



Testimony

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MEDICARE POST-ACUTE CARE

Home Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment

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Medicare Post-Acute Care: Home Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss Medicare's skilled nursing facility (SNF) and home health care benefits and the administration's forthcoming legislative proposals related to them. After relatively modest growth during the 1980s, Medicare's expenditures for SNFs and home health care have grown rapidly in the 1990s. SNF payments increased from \$2.8 billion in 1989 to \$11.3 billion in 1996, while home health care costs grew from \$2.4 billion to \$17.7 billion over the same period. Over that period, annual growth averaged 22 percent for SNFs and 33 percent for home health care.

My comments today will specifically focus on the reasons for cost growth for SNFs and home health care and the administration's announced legislative proposals for these two Medicare benefits. The information presented today is based mainly on our previous work. We also examined recent data on the two benefits from the Health Care Financing Administration (HCFA), which manages Medicare. The detailed legislative proposals are not yet available from the administration, so we reviewed the summaries of them that have been publicly released and talked with HCFA officials about these summaries.

In brief, Medicare's SNF costs have grown primarily because a larger portion of beneficiaries use SNFs than in the past and because of a large increase in the provision of ancillary services. For home health care costs, both the number of beneficiaries and the number of services used by each beneficiary have more than doubled. A combination of factors led to the increased use of both benefits:

- legislation and coverage policy changes in response to court decisions liberalized coverage criteria for the benefits, enabling more beneficiaries to qualify for care;
- these changes also transformed the nature of home health care from primarily posthospital care to more long-term care for chronic conditions;
- earlier discharges from hospitals led to the substitution of days spent in SNFs for what in the past would have been the last few days of hospital care, and increased use of ancillary services, such as physical therapy, in SNFs; and
- a diminution of administrative controls over the benefits, resulting at least in part from fewer resources being available for such controls, reduced the likelihood of inappropriately submitted claims being denied.

The major proposals by the administration for both SNFs and home health care are designed to give the providers of these services increased incentives to operate efficiently by moving them from a cost reimbursement to a prospective payment system. However, what remains unclear about these proposals is whether an appropriate unit of service can be defined for calculating prospective payments and whether HCFA's databases are adequate for it to set reasonable rates. The administration is also proposing that SNFs be required to bill for all services provided to their Medicare residents rather than allowing outside suppliers to bill. This latter proposal has merit, because it would make control over the use of ancillary services significantly easier.

Background

Medicare covers up to 100 days of care in a SNF after a beneficiary has been hospitalized for at least 3 days. To qualify for the benefit, the patient must need skilled nursing or therapy on a daily basis. For the first 20 days of SNF care, Medicare pays all the costs, and for the 21st through the 100th day, the beneficiary is responsible for daily coinsurance of \$95 in 1997.

To qualify for home health care, a beneficiary must be confined to his or her residence ("homebound"); require part-time or intermittent skilled nursing, physical therapy, or speech therapy; be under the care of a physician; and have the services furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions are met, Medicare will pay for skilled nursing; physical, occupational, and speech therapy; medical social services; and home health aide visits. Beneficiaries are not liable for any coinsurance or deductibles for these home health services, and there is no limit on the number of visits for which Medicare will pay.

Medicare pays SNFs and home health agencies on the basis of their reasonable costs—those that are found to be necessary and related to patient care—up to specified cost limits. For SNFs, limits are imposed on the amount of routine costs—those for general nursing, room and board, and administrative overhead—that will be reimbursed. Separate limits are set for freestanding SNFs in urban and rural areas at 112 percent of mean routine costs. Hospital-based SNF limits are set midway between the freestanding limits and 112 percent of the mean routine costs of hospital-based SNFs in each area. Home health agency cost limits are established at 112 percent of the mean costs of freestanding agencies in urban and rural areas. Hospital-based agencies have the same limits. Separate limits are set

for each type of visit (skilled nursing, physical therapy, and so on) but are applied in the aggregate; that is, an agency's costs over the limit for one type of visit can be offset by costs below the limit for another. Both SNF and home health cost limits are adjusted for differences in wage levels across geographic areas. Also, exemptions from and exceptions to the cost limits are available to SNFs and home health agencies that meet certain conditions.

