

April 2000

MEDICARE HOME HEALTH CARE

Prospective Payment System Will Need Refinement as Data Become Available



G A O

Accountability * Integrity * Reliability

Contents

Letter		3
Appendixes	Appendix I: Scope and Methodology	32
	Appendix II: HCFA Projects to Develop a Prospective Payment System for Home Health Agencies	33
	Appendix III: Comments From the Health Care Financing Administration	37
Tables	Table 1: HCFA-Funded HHA Research Spending, 1988-99, by Project Category	16

Abbreviations

BBA	Balanced Budget Act of 1997
HCFA	Health Care Financing Administration
HHA	home health agency
HHRG	home health resource group
HHS	Department of Health and Human Services
IPS	interim payment system
MedPAC	Medicare Payment Advisory Commission
OASIS	Outcome and Assessment Information Set
PPS	prospective payment system
SCIC	significant change in condition



B-282264

April 7, 2000

Congressional Committees

Medicare spending for home health care rose from \$3.7 billion in 1990 to \$17.8 billion in 1997, making it one of the fastest growing components of the program. Since then, spending has moderated. In 1998 Medicare outlays were \$17.3 billion, and expenditures in 1999 are projected to be around \$15 billion. The historic rise in expenditures for home health care primarily was due to more beneficiaries receiving services and more visits provided per user. To control spending, the Congress enacted fundamental payment reforms in the Balanced Budget Act of 1997 (BBA). Notably, the act required the Secretary of Health and Human Services to develop a prospective payment system (PPS) to replace cost-based payments for home health agencies (HHA). The BBA outlined the general terms for the HHA PPS, specifying that it pay a fixed, predetermined amount for a unit of service, adjusted for patient characteristics that affect the costs of providing care.

The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), has been conducting research on a home health PPS for some time. This research is especially important because designing an effective payment system is difficult, given Medicare's broad definition of who qualifies for home health coverage and the lack of standards for what constitutes appropriate care. The challenges lie in defining the service unit that will be used for payment purposes and developing the case-mix adjustment method to vary payments for differences in patient needs. These and other system design decisions, as well as their implementation, will determine the extent to which the PPS rewards HHAs that deliver care efficiently, protects beneficiaries from inadequate care, and ensures that the Medicare program is only paying for medically necessary care.

Concerned about HCFA's ability to develop the PPS on time, the Congress, in the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 (P.L. 105-277), delayed the PPS implementation date by a year to October 1, 2000. The legislation also mandated three reports on the PPS for HHAs. First, the Secretary, HHS, was required to submit a report on HCFA's research relevant to the PPS for HHAs and the schedule for implementing the PPS. Second, the Medicare Payment Advisory

Commission (MedPAC) was required to analyze the Secretary's report and make recommendations regarding its contents. Finally, we were asked to review and report to the Congress on the expenditures for HCFA's research on the home health PPS. (Addressees are listed at the end of this letter.)

After reviewing the other mandated reports and in consultation with your staffs, we agreed to (1) document the objectives, findings, and costs of the research and demonstration projects HCFA has funded that were related to the design of the PPS and (2) assess how these projects contributed to the proposed PPS design and determine which design decisions were based on incomplete information. To address these objectives, we examined materials and reports for projects listed in HCFA's Active Projects Reports, the Secretary's report to the Congress, and MedPAC's letter to the Congress. In addition, we analyzed the proposed design for the PPS¹ and discussed the proposal with HCFA officials and their primary contractor, Abt Associates, Inc. (App. I contains a complete description of our methodology.) We performed our work between December 1998 and February 2000 in accordance with generally accepted government auditing standards.

