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MEDICARE

Home Health Cost Growth
and Administration's
Proposal for Prospective
Payment

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Medicare: Home Health Cost Growth and Administration's Proposal for Prospective Payment

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss Medicare's home health care benefit and the administration's forthcoming legislative proposals related to it. After relatively modest growth during the 1980s, Medicare's expenditures for home health care have grown rapidly in the 1990s. Home health care costs grew from \$2.4 billion in 1989 to \$17.7 billion in 1996, an average annual increase of 33 percent.

My comments will focus on the reasons for cost growth for home health care and the administration's announced legislative proposals for this Medicare benefit. The information presented is based mainly on our previous work. We also examined recent data on the benefit 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 home health care costs have grown because a larger portion of beneficiaries use this benefit than in the past and the number of services used by each beneficiary has more than doubled. A combination of factors led to the increased use of the benefit:

- legislation and coverage policy changes in response to court decisions liberalized coverage criteria for the benefit, 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; and
- a diminution of administrative controls over the benefit, resulting at least in part from fewer resources being available for such controls, reduced the likelihood that inappropriate claims would be detected.

The major proposals by the administration for home health care are designed to give providers increased incentives to operate efficiently by immediately tightening the limits on the amount of cost per visit that will be paid and imposing a new cap on per-beneficiary costs. After these changes, in 1999, the proposal would move home health payments from cost reimbursement to a prospective payment system (PPS). Estimated savings from these two proposals are \$12.4 billion over the next 5 fiscal years. What remains unclear about the reasonableness of the PPS proposal is whether an appropriate unit of service for calculating prospective

payments can be defined and whether HCFA's databases are adequate for it to set reasonable rates.

Background

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 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. Home health agency cost limits are set separately for agencies in rural and urban areas, at 112 percent of the mean costs of freestanding agencies. 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, costs over the limit for one type of visit can be offset by costs below the limit for another. 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 home health agencies that meet certain conditions.

While the per-visit cost-limit provision of Medicare's reimbursement system for home health agencies gives some incentives for providers to control their costs, these incentives are considered by health financing experts to be relatively weak. For providers with per-visit costs considerably below their limit, there is little incentive to control costs, and for all providers, there is no incentive to control number of visits. It is generally agreed that prospective payment systems give providers increased cost-control incentives.

Home Health Cost Growth

The Medicare home health benefit is one of the fastest growing components of Medicare spending. From 1989 to 1996, part A expenditures for home health increased from \$2.4 billion to

\$17.7 billion—an increase of over 600 percent. Home health payments currently represent 13.5 percent of Medicare part A expenditures.

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 hospital PPS in 1983, the utilization of the home health benefit 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 home health benefit that had the effect of liberalizing coverage criteria, thereby making it easier for beneficiaries to obtain home health coverage. Additionally, the changes prevent HCFA's claims processing contractors from denying physician-ordered 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 the home health benefit in the 1990s, both in terms of the number of beneficiaries receiving services and in the extent of these services. (App. I contains a figure that shows growth in 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

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.

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.

Rapid growth in 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, the contractors' review target was 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 contractor 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.

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 are charging Medicare for costs unrelated to patient care or other unallowable costs. Because of the lack of adequate program controls, it is possible that some of the recent increase in home health costs stems from abusive practices. Recent legislation, 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 Proposal for a Home Health Prospective Payment System

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 at least recover their costs. If payments are set too high, Medicare will not save money and cost control incentives will 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. Another important factor is the reliability of the cost and utilization data used to compute rates. A good choice for unit of service can be overwhelmed by bad data.

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 the 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 are concerned about the quality of HCFA's home health care cost report database for PPS rate-setting purposes. Our work and that of the Department of Health and Human Services' Inspector General has found examples of questionable costs in home health agency cost reports. For example, we reported in August 1995 on a number of problems with

contractor payments for medical supplies such as surgical dressings, which indicate that excessive costs are being included and not removed from home health agency cost reports.² Also, the Inspector General found substantial amounts of unallowable costs in the cost reports of a large home health agency chain, which was convicted of fraud on the basis of these findings. We believe that it would be prudent for HCFA to audit thoroughly a projectable sample of home health agency cost reports. The results could then be used to adjust HCFA's database to help ensure that unallowable costs are not included in the base for setting prospective rates.

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. Our report included a number of examples of noncovered services that are billed to Medicare. For example, a physician called a claims processing contractor to complain that some of his patients were being told by a home health agency that they were homebound merely because they did not own a car. In another report, we found that some home health agency staff were directed to alter or falsify medical records to ensure continued or prolonged visits, including recording visits that were never made or noting that patients were homebound even after they were no longer confined to their homes.³ Also, Operation Restore Trust, a joint effort by federal and several state agencies to identify fraud and abuse in Medicare and Medicaid, found very high rates of noncompliance with Medicare's coverage conditions. For example, in a sample of 740 patients 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 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.

²Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

³Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

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In conclusion, Medicare's current payment mechanisms for home health services need to be improved. As more details concerning the administration's or others' proposals become available, we would be glad to work with the Subcommittee to help sort out the potential implications of suggested revisions.

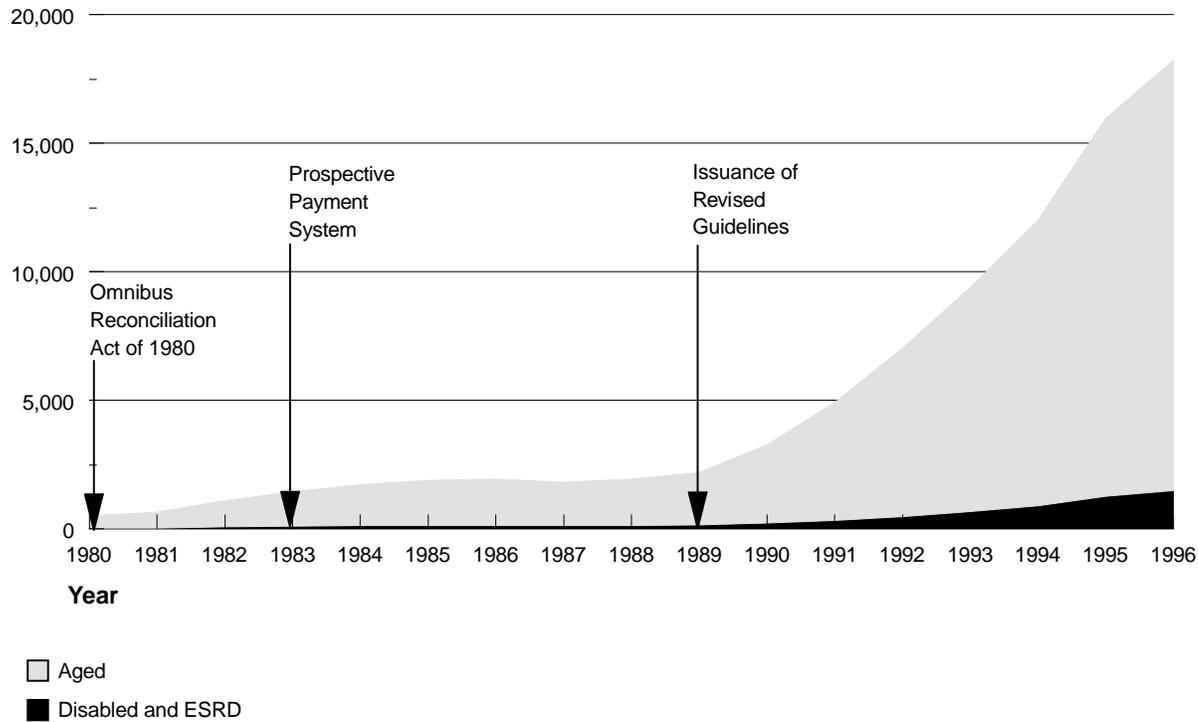
This concludes my prepared remarks, and I will be happy to answer any questions.

Contributors

For more information on this testimony, please call William Scanlon on (202) 512-7114 or Thomas Dowdal, Senior Assistant Director, on (202) 512-6588. Patricia Davis also contributed to this statement.

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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