While the cost-limit provisions of Medicare's cost reimbursement system for SNFs and home health agencies give some incentives for providers to control the affected costs, these incentives are considered by health financing experts to be relatively weak, especially for providers with costs considerably below their limit. On the other hand, it is generally agreed that prospective payment systems (PPS) give providers increased cost-control incentives. The administration proposes establishing PPSS for SNF and home health care and estimates that Medicare savings exceeding \$10 billion would result over the next 5 fiscal years.

SNF and Home Health Cost Growth

The Medicare SNF and home health benefits are two of the fastest growing components of Medicare spending. From 1989 to 1996, Medicare part A SNF expenditures increased over 300 percent from \$2.8 billion to \$11.3 billion. During the same period, part A expenditures for home health increased from \$2.4 billion to \$17.7 billion—an increase of over 600 percent. SNF and home health payments currently represent 8.6 percent and 13.5 percent of part A Medicare expenditures, respectively.

At Medicare's inception in 1966, the home health benefit under part A provided limited posthospital care of up to 100 visits per year after a hospitalization of at least 3 days. In addition, the services could only be provided within 1 year after the patient's discharge and had to be for the same illness. Part B coverage of home health was limited to 100 visits per year. These restrictions under part A and part B were eliminated by the Omnibus Reconciliation Act of 1980 (ORA, P.L. 96-499), but little immediate effect on Medicare costs occurred.

With the implementation of the Medicare inpatient PPS in 1983, the utilization of the SNF and home health benefits was expected to grow as patients were discharged from the hospital earlier in their recovery periods. However, HCFA's relatively stringent interpretation of coverage and eligibility criteria held growth in check for the next few years. As a result of court decisions in the late 1980s, HCFA issued guideline changes

for the SNF and home health benefits that had the effect of liberalizing coverage criteria, thereby making it easier for beneficiaries to obtain SNF and home health coverage. Additionally, the changes prevent HCFA's claims processing contractors from denying physician-ordered SNF or home health services unless the contractors can supply specific clinical evidence that indicates which particular services should not be covered.

The combination of these legislative and coverage policy changes has had a dramatic effect on utilization of these two benefits in the 1990s, both in terms of the number of beneficiaries receiving services and in the extent of these services. (App. I contains figures that show growth in SNF and home health expenditures in relation to the legislative and policy changes.) For example, ORA 1980 and HCFA's 1989 home health guideline changes have essentially transformed the home health benefit from one focused on patients needing short-term care after hospitalization to one that serves chronic, long-term care patients as well. The number of beneficiaries receiving home health care more than doubled in the last few years, from 1.7 million in 1989 to about 3.9 million in 1996. During the same period, the average number of visits to home health beneficiaries also more than doubled, from 27 to 72. In a recent report on home health,¹ we found that from 1989 to 1993, the proportion of home health users receiving more than 30 visits increased from 24 percent to 43 percent and those receiving more than 90 visits tripled, from 6 percent to 18 percent, indicating that the program is serving a larger proportion of longer-term patients. Moreover, about a third of beneficiaries receiving home health care did not have a prior hospitalization, another possible indication that chronic care is being provided.

Similarly, the number of people receiving care from SNFs has also almost doubled, from 636,000 in 1989 to 1.1 million in 1996. While the average length of a Medicare-covered SNF stay has not changed much during that time, the average Medicare payment per day has almost tripled—from \$98 in 1990 to \$292 in 1996. Use of ancillary services, such as physical and occupational therapy, has increased dramatically and accounts for most of the growth in per-day cost. For example, our analysis of 1992 through 1995 SNF cost reports shows that reported ancillary costs per day have increased 67 percent, from \$75 per day to \$125 per day, while reported routine costs per day have increased only 20 percent, from \$123 to \$148. Unlike routine costs, which are subject to limits, ancillary services are only subject to medical necessity criteria, and relatively little review of

¹Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996). This report includes an extensive discussion of the reasons for home health cost growth.

their use is done by Medicare. Moreover, SNFs can cite high ancillary service use to justify an exception to routine service cost limits, thereby increasing routine service payments.

Between 1990 and 1996, the number of hospital-based SNFs increased over 80 percent, from 1,145 such agencies to 2,088. Hospitals can benefit from establishing a SNF unit in a number of ways. Hospitals receive a set fee for a patient's entire hospital stay, based on a patient's diagnosis related group (DRG).² Therefore, the quicker that hospitals discharge a patient into a SNF, the lower that patient's inpatient hospital care costs are. We found that in 1994, patients with any of 12 DRGs commonly associated with posthospital SNF use had 4 to 21 percent shorter stays in hospitals with SNF units than patients with the same DRGs in hospitals without SNF units.³ Additionally, by owning a SNF, hospitals can increase their Medicare revenues through receipt of the full DRG payment for patients with shorter lengths of stay and a cost-based payment after the patients are transferred to the SNF.

Rapid growth in SNF and home health expenditures has been accompanied by decreased, rather than increased, funding for program safeguard activities. For example, our March 1996 report found that part A contractor funding for medical review had decreased by almost 50 percent between 1989 and 1995. As a result, while contractors had reviewed over 60 percent of home health claims in fiscal year 1987, their review target had been lowered by 1995 to 3.2 percent of all claims (or even, depending on available resources, to a required minimum of 1 percent). We found that a lack of adequate controls over the home health program, such as little intermediary medical review and limited physician involvement, makes it nearly impossible to know whether the beneficiary receiving home care qualifies for the benefit, needs the care being delivered, or even receives the services being billed to Medicare. Also, because of the small percentage of claims now selected for review, home health agencies that bill for noncovered services are less likely to be identified than was the case 10 years ago. Similarly, the low level of review of SNF services makes it difficult to know whether the recent increase in ancillary use is medically necessary (for example, because patient mix has shifted toward those who need more services) or simply a way for SNFs to get more revenues.

²DRGs are sets of diagnoses that are expected to require about the same level of hospital resources to treat beneficiaries suffering from them.

³Skilled Nursing Facilities: Approval Process for Certain Services May Result in Higher Medicare Costs (GAO/HEHS-97-18, Dec. 20, 1996). This report also includes information on cost growth for SNF services and the characteristics of Medicare beneficiaries who receive SNF care.

Finally, because relatively few resources are available for auditing end-of-year provider cost reports, HCFA has little ability to identify whether home health agencies or SNFs are charging Medicare for costs unrelated to patient care or other unallowable costs. Because of the lack of adequate program controls, it is quite possible that some of the recent increase in home health and SNF expenditures stems from abusive practices. The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), also known as the Kassebaum-Kennedy Act, has increased funding for program safeguards. However, per-claim expenditures will remain below the level in 1989, after adjusting for inflation. We project that, in 2003, payment safeguard spending as authorized by Kassebaum-Kennedy will be just over one-half of the 1989 per-claim level, after adjusting for inflation.

Administration's Proposals for Prospective Payment Systems

The goal in designing a PPS is to ensure that providers have incentives to control costs and that, at the same time, payments are adequate for efficient providers to furnish needed services and at least recover their costs. If payments are set too high, Medicare will not save money and cost-control incentives can be weak. If payments are set too low, access to and quality of care can suffer.

In designing a PPS, selection of the unit of service for payment purposes is important because the unit used has a strong effect on the incentives providers have for the quantity and quality of services they provide. Taking account of the varying needs of patients for different types of services—routine, ancillary, or all—is also important. A third important factor is the reliability of the cost and utilization data used to compute rates. Good choices for unit of service and cost coverage can be overwhelmed by bad data.

Proposal for a SNF PPS

We understand that the administration will propose a SNF PPS that would pay per diem rates covering all facility cost types and that payments would be adjusted for differences in patient case mix. Such a system is expected to be similar to HCFA's ongoing SNF PPS demonstration project that is testing the use of per diem rates adjusted for resource need differences using the Resource Utilization Group, version III (RUG-III) patient classification system.⁴ This project was recently expanded to include coverage of ancillary costs in the prospective payment rates.

⁴RUG-III is a method for classifying SNF residents according to health characteristics and the amount and type of resources they need.

An alternative to the proposal's choice of a day of care as the unit of service is an episode of care—the entire period of SNF care covered by Medicare. While substantial variation exists in the amount of resources needed to treat beneficiaries with the same conditions when viewed from the day-of-care perspective, even more variation exists at the episode-of-care level. Resource needs are less predictable for episodes of care. Moreover, payment on an episode basis may result in some SNFs inappropriately reducing the number of covered days. Both factors make a day of care the better candidate for a PPS unit of service. Furthermore, the likely patient classification system, RUG-III, is designed for and being tested in a per diem PPS. On the other hand, a day-of-care unit gives few, if any, incentives to control length of stay, so a review process for this purpose would still be needed.

The states and HCFA have a lot of experience with per diem payment methods for nursing homes under the Medicaid program, primarily for routine costs but also, in some cases, for total costs. This experience should prove useful in designing a per diem Medicare PPS.

Regarding the types of costs covered by PPS rates, a major contributor to Medicare's SNF cost growth has been the increased use of ancillary services, particularly therapy services. This, in turn, means that it is important to give SNFs incentives to control ancillary costs, and including them under PPS is a way to do so. However, adding ancillary costs does increase the variability of costs across patients and place additional importance on the case-mix adjuster to ensure reasonable and adequate rates.

Turning to the adequacy of HCFA's databases for SNF PPS rate-setting purposes, our work, and that of the Department of Health and Human Services' (HHS) Inspector General, has found examples of questionable costs in SNF cost reports. For example, we found extremely high charges for occupational and speech therapy with no assurance that cost reports reflected only allowable costs.⁵ Cost report audits are the primary means available to ensure that SNF cost reports reflect only allowable costs. However, the resources expended on auditing cost reports have been declining in relation to the number of SNFs and SNF costs for a number of years. The percentage of SNFs subjected to field audits has decreased as has the extent of auditing done at the facilities that are audited. Under these circumstances, we think it would be prudent for HCFA to do thorough

⁵Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

audits of a projectable sample of SNF cost reports. The results could then be used to adjust cost report databases to remove the influence of unallowable costs, which would help ensure that inflated costs are not used as the base for PPS rate setting.

Proposal for a Home Health PPS

The summary of the administration's proposal for a home health PPS is very general, saying only that a PPS for an appropriate unit of service would be established in 1999 using budget neutral rates calculated after reducing expenditures by 15 percent. HCFA estimates that this reduction will result in savings of \$4.7 billion over fiscal years 1999 through 2002.

The choice of the unit of service is crucial, and there is limited understanding of the need for and content of home health services to guide that choice. Choosing either a visit or an episode as the unit of service would have implications for both cost control and quality of care, depending on the response of home health agencies. For example, if the unit of service is a visit, agencies could profit by shortening the length of visits. At the same time, agencies could attempt to increase the number of visits, with the net result being higher total costs for Medicare, making the per-visit choice less attractive. If the unit of service is an episode of care over a period of time such as 30 or 100 days, agencies could gain by reducing the number of visits during that period, potentially lowering quality of care. For these reasons, HCFA needs to devise methods to ensure that whatever unit of service is chosen will not lead to increased costs or lower quality of care. If an episode of care is chosen as the unit of service, HCFA would need a method to ensure that beneficiaries receive adequate services and that any reduction in services that can be accounted for by past overprovision of care does not result in windfall profits for agencies. In addition, HCFA would need to be vigilant to ensure that patients meet coverage requirements, because agencies would be rewarded for increasing their caseloads. HCFA is currently testing various PPS methods and patient classification systems for possible use with home health care, and the results of these efforts may shed light on the unit-of-service question.

We have the same concerns about the quality of HCFA's home health care cost report databases for PPS rate-setting purposes as we do for the SNF database. Again, we believe that adjusting the home health databases, using the results of thorough cost report audits of a projectable sample of agencies, would be wise.

We are also concerned about the appropriateness of using current Medicare data on visit rates to determine payments under a PPS for episodes of care. As we reported in March 1996, controls over the use of home health care are virtually nonexistent. Operation Restore Trust, a joint effort by federal and state agencies in several states to identify fraud and abuse in Medicare and Medicaid, found very high rates of noncompliance with Medicare's coverage conditions in targeted agencies. For example, in a sample of 740 beneficiaries drawn from 43 home health agencies in Texas and 31 in Louisiana that were selected because of potential problems, some or all of the services received by 39 percent of the beneficiaries were denied. About 70 percent of the denials were because the beneficiary did not meet the homebound definition. Although these are results from agencies suspected of having problems, they illustrate that substantial amounts of noncovered care are likely to be reflected in HCFA's home health care utilization data. For these reasons, it would also be prudent for HCFA to conduct thorough on-site medical reviews of a projectable sample of agencies to give it a basis to adjust utilization rates for purposes of establishing a PPS.

Consolidated Billing for SNFs

The administration has also announced that it will propose requiring SNFs to bill Medicare for all services provided to their beneficiary residents except for physician and some practitioner services. We support this proposal as we did in a September 1995 letter to you, Mr. Chairman. We and the HHS Inspector General have reported on problems, such as overutilization of supplies, that can arise when suppliers bill separately for services for SNF residents.

A consolidated billing requirement would make it easier for Medicare to identify all the services furnished to residents, which in turn would make it easier to control payments for those services. The requirement would also help prevent duplicate billings for supplies and services and billings for services not actually furnished by suppliers. In effect, outside suppliers would have to make arrangements with SNFs under such a provision so that nursing homes would bill for suppliers' services and would be financially liable and medically responsible for the care.

In conclusion, it is clear that the current payment systems for providers of skilled nursing and home health services to Medicare beneficiaries need to be revised. As more details concerning the administration's or others' proposals for revising those systems become available, we would be glad

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to work with the Subcommittee and others to help sort out the potential implications of suggested revisions.

This concludes my prepared remarks, and I will be happy to answer any questions.

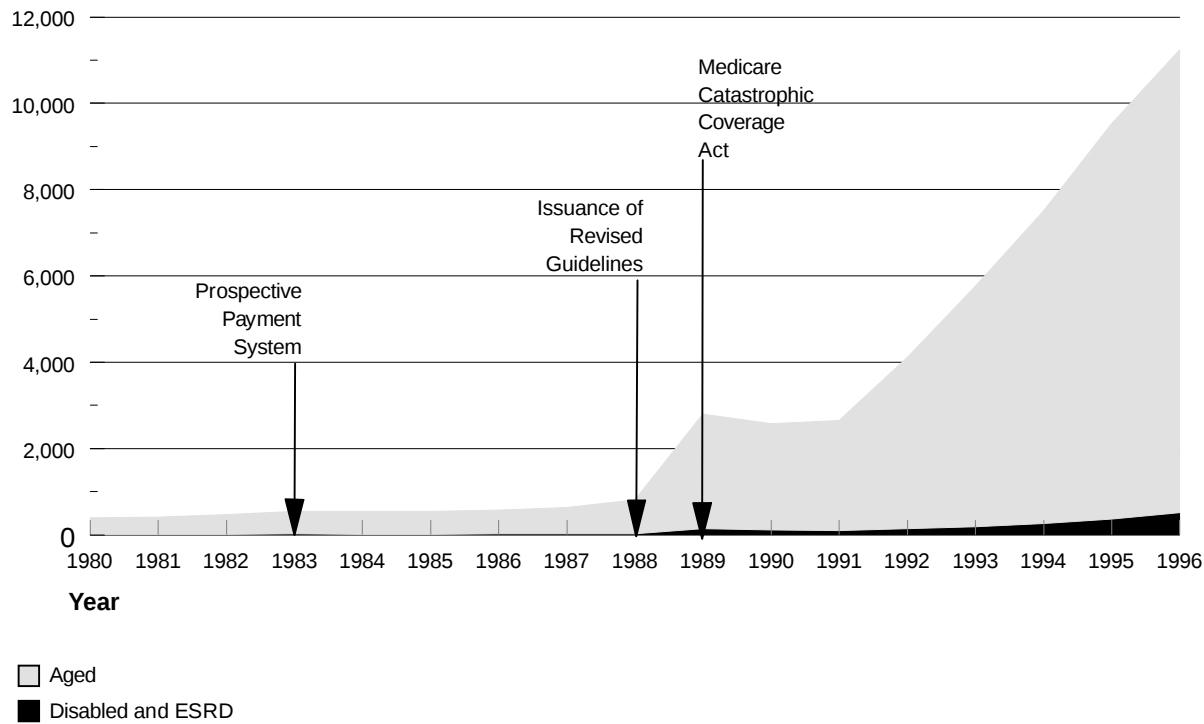
Contributors

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Medicare Skilled Nursing Facility and Home Health Expenditures, 1980-96

Figure I.1: Medicare Skilled Nursing Facility Expenditures, 1980-96

Dollars in Millions



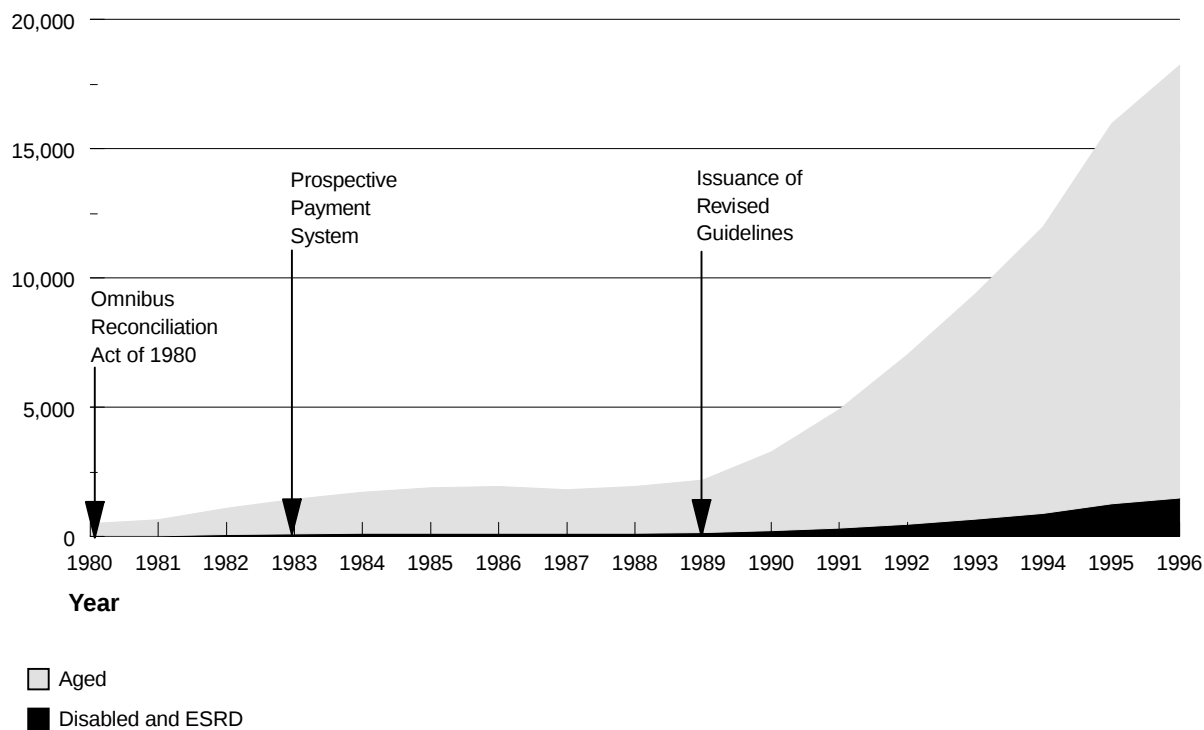
Note: ESRD = end-stage renal disease.

Source: HCFA's Office of the Actuary.

Appendix I
Medicare Skilled Nursing Facility and Home
Health Expenditures, 1980-96

Figure I.2: Medicare Home Health Expenditures, 1980-96

Dollars in Millions



Note: ESRD = end-stage renal disease.

Source: HCFA's Office of the Actuary.

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