including for-profit companies; government agencies, such as public health departments; and not-for-profit agencies, such as visiting nurse associations (VNA).

The impetus for the home health PPS was the persistent rapid growth in home health spending from the late 1980s through the mid-1990s. Between 1990 and 1997, Medicare spending for home health care grew at an average annual rate of 25 percent and the number of home health visits more than doubled. The rapid growth in home health use was due, in part, to Medicare's cost-based payment method. Under this method, HHAs were paid their reasonable costs up to a limit for each visit provided.<sup>5</sup> This method, at a time when there was little program oversight, offered few incentives to provide visits efficiently or only when needed.

Moreover, standards for necessary or appropriate care were lacking, allowing home health use to vary widely. In Hawaii, 48 Medicare beneficiaries per 1,000 received home health care in 1997. In Louisiana in the same year, more than 157 beneficiaries per 1,000 received home health

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<sup>4</sup>U.S. General Accounting Office, *Medicare Home Health: Prospective Payment System Will Need Refinement as Data Become Available*, [GAO-HEHS-00-9](#) (Washington, D.C.: Apr. 7, 2000) and 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).

<sup>5</sup>There were separate limits for skilled nursing, home health aide, and other types of visits.



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care. Meanwhile, Medicare home health users in Washington received an average of 32 visits, compared to an average of 161 visits per user in Louisiana. This wide variation in use was not a result of differences in patient diagnosis.

In an attempt to slow the rapid growth of Medicare home health expenditures, the Congress mandated a new payment system in the Balanced Budget Act of 1997 (BBA).<sup>6</sup> The BBA required that a PPS for home health services replace Medicare's cost-based, per-visit payment method by fiscal year 2001.<sup>7</sup> Under Medicare's PPS, the standard payment for home health services provided within the 60-day episode is based on the historical national average cost of home health care services and does not vary with the number of visits.<sup>8</sup> Until the PPS could be fully developed and implemented, the BBA put in place an interim payment system (IPS), which incorporated tighter per-visit cost limits than had previously been in place and placed a cap on each HHA's annual Medicare revenue.

The effectiveness of the PPS in containing expenditures while maintaining access for Medicare beneficiaries partly depends on the adequacy of payment adjustments to account for HHA cost differences due to differences in patients' expected resource needs. The adjustment is derived from each patient's categorization into a payment group and the costliness of patients in each group relative to the average patient.<sup>9</sup> The PPS's 80 payment groups were based in part on research conducted in the early and mid-1990s on home health patient characteristics and costs. The standard home health payment is adjusted upward or downward, depending on the patient's classification into one of the payment groups. Adjusted payments are appropriate when the groups distinguish among

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<sup>6</sup>Pub. L. No. 105-33, § 4603, 111 Stat. 251, 467 (codified as amended at 42 U.S.C. § 1395fff (2000)).

<sup>7</sup>The original requirement was that the new PPS apply "for cost reporting periods beginning on or after October 1, 1999," but the requirement was amended to apply "for portions of cost reporting periods occurring on or after October 1, 2000." Tax and Trade Relief Extension Act of 1998, Pub. L. No. 105-277, § 5101(c), 112 Stat. 2681, 2681-914.

<sup>8</sup>The standard payment is prospective, but four circumstances can trigger a retroactive payment adjustment: if the patient's care was unusually costly, if the number of visits was less than five, if the episode was incomplete, or if the patient's condition changed significantly, resulting in the need for more or less care.

<sup>9</sup>These groups are known as home health resource groups (HHRG). They reflect three dimensions of care: clinical severity, functional severity, and service utilization.

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types of patients (and their episode costs) and when the amount of the payment adjustments accurately reflects differences in episode costs across the different payment groups. Shortcomings in either will result in some patients or payment groups being less or more financially attractive than others for HHAs to treat.

Under the PPS payment group adjustment, the payment for a patient in the most resource-intensive payment group is about five times greater than the payment for a patient in the least intensive group. In fiscal year 2001, the adjusted payment ranged from about \$1,110 to about \$5,950 per episode. The payment is also adjusted for geographic differences in wages, based on the area where the patient is served. In addition, for home health patients living in rural areas, the Congress increased payments by 10 percent for a 2-year period beginning April 1, 2001.<sup>10</sup> For a 1-year period beginning April 1, 2004, the Congress increased payments by 5 percent for home health patients living in rural areas.<sup>11</sup> On October 1, 2002, the beginning of fiscal year 2003, the home health payment rate for all HHAs was reduced by about 7 percent.

In 2000, we reported that Medicare's home health PPS payment group adjustment was not sufficiently fine-tuned and that the PPS could lead to substantial excess payments for some HHAs relative to the level of services being provided.<sup>12</sup> In the first 6 months of 2001, Medicare's payments, on average, were considerably higher than the estimated costs of the home health care actually provided.<sup>13</sup> The disparity between PPS payments and costs resulted from basing an episode payment amount on historical data that reflected patterns of care prior to the IPS and the PPS. After IPS and PPS implementation, HHAs reduced the number of visits provided per episode, which lowered their per-episode costs. For that 6-month period in 2001, we found that payments were above estimated average costs for 75 of

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<sup>10</sup>Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, App. F, § 508(a), 114 Stat. 2763, 2763A-533.

<sup>11</sup>Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 421(a), 117 Stat. 2066, 2283.

<sup>12</sup>U.S. General Accounting Office, *Medicare Home Health Care: Prospective Payment System Could Reverse Recent Declines in Spending*, [GAO-HEHS-00-176](#) (Washington, D.C.: Sept. 8, 2000) and [GAO-HEHS-00-9](#).

<sup>13</sup>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).

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the 80 payment groups. The difference between payments and costs was much greater for some payment groups, indicating that the payment adjustment may not adequately account for cost differences due to variation in patient needs. Thus, HHAs could be financially advantaged or disadvantaged under the PPS, based on the mix of patients they treated, and the access of some patients could be impaired.

As a means of minimizing either excessive payments or extreme losses under the PPS, we have previously recommended that Medicare share some of an HHA's financial risk of serving patients.<sup>14</sup> Under our proposed risk-sharing arrangement, an HHA would be limited in the amount it could gain or lose under the PPS. Payments above costs would be constrained, as would HHA losses. CMS, which at the time of our 2000 report was called the Health Care Financing Administration, did not agree to adopt risk sharing in the near term. It stated that the payment mechanism would continue to be refined in future years. In 2003 CMS announced that the same payment group adjustment would be used in 2004.

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## Total Medicare Payments to Freestanding HHAs More Than Covered Overall Costs Of Care

In the first 2 years of the PPS, the total amount that Medicare paid freestanding HHAs as a group was more than sufficient to cover the overall costs of caring for their Medicare patients. In 2001, the aggregate Medicare margin for home health services provided by freestanding HHAs was 16.2 percent;<sup>15</sup> in 2002, the aggregate margin rose to 17.8 percent.<sup>16</sup>

For the same 2-year period, the total amount that Medicare paid freestanding rural HHAs—that is, HHAs serving exclusively rural patients—was also more than sufficient to cover the overall costs of providing Medicare-covered home health services. Similarly, total Medicare payments more than covered aggregate costs of both urban HHAs—those serving exclusively urban patients—and HHAs serving a mix of rural and urban patients. In both years, rural HHAs had an aggregate

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<sup>14</sup>GAO-HEHS-00-9 and GAO-02-663.

<sup>15</sup>In May 2002, we reported that payments were considerably higher than costs, based on preliminary information for the first 6 months of 2001 on the number of visits per episode and the projected cost per visit. See GAO-02-663.

<sup>16</sup>If the 7 percent payment rate reduction, in effect in fiscal year 2003, had been in effect in 2002, we estimate that the aggregate Medicare margin for freestanding HHAs in 2002 would have been 13.0 percent.

margin that exceeded the urban HHAs' margin. In 2001, the difference was about 3 percentage points, which in 2002 shrank to about two-tenths of a point.<sup>17</sup> (See table 1.)

**Table 1: Aggregate Medicare Margins of Freestanding HHAs by Location of Patients Served, 2001 and 2002 (in percentage)**

<b>Patients served by HHAs</b>	<b>2001</b>	<b>2002</b>
All urban patients	16.0	18.0
All rural patients	19.0	18.2
Both urban and rural patients	16.4	16.8

Source: GAO analysis of CMS data.

Note: The years 2001 and 2002 refer to Medicare cost-reporting years.

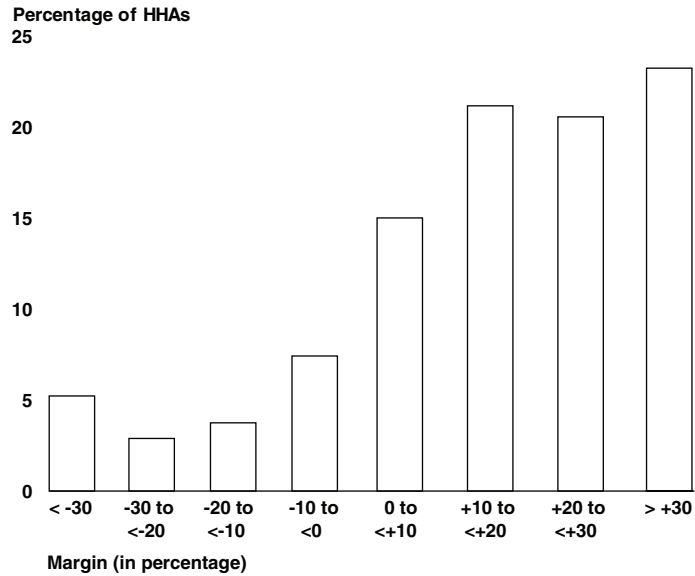
HHAs with rural patients benefited considerably from the 10 percent payment increase for home health services provided to Medicare patients located in rural areas. The increase took effect on April 1, 2001, and expired 2 years later.<sup>18</sup> Without the increase, the aggregate margins for HHAs with all rural patients would have been lower—about 12 percent in 2001 and 10 percent in 2002. For HHAs that served a mix of rural and urban patients, the aggregate margins would have been about 14 percent in 2001 and 15 percent in 2002 without the increase.

When we examined the 2001 financial performance of individual HHAs, we found that more than four-fifths had positive Medicare margins and nearly two-thirds had margins of 10 percent or higher. (See fig. 1.) In 2001, the median margin was about 17 percent, and more than 1 in 5 HHAs had margins over 30 percent. At the same time, nearly one-fifth of freestanding HHAs had negative margins and about 1 in 12 had margins of -20 percent or lower.

<sup>17</sup>We also examined Medicare margins by other characteristics, including HHAs' ownership type. In both 2001 and 2002, not-for-profit HHAs had aggregate Medicare margins that were lower than those of for-profit HHAs. For example, in 2002, the aggregate Medicare margin of not-for-profit HHAs was 15.3 percent, compared to for-profit HHAs' 19.6 percent margin.

<sup>18</sup>Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, rural HHAs will receive a 5 percent increase for 1 year effective April 1, 2004. Pub. L. No. 108-173, § 421(a), 117 Stat. 2066, 2283.

**Figure 1: Percentage of Freestanding HHAs by Medicare Margin, 2001**



Source: GAO analysis of CMS data.

Note: Data refer to Medicare cost-reporting year 2001. Margins are calculated separately for each HHA.

## High Costs Distinguished HHAs With Weak Financial Performance

Our analysis suggests that special circumstances were not the primary factor accounting for those HHAs—nearly one-fifth—that did not perform well financially under Medicare’s PPS. HHAs with negative margins generally had high costs for a 60-day episode of care, largely because their visits were much more costly. A home health visit’s chief cost components are direct patient care (wages and benefits for nurses, therapists, medical social workers, and aides) and overhead. Financially weak performers’ high costs reflected primarily high overhead; direct patient care was a secondary factor. In addition, we found that rural and urban HHAs with negative margins were in some cases located in the same urban or rural area as HHAs with positive margins, suggesting that geographically linked special circumstances were not the primary factor accounting for an HHA’s weak financial performance.

**High Per-Visit Cost, Particularly High Overhead, Characterized HHAs with Weak Financial Performance**

HHAs with weak financial performance (those with negative margins) generally had high costs compared to high-margin HHAs (those with margins over 30 percent). Differences between the two groups of HHAs in their 2001 Medicare episode payments were relatively small—on average, the financially weak-performing HHAs received \$233 less. However, the per-episode cost difference was much larger—on average, \$1,350 more for negative-margin HHAs. (See table 2.)

**Table 2: Average Medicare Per-Episode Payments and Costs of Freestanding HHAs by Margin Groups, 2001**

	Medicare margin		
	Less than zero	Zero to 30 percent	Over 30 percent
Medicare per-episode payment	\$2,448	\$2,571	\$2,681
Medicare per-episode cost	\$2,865	\$2,066	\$1,515
Medicare visits per episode	23.3	22.4	21.2
Medicare per-visit cost	\$130	\$97	\$75
Number of HHAs <sup>a</sup>	433	1,241	505

Source: GAO analysis of CMS data.

Note: Table entries refer to Medicare cost-reporting year 2001.

<sup>a</sup>The numbers include HHAs that had submitted cost reports to CMS by September 30, 2003. We excluded HHAs for which key data were missing or appeared likely to be in error.

The difference in the cost of an episode was due primarily to the high cost of a visit incurred by the negative-margin HHAs—on average over 70 percent higher than that of high-margin HHAs.<sup>19</sup> The difference in per-visit cost was much greater than the difference in the number of visits per episode. Compared to high-margin HHAs, negative-margin HHAs averaged only about 10 percent more visits per episode.

Overhead costs accounted for most of the difference in the cost of a visit. Negative-margin HHAs spent more than twice as much as high-margin HHAs on overhead. Of the \$55 per-visit difference in cost between the

<sup>19</sup>The cost of an episode is the per-visit cost multiplied by the number of visits per episode.

negative-margin and high-margin HHAs, two-thirds of the difference was attributable to overhead costs.<sup>20</sup> (See table 3.)

**Table 3: Average Medicare Per-Visit Cost, Including Direct Patient Care and Overhead, and Average Case-Mix Index of Freestanding HHAs by Margin Groups, 2001**

	Medicare margin		
	Less than zero	Zero to 30 percent	More than 30 percent
Medicare per-visit cost	\$130	\$97	\$75
Direct patient care <sup>a</sup>	\$57	\$45	\$41
Overhead	\$70	\$49	\$33
Case-mix index <sup>b</sup>	.96	1.00	1.02
Number of HHAs <sup>c</sup>	433	1,241	505

Source: GAO analysis of CMS data.

Note: Table entries refer to Medicare cost-reporting year 2001.

<sup>a</sup>Direct patient care and overhead costs do not add to per-visit cost because miscellaneous costs are omitted.

<sup>b</sup>The case-mix index is a measure of the relative costliness of patients treated by an HHA, based on an HHA's distribution of patients across CMS's payment groups, which distinguish among Medicare patients based on their expected resource needs. We set the average case-mix index for all HHAs in our sample to 1.0. A case-mix index that exceeds 1.0 indicates that an HHA's patients generally had above-average costs because of higher expected resource needs; a case-mix index less than 1.0 indicates below-average costs because of lower expected resource needs.

<sup>c</sup>The numbers include HHAs that had submitted cost reports to CMS by September 30, 2003. We excluded HHAs for which key data were missing or appeared likely to be in error.

Some of the difference in overhead costs was attributable to an HHA's size, as measured by the number of visits,<sup>21</sup> but other factors were also at work. Per-visit overhead cost is necessarily higher when total overhead costs are distributed across a smaller number of visits. We found that negative-margin HHAs had about one-fourth fewer visits in 2001 than high-margin HHAs and per-visit overhead cost that was more than twice as high. However, size alone was not the primary factor accounting for poor

<sup>20</sup>HHAs' overhead costs include such items as legal, accounting, and data processing services; taxes; malpractice insurance; and office and equipment rental.

<sup>21</sup>For the purpose of this report, size refers to an HHA's total visits to both Medicare and non-Medicare patients.

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financial performance, as 19 percent of the high-margin HHAs were also low-volume providers.<sup>22</sup>

Direct patient care costs accounted for nearly 30 percent of the difference in the cost of a visit. These higher costs did not appear to stem from patients' higher expected care needs. Compared to the patients of high-margin HHAs, those served by the negative-margin HHAs needed slightly less intensive care, as measured by the case-mix index. The index indicates the relative costliness of an HHA's patients, as reflected in the HHA's mix of patients across Medicare payment groups.<sup>23</sup> When we used the index to adjust the per-visit cost of direct patient care for the mix of patients, the cost disparity between negative-margin HHAs and high-margin HHAs widened, rather than narrowed. This indicates that higher direct patient care costs were not due to greater expected patient needs.

Moreover, the higher direct care spending by negative-margin HHAs—\$16 per visit or almost 40 percent more than high-margin HHAs spent—does not necessarily indicate that they delivered more care in a visit. When we compared the two groups of HHAs, average length of a visit differed by about 3 minutes: the negative-margin group's visits averaged roughly 54 minutes, compared to 51 minutes for the high-margin group. Finally, on average, negative-margin HHAs delivered somewhat less, not more, skilled care: 72 percent of the negative-margin group's visits were by therapists and other skilled personnel, compared to 77 percent in the high-margin group.

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## Similarly Situated HHAs Exhibited Very Different Financial Profiles

HHAs with similar characteristics that could contribute to higher costs—location, patient mix, and size—did not all experience low margins. While some HHAs had low margins, other similarly situated HHAs had high margins. This suggests that special circumstances beyond the HHA's control (such as urban or rural location) were not the primary factors

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<sup>22</sup>We defined low-volume providers as HHAs that had less than 10 visits per day, or 3,650 visits per year.

<sup>23</sup>The case-mix index is set at 1.0 for the average of all home health patients. A case-mix index that exceeds 1.0 indicates that an HHA's patients generally had above-average expected resource needs; a case-mix index less than 1.0 indicates below-average expected resource needs.



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accounting for an HHA's poor financial performance.<sup>24</sup> For example, of the 29 HHAs that we studied in St. Louis, we selected 4 with disparate margins in 2001 but about the same case-mix index and roughly the same size. Consistent with our findings on per-visit cost, the 2 HHAs with margins of –30 percent had per-visit costs that were twice as high as the 2 HHAs with margins over 20 percent, largely because of higher overhead costs. Similarly, of the 45 HHAs that we studied in Chicago, we selected 6 of broadly comparable size and average or below-average case mix in 2001 and found a similar pattern: 3 that had margins averaging –7 percent had high per-visit costs, whereas the other 3 with margins averaging 37 percent had low per-visit costs. We also examined 8 HHAs located in rural areas in Illinois, all of which were relatively small and had below-average case-mix indexes. Four had margins that ranged from 38 to 47 percent; the other 4 had margins that ranged from less than 1 percent to a low of –32 percent, illustrating that similarly situated HHAs may have very different margins.

Although for similarly situated HHAs high per-visit cost was the usual reason for low margins, we identified several cases in which low margins were accounted for by a high number of visits per episode. We selected three HHAs that were VNAs in large metropolitan areas—two with small positive margins and one with a margin of 18 percent. All had average or below-average case-mix indexes. The VNA with the lowest margin had twice as many visits per episode as the VNA with the 18 percent margin.<sup>25</sup> Similarly, when we compared four HHAs in New York City, we found that variation in the number of visits per episode distinguished more sharply than costs the negative-margin HHAs from the high-margin HHAs.

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## Concluding Observations

Freestanding HHAs' aggregate Medicare margins in 2001 and 2002 of roughly 16 percent and 18 percent, respectively, demonstrate that, as a group, these HHAs received Medicare payments that more than covered their Medicare costs. Furthermore, this excess of payments over costs did

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<sup>24</sup>The three national HHA associations that we interviewed did not consider the cost of security to be a major issue. The cost of security is not explicitly identified in the Medicare cost reports, although this cost was included in the average cost used to set the Medicare payment rate for home health services.

<sup>25</sup>Some of the variation in the number of visits may reflect differing regional patterns of care. In 2001, the average number of visits per episode ranged from 17.7 in the states covered by CMS's Seattle region (Alaska, Idaho, Oregon, and Washington) to 26.5 in the states in CMS's Denver region (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming).

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not flow to a small segment of freestanding HHAs: more than four-fifths had Medicare payments greater than costs, the median HHA's margin in 2001 was about 17 percent, and more than one-fifth of HHAs had very strong financial performance in their Medicare business—margins over 30 percent.

Financial performance under Medicare was weak for a minority of freestanding HHAs. Weak financial performance was linked to high per-visit cost—especially to high overhead costs. Negative-margin HHAs' per-visit overhead cost was roughly double that of high-margin HHAs. We also found that HHAs with similar characteristics in the same urban or rural areas had both negative and high positive margins. This suggests that geographically linked special circumstances such as transportation costs or the costs of security were unlikely to have been the primary factor accounting for HHAs' negative margins.

Nevertheless, under a PPS based on historical national average costs, we remain concerned that inadequate payment adjusters for patient differences could result in substantial underpayments for some types of patients and overpayments for others. We continue to believe that the sharing of financial risk between Medicare and the HHAs—to limit aggregate losses or gains for each HHA—is an appropriate way to protect beneficiaries from impaired access, insulate HHAs from extreme financial losses, and shield Medicare from burgeoning expenditures. Such risk sharing could mitigate any extreme losses that HHAs might incur owing to special circumstances.

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## Agency and Industry Comments and Our Evaluation

We received written comments on a draft of this report from CMS (see app. II) and from three national home health associations—the American Association for Homecare (AAHomecare), the National Association for Home Care & Hospice (NAHCH), and the Visiting Nurse Associations of America (VNAA). We also received comments from the Visiting Nurse Service of New York (VNSNY), the largest not-for-profit HHA in the country.

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## CMS Comments and Our Evaluation

CMS affirmed the importance of monitoring the effects of payment changes and improving Medicare payment systems over time. It stated that it is sponsoring substantial research related to the home health PPS, including case-mix payment adjustment issues. In discussing risk sharing for the

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home health PPS, CMS stated that risk sharing would inhibit the incentive for HHAs to operate efficiently and would be burdensome to implement. CMS also stated that changing the PPS to include risk sharing would be premature, because there is ongoing research on case-mix payment adjustments and because there is no evidence of widespread access problems.

We share CMS's view that monitoring and improving Medicare payment systems over time are important and that, in particular, home health case-mix payment adjustment issues require examination. CMS has not committed to a date for implementing a more accurate case-mix payment adjustment. As we have recommended in previous reports<sup>26</sup> and discuss in this report, we believe that risk sharing would improve Medicare's system for paying HHAs and help address concerns about access for certain subgroups of patients, mitigate extreme financial difficulties of HHAs, and moderate excessive payments by Medicare. Risk sharing could be structured so that it would not eliminate incentives for efficiency or increase providers' administrative burden.

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

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## Industry Comments

The associations' concerns centered on the report's Medicare margins, which they contended did not reflect current HHA experience and were not representative of all HHAs. In particular, the associations stated that our 2001 and 2002 data did not include recent reductions in Medicare payment and recent increases in HHAs' costs. One association (AAHomecare) cited an industry study that reported a Medicare margin considerably lower than ours. AAHomecare added that our data were incomplete because we used only 20 to 30 percent of HHA cost reports and were unrepresentative because we excluded hospital-based HHAs.

Two associations also stated that the report ignored certain key factors accounting for negative margins and that our analysis was misleading. One association (NAHCH) maintained that, in explaining the differences between negative-margin and high-margin HHAs, we focused primarily on overhead costs and ignored revenue and service use as important factors

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<sup>26</sup>[GAO-HEHS-00-9](#) and [GAO-02-663](#).

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distinguishing the two groups of HHAs. Another association (VNAA) stated that the report might lead readers to conclude that overhead costs are frivolous. VNAA also stated that a large portion of overhead costs stems from federal requirements. NAHCH emphasized that all HHAs, regardless of size, must maintain a minimum infrastructure to meet Medicare and state requirements. Furthermore, regarding the effect of low visit volume on per-visit costs and margins, NAHCH and VNAA noted that low population density—especially in very rural areas—may limit the size of some HHAs and their ability to spread overhead costs over more visits. NAHCH also asserted that the report was inconsistent regarding whether an HHA's visit volume affected its per-visit overhead costs and margin.

Some comments represented the distinctive perspective of not-for-profit VNAs. According to VNAA, the report did not reflect the current margins of its members, because not-for-profit HHAs have lower margins than for-profit HHAs. VNSNY stated that Medicare margins must be interpreted in the context of total margins, which include Medicare and non-Medicare payments and costs. VNSNY, a not-for-profit HHA, also noted that HHAs differ in their commitment to indigent care and public health initiatives. VNSNY maintained that, due to its charitable mission, a substantial percentage of its patients are “dual eligibles”—patients enrolled in both Medicare and Medicaid<sup>27</sup>—and that these patients are costly and affect an HHA's Medicare margin. VNSNY added that the report should have addressed whether HHAs avoid patients who need costly care because of their complex conditions or their need for services not covered by Medicare. VNAA and VNSNY asserted that VNAs provide extra services—for example, to ensure that patients remain independent at home—but that Medicare does not cover these services. VNSNY also said that the report did not ascertain whether Medicare's home health PPS adequately accounts for the cost of security incurred when care is provided to patients in high-risk areas.

Regarding Medicare's payment policy, VNSNY suggested that payment inequities may result from Medicare's patient classification system (HHRGs), which needs to be refined because it does not include factors such as cognitive impairment and multiple diagnoses that may affect service needs. VNAA recommended that HHAs be paid based on their

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<sup>27</sup>Medicaid is a federal-state program that provides health coverage to certain categories of low-income adults and children.

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costs when their low margins are related to size and location rather than inefficiency.

Two associations stated that the draft report should have addressed additional issues. VNAA stated that we should analyze how the revenues generated by positive margins are used by different segments of the home health industry. AAHomecare raised several questions, including whether skilled nursing facility (SNF) care is being substituted for home health care.

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## Our Evaluation of Industry Comments

We used the most recent data available to calculate Medicare margins. In response to comments about recent changes to Medicare payments, we added to the report an estimate of the impact of the fiscal year 2003 payment reduction on 2002 margins, assuming that it had taken effect 1 year earlier than it did. We also included in the draft report an estimate of the effect of eliminating the 10 percent payment increase for rural patients, although, as we noted, the Congress has partially restored it. With respect to the industry study of margins, we cannot evaluate its results because it did not contain sufficient information on its methodology. Regarding the completeness and representativeness of our data, the draft report noted that the cost reports we used to calculate Medicare margins represented more than 62 percent of freestanding HHAs' cost reports and were similar to all freestanding HHA cost reports in terms of HHA ownership and location. (See app. I.) As the draft report indicated, we excluded hospital-based HHAs from our analysis because hospitals allocate a portion of the larger institution's overhead costs to the HHA, making their reported costs and margins difficult to interpret.

Concerning the suggestion that the report ignored key factors affecting margins, the draft report noted the differences in per-episode payment and service use between the negative-margin and high-margin HHAs. These differences were much smaller than the difference in per-visit cost, particularly the per-visit cost of overhead. While noting that on average the per-visit overhead cost of negative-margin HHAs was more than double that of high-margin HHAs, we did not imply, as VNAA suggested, that HHAs' overhead costs are frivolous. We agree that HHAs necessarily incur overhead costs, some of which are due to federal requirements. With respect to the impact of low population density on overhead costs, we agree that HHAs in less densely populated areas may have fewer patients, contributing to higher per-visit overhead cost. This is consistent with our draft report, which explained the linkage between fewer visits and higher

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per-visit overhead cost. In response to comments about the report's treatment of HHA size and financial performance, we have modified the text to make clearer that an HHA's size may affect its per-visit overhead cost and its margin.

With respect to the financial status of not-for-profit HHAs, while their aggregate Medicare margin was lower than that for-profit HHAs, it was still substantial at 15.3 percent in 2002; we have added this information to the report. Total margins, which reflect both Medicare and non-Medicare payments and costs, may be important in assessing an HHA's overall financial condition, but we did not examine them because they are not an appropriate measure of the adequacy of Medicare payments. Regarding VNSNY's comment concerning resource needs of its mix of patients, the draft report compared HHAs' per-visit cost, accounting for differences in Medicare patients' resource needs as measured by HHRGs. Other factors, including whether an HHA's patients are dually eligible for Medicare and Medicaid, may affect patients' relative costliness, but these other factors could not be measured due to the limitations of the data. Furthermore, the Medicare home health PPS does not account for the cost of services not covered by Medicare. With respect to the cost of security, we could not directly estimate that cost because it is not explicitly identified in the Medicare cost reports, although it was included in the costs used to set Medicare payment rates for HHAs. Instead, we identified groups of HHAs that serve urban areas and were more likely to incur these costs. Some of these HHAs had high margins, indicating that security costs were unlikely to be the cause of poor financial performance. In addition, we asked the three national associations about the importance of security costs, and none of them considered these costs a major issue; we added this information to the report.

Regarding whether inadequacies in the HHRGs contribute to payment inequities across HHAs, we agree that if HHRGs do not account adequately for differences in patients' resource needs, Medicare payments may be too high for some patients and too low for others. However, possible inadequacies in HHRGs cannot account for the high aggregate margins of HHAs as a group. Regarding VNAA's proposal that Medicare make cost-based payments to agencies that have low margins because of their size and location, risk sharing, which we have previously proposed, could better address this issue. Cost reimbursement would remove any incentive for HHAs to deliver services efficiently, whereas risk sharing would retain the home health PPS's incentives for efficiency, while limiting extreme gains and losses.

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The home health organizations raised several issues that were beyond the scope of our report. They included how HHAs use the revenues generated by positive margins and whether SNF care is being substituted for home health care.

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We are sending copies of this report to appropriate congressional committees and other interested parties. We will also make copies available to others upon request. This report will be available at no charge on GAO's Web site at <http://www.gao.gov>. If you or your staffs have any questions, please call me at (202) 512-7119 or Phyllis Thorburn at (202) 512-7012. Other contributors to this report include Hannah Fein, Jon Ratner, Eric Wedum, and Michael C. Williams.



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

# Data and Methods

This appendix describes the data and methods we used to calculate Medicare margins for freestanding HHAs in the aggregate and individually, determine HHA case-mix indexes, and examine factors that could help explain differences among HHAs in their financial performance under the PPS.

## Data Used in Our Analysis

We determined HHA payments and costs from HHA cost reports for 2001 and 2002 submitted by freestanding HHAs to CMS through September 30, 2003.<sup>1</sup> By that date, CMS had received an estimated 83 percent (4,312) of all Medicare-certified freestanding HHA cost reports for 2001 and an estimated 62 percent (3,215) of all cost reports for 2002. After certain exclusions, our sample of HHAs included 3,061 HHAs in 2001 and 2,109 in 2002. (See table 4.)

**Table 4: Number of Cost Reports from Freestanding HHAs, Before and After Exclusions, 2001 and 2002**

	2001	2002
Cost reports received by CMS	4,312	3,215
Cost reports excluded		
All data missing	588	454
Implausible values	625	622
Low extreme values	22	13
High extreme values	16	17
Cost reports used in the analysis	3,061	2,109

Source: GAO analysis of CMS data.

Notes: The years are HHAs' fiscal years that began during federal fiscal years 2001 and 2002. The cost reports received by CMS contained duplicates: 113 in 2001 and 76 in 2002. After applying the exclusions listed in the table, all duplicates had been removed. Implausible values refer to data entries that appeared likely to be in error. Extreme values are calculated Medicare margins that were outside a plausible range.

<sup>1</sup>The payment and cost information are for HHAs' cost-reporting years. A cost-reporting year reflects each HHA's fiscal year that begins during the federal fiscal year (from October 1 of one year through September 30 of the following year). A large portion of these cost reports had not been settled for final payment, although they had passed initial automated checks.



We followed procedures developed by the Medicare Payment Advisory Commission for screening out problematic data. We applied further screening procedures to address additional data anomalies. For each year, we excluded over 1,000 HHAs because key data in their cost reports were missing or had implausible values—that is, they appeared likely to be in error. We excluded some HHAs from our analysis because their data resulted in extreme values—implausibly high or low margins that suggested data error. To identify extreme values, we used a standard statistical distribution (the lognormal) and removed HHAs where margins were three or more standard deviations above or below the mean.

The freestanding HHAs for which we calculated margins generally were similar to all Medicare-certified freestanding HHAs in terms of key characteristics—type of ownership, location of HHA (urban or rural), and census region. For 2001, the distribution of HHAs closely matched the distribution of all freestanding HHAs. (See table 5.) For 2002, the distribution closely matched the distribution of all HHAs by location and census region but had a larger proportion of for-profit HHAs and a correspondingly smaller proportion of not-for-profit and government HHAs.

Appendix I  
Data and Methods

**Table 5: Freestanding HHAs Analyzed and All Freestanding HHAs by Ownership Type, Location of HHA, and Census Region, 2001 and 2002 (in percentage)**

	Year			
	2001		2002	
	Freestanding HHAs analyzed	All freestanding HHAs <sup>a</sup>	Freestanding HHAs analyzed	All freestanding HHAs <sup>a</sup>
Type of ownership				
For-profit	68	68	75	69
Not for-profit	21	21	17	20
Government	11	11	8	11
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>
Location of HHA				
Urban	72	73	74	74
Rural	28	27	26	26
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>
Census region				
Northeast	14	13	14	12
South	45	44	45	45
Midwest	26	26	24	26
West	15	17	17	17
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

Source: GAO analysis of CMS data.

Note: The years are HHAs' fiscal years that began during federal fiscal years 2001 and 2002.

<sup>a</sup>Freestanding HHAs listed in CMS's Provider of Service file.

To examine the relationship between an HHA's financial status and its patient mix and length of visits, we obtained HHA claims data for calendar year 2001. CMS had reviewed and edited these data—for example, by excluding duplicate claims and summarizing the claims to the HHA. The claims data included, for each HHA, summary information on the case-mix index and the number of minutes for each visit type, such as therapy visits and skilled nursing visits. We matched the claims data with 2001 cost report data and obtained 2,179 HHAs for analysis.

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## Methods Used to Calculate and Analyze Medicare Margins

To calculate freestanding HHAs' aggregate Medicare margins<sup>2</sup> for a given year, we summed the Medicare payments of all HHAs in a group and separately summed these HHAs' Medicare costs.<sup>3</sup> Using these sums or aggregates, we calculated a margin for the group as the difference between its aggregate Medicare payments and aggregate Medicare costs, divided by its aggregate Medicare payments. We expressed this ratio as a percentage.

To calculate Medicare margins for individual freestanding HHAs, we took the difference between each HHA's Medicare payments and Medicare costs, divided by its Medicare payments. We expressed this ratio as a percentage. Using these individual Medicare margins, we classified HHAs into three groups—those with negative margins, those with positive margins between zero and 30 percent, and those with high positive margins (greater than 30 percent). We compared the characteristics of the negative-margin HHAs and the high-margin HHAs to identify factors that contributed to weak or strong HHA financial performance under Medicare.

In analyzing factors that could help explain differences among HHAs in the size of their margins, we examined differences in case-mix indexes among the three HHA groups in our analysis. The case-mix index for each HHA reflects the average expected costliness of the HHA's mix of patients. The index is based on the distribution of patients across CMS's payment groups and the costliness of each group relative to the average patient. We set the average case-mix index for all freestanding HHAs in our sample to 1.0. Thus, HHAs with a case-mix index greater than 1.0 had patients with above-average expected costs because of higher expected resource needs, and those with an index less than 1.0 had patients with below-average expected costs because of lower expected resource needs.

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<sup>2</sup>Aggregate margins could also be termed revenue-weighted margins, because HHAs with the highest revenues have the greatest effect on the margins. They indicate the extent to which Medicare's payments to a group of providers—in this case, freestanding HHAs—cover their Medicare costs.

<sup>3</sup>The definition of Medicare costs excludes costs of services such as private-duty nursing that Medicare does not cover.

# Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** FEB 12 2004

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

**FROM:** Dennis G. Smith *Dennis G. Smith*  
Acting Administrator

**SUBJECT:** General Accounting Office Draft Report (GAO): *Medicare Home Health: Payments to Most Freestanding Home Health Agencies More Than Cover Their Costs* (GAO-04-359)

Thank you for the opportunity to review and comment on the GAO's draft report entitled "Medicare Home Health: Payments to Most Freestanding Home Health Agencies More Than Cover Their Costs."

Representatives from home health agencies (HHAs) are concerned that the home health (HH) prospective payment system (PPS) financially disadvantages certain urban and rural HHAs. A specific concern for rural HHAs is the high transportation costs relative to the number of patients served. A specific concern for urban HHAs is the cost associated with security guards and escorts for staff protection during the course of visiting the patient in their home. Specifically, this report examines whether or not Medicare payment covers these unique costs and what factors distinguish financially weak HHAs from financially strong HHAs.

The report concludes that the aggregate margins for freestanding HHAs in 2001 and 2002 demonstrate that generally HHAs received Medicare payments that more than cover their Medicare costs. Weak financial performance was linked to high per-visit costs, specifically high overhead costs. The report also found that HHAs with similar characteristics in the same rural and urban areas had both negative and positive margins, suggesting that geographically linked special circumstances were not a primary factor accounting for negative margins.

**GAO Concluding Observation**

The GAO believes in a risk-sharing provision to limit aggregate losses or gains for HHAs, to ensure beneficiary access to care, and to protect Medicare from increasing expenditures.

**CMS Response**

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

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**Appendix II**  
**Comments from the Centers for Medicare &**  
**Medicaid Services**

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Page 2 — Laura A. Dummit

time. The CMS is sponsoring substantial research related to the HH PPS in this regard. In this report, and previous reports, the GAO raises concerns that the HH PPS payment adjustment may not adequately account for cost differences due to variation in patient needs. Our continuing home health PPS research includes an in-depth examination of case-mix issues.

Both phases of the PPS demonstration included a risk sharing provision. Risk sharing was one of the many features of early research for home health PPS that were used to entice voluntary participation in the demonstration. However, CMS is concerned that risk sharing is not appropriate for HH PPS at this time. Providers would not know that they could rely upon the government's payments until after the fact. Risk sharing would inhibit the incentive for HHAs to manage their operations in an efficient, cost-effective manner.

A risk sharing provision would potentially require Medicare to provide additional payments to an HHA at the end of the year if the HHA's costs were higher than its total PPS payments capped at a certain percentage. Or, in the alternative, Medicare would recoup payments already made to the HHA if the HHA's costs were lower than its total PPS payments capped at a certain percentage. One of the beneficial features of PPS is that all payments occur in a predictable and timely manner. A cost-based risk-sharing provision could, in effect, reinstate retrospective reimbursement.

As a practical matter, the data needed to implement a risk sharing provision is not readily available for end-of the year adjustments. Agency-specific data is required to determine cost margins, and the earliest clean cost reports are settled, without fiscal intermediary fieldwork or audit work, 18 months after the end of an HHA's cost reporting period. Thus, this is the earliest point Medicare would be able to compare an HHA's allowable costs with its total PPS payments.

The industry has raised issues with regulatory burden associated with cost reporting requirements. A risk-sharing provision based on cost-report data would perpetuate the use of cost reports in their current form and hinder attempts to reduce cost reporting burden. It would also require continued audit and review functions to a greater degree than a PPS system.

Early examinations of access concerns under HH PPS, including studies by the Office of Inspector General and others, generally have not found direct evidence of increasing difficulty accessing Medicare home health benefits. These reports do note, however, that there could be some patients in certain subgroups that may be experiencing some difficulty with home health placement. Based on these preliminary findings, and the refinement research currently in progress, we believe that it is premature to change the payment system to include a risk-sharing provision.

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