Results in Brief

Recognizing the need for home health payment reform, HCFA has sponsored a number of research and demonstration projects on payment design and home health care users and service delivery since 1987 at a cost of almost \$27 million. Despite these important efforts, key features of a PPS were not evaluated in these projects, which limits the ability to evaluate the effects of certain payment policies on home health care service delivery and spending. HCFA's major HHA payment demonstration project provided evidence that HHAs would reduce their costs of providing home health visits when paid under a PPS model that tightly limited both their profits and their losses. The demonstration did not examine alternative levels of payments. Furthermore, the demonstration did not develop a case-mix adjustment method to alter payments for expected differences in resource use across groups of patients. However, an ongoing research project has constructed an initial case-mix adjustment method for the PPS and will continue to refine this method as more data become available. Other HCFA-sponsored research projects have documented the variation in home health care service delivery. These projects have demonstrated that

¹"Medicare Program: Prospective Payment System for Home Health Agencies," proposed rule, *Federal Register*, Vol. 64, No. 208 (Oct. 28, 1999).

methods for quality measurement and monitoring are not well developed, which will impair the ability to evaluate the effect of payment changes.

Although HCFA's research and demonstration projects have proven useful in designing the PPS, information gaps remain. These gaps, coupled with substantial variation in the way home health care services are delivered and the lack of standards for what constitutes appropriate care, mean that the PPS could cause unintended consequences for some beneficiaries, some HHAs, or the level of Medicare spending. For example, the proposed unit of payment, a 60-day episode, is likely to be too long for many beneficiaries and could result in unnecessary expenditures if payments are not adequately adjusted for patient needs. Also, the level of payments per episode will be based on national average costs, which could result in sharp revenue increases for some agencies and large declines for others. Concerns remain about whether the case-mix adjustment method will adequately group patients with like resource needs and then appropriately adjust payments for beneficiaries in each group. Furthermore, how a patient is classified and how much the agency is paid are very dependent on whether, and how much, therapy services² are provided—something that is directly controlled by HHAs. Without adequate design features, Medicare could overpay for unneeded services or underpay for required care, resulting in beneficiaries facing access problems or receiving poor quality of care.

Although the change from cost-based payments to prospective payments is intended to help Medicare control its spending, how costs and service provision will change under the new system is unknown. Therefore, HCFA will need to have sufficient resources to monitor service delivery across types of beneficiaries and across HHAs so that inadequate or medically inappropriate care can be identified. We are recommending that HCFA devote the resources necessary to perform these monitoring activities. And, as more information becomes available about what services are delivered within an episode and how long visits last, efforts should be pursued to develop criteria for service adequacy and appropriateness and to identify the outcomes for beneficiaries. In the interim, a risk-sharing arrangement, in which aggregate Medicare payments are adjusted at year-end to reflect a provider's actual costs, would mitigate any unintended consequences of the payment change. Limiting an HHA's losses or gains would help protect the industry, the Medicare program, and beneficiaries

²Therapy services include physical, speech, and occupational therapies.

from possible negative effects of the PPS until more is known about how best to design the PPS and the most appropriate home health treatment patterns. We are also recommending that as new data are available and experience is gained with the PPS, HCFA should study practice patterns and provider responses to the PPS and make any needed modifications to the PPS design and implementation.

Background

Medicare's home health care benefit enables certain beneficiaries with post-acute-care needs (such as recovery from joint replacement) and chronic conditions (such as congestive heart failure) to receive care in their homes rather than in other settings. To qualify for home health care, a beneficiary must be confined to his or her residence ("homebound");³ require 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 part-time or intermittent skilled nursing; physical, occupational, and speech therapy; medical social services; and home health aide visits.⁴ Beneficiaries are not liable for any coinsurance or deductibles for these services and may receive an unlimited number of visits, provided the coverage criteria are met.

Changes in the Home Health Care Benefit Have Expanded Spending and Coverage

Between 1990 and 1997, Medicare home health payments rose an average of 25.2 percent annually. This increase was due primarily to a steady rise through 1997 of the proportion of beneficiaries receiving home health care and in the number of visits per person served. The number of home health users per 1,000 beneficiaries increased from 57 to 109, and the average number of visits per user doubled from 36 to 73.⁵ This growth can be attributed to many factors, including changes in patient demographics and in the delivery of health care services, particularly following the

³A beneficiary is homebound when he or she has a condition that results in a normal inability to leave home except with considerable and taxing effort, and absences from home are infrequent or of relatively short duration or are attributable to receiving medical treatment.

⁴"Part-time or intermittent" means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished fewer than 8 hours each day and for 28 or fewer hours each week.

⁵These data on service use include Medicare fee-for-service beneficiaries only.

introduction of the inpatient hospital PPS in 1983, which encouraged hospitals to discharge beneficiaries to alternative settings. Most notably, the relaxation of coverage guidelines as a result of legislative changes and a landmark court case resulted in more services being provided.

Originally, home health care coverage distinguished between services provided under Medicare part A (hospital insurance) and part B (supplemental medical insurance). Under part A, up to 100 visits a year were provided to a beneficiary following a hospital or nursing home stay, with no beneficiary cost-sharing. A beneficiary could also receive up to 100 visits under part B, with no institutional stay required, but had to pay 20 percent coinsurance. In 1980, legislation removed the institutional stay requirement under part A, eliminated the coinsurance requirement under part B, and lifted the visit limits under parts A and B. It also changed the program financing, with part A covering all home health care received by beneficiaries unless the beneficiary only had part B coverage, in which case part B would pay for the services.

Following these changes, home health care spending nearly doubled from 1980 to 1985, which prompted a series of additional regulatory actions by HCFA to tighten the benefit and coverage. This, in turn, triggered a class action suit in 1987 (*Duggan v. Bowen*) in which a coalition of beneficiaries and providers charged that Medicare's interpretation of the statutory phrase "part-time or intermittent" with regard to covered visits was too narrow, leading to the denial of care for eligible beneficiaries. Under a settlement agreement in 1989, the coverage guidelines for home health care were broadened, allowing more beneficiaries to qualify for more visits. As a result of these expansions, the benefit was transformed from one that primarily covered patients receiving short-term care following an acute event to one that covers chronic and long-term care patients as well.

At the same time this growth occurred, program controls were essentially nonexistent. Few claims were subject to medical review and most were paid without question. Previous work conducted by GAO and by the HHS Office of Inspector General has documented that some of the care provided was not medically necessary or lacked supporting documentation.⁶

⁶A 1999 study found that 19 percent of the services in four states were improper or highly questionable and did not meet Medicare reimbursement requirements. HHS Office of Inspector General, *Review of Medicare Home Health Services in California, Illinois, New York and Texas*, A-04-99-01194 (Washington, D.C.: HHS, Nov. 1999).

Growth Encompasses a Wide Range in Service Use

The majority of home health users receive few visits, but a small and growing proportion make extensive use of the benefit. According to MedPAC, 51 percent of recipients received fewer than 30 visits and accounted for 9 percent of all home health visits in 1996. By contrast, 15 percent of users had 150 visits or more and accounted for 59 percent of all Medicare home health visits that year. Approximately one-third of the beneficiaries in this latter group received over 300 visits.⁷

Home health users also differ in the mix of services they receive. A small proportion of Medicare users appears to need long-term care and gets a significant amount of aide services,⁸ as opposed to skilled care, from the program. In 1996, about 56 percent of the visits for beneficiaries who had 100 visits or more were for home health aide services. By contrast, only 6 percent of all visits to short-term users—beneficiaries who received nine or fewer visits—were for aide services; skilled nursing care comprised over 75 percent of their total visits.

⁷MedPAC, *Report to the Congress: Context for a Changing Medicare Program* (Washington, D.C.: MedPAC, June 1998).

⁸For Medicare coverage, aide services include personal care (such as help with dressing and bathing), simple wound dressing changes and assistance with medications that do not require the skills of a licensed nurse, routine exercises, and routine care of orthotic and prosthetic devices.

There also is marked variation in home health use across geographic areas and types of agencies. For example, Medicare home health users in Maryland received an average of 37 visits in 1997, with an average payment per user of \$3,088. In that same year, home health users in Louisiana received an average of 161 visits per user, with an average Medicare payment per user of \$9,278. This wide variation in usage has been evident even after controlling for patient diagnosis. Patterns of care also differed across agency types.⁹ Proprietary agencies tended to deliver more visits per beneficiary than other types of agencies and to provide more aide visits. For example, in 1993, beneficiaries who received care from proprietary agencies were given an average of 69 home health aide visits, compared with 43 and 48 visits from voluntary and government agencies, respectively.¹⁰ Such variation could be due to a variety of factors, including provider responses to financial incentives, differences in patient needs, regional practice patterns, states' varying Medicaid coverage and eligibility policies, and the use of home health care to substitute for services in other clinical settings.

The variation in service provision may also reflect the lack of standards for what constitutes necessary or appropriate home health care. As a result, it is not clear when home health care is warranted or when services should be stopped. Many home health users have chronic and multiple needs, so the beginning and end of care for a particular problem may overlap with care for another. Furthermore, even the most basic unit of service—the visit—is not well defined. Only recently have HHAs been required to record the time involved in a visit, and services and procedures provided are still not documented on the payment record.

BBA Changed Medicare Payment Method to Control Spending

Before the BBA, agencies were paid on the basis of their costs, up to preestablished per-visit limits equal to 112 percent of the national average cost for each type of visit. Although there was a separate payment limit for each type of visit (skilled nursing; physical, occupational, or speech therapy; medical social service; or home health aide), the limits were applied in the aggregate for the agency. That is, costs above the limit for one type of visit would still be paid if costs were sufficiently below the limit

⁹Agencies may be not-for-profit (or voluntary, including visiting nurse associations), for-profit (or proprietary), or government-owned.

¹⁰*Medicare: Home Health Utilization Expands While Program Controls Deteriorate* (GAO/HEHS-96-16, Mar. 27, 1996).

for other types of visits. There were no incentives to control the volume of services delivered; as a result, agencies could enhance their revenues by providing beneficiaries with more services.

The BBA changed the home health payment method beginning October 1, 1997, with the implementation of the interim payment system (IPS), a temporary measure to bring Medicare spending under control until the PPS is implemented. The per-visit limits are generally lower under the IPS, and agencies are subject to a Medicare revenue cap that is based on an aggregate per-beneficiary amount.¹¹ Generally, the per-beneficiary amount reflects each agency's historical average payments for treating a Medicare beneficiary and the regional or national average amount.¹² An agency's revenue cap is the product of its per-beneficiary amount and the number of patients it serves.

The IPS is designed to limit the Medicare per-visit payment and to give agencies the financial incentives to limit the number of services each provides to beneficiaries. It does not, however, limit the services an individual beneficiary can receive, nor does it restrain the number of beneficiaries an HHA can serve. Because the revenue cap applies to the average payment for a beneficiary for a year of services at an HHA, the services and costs associated with any particular beneficiary can vary. To ensure that Medicare payments will cover its costs, an HHA will need to keep the average cost of its visits below the per-visit limits and keep its

¹¹Originally, the IPS per-visit limit was based on 105 percent of the national median per-visit cost. Section 5101(b) of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (P.L. 105-277) revised the IPS and increased the per-visit limit to 106 percent of the national median per-visit cost.

¹²For an agency that had been in operation for a full year before October 1, 1994, the per-beneficiary amount is calculated as 98 percent of a blend of 75 percent of the agency's own fiscal year 1994 average per-beneficiary payment and 25 percent of the comparable regional average. The per-beneficiary amount for new agencies—those that had not participated in Medicare for a full year by October 1994—equals 100 percent of the 1994 national median per beneficiary payment. The Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (P.L. 105-277, sec. 5105 (a)) made several changes to the revenue cap. For HHAs with per-beneficiary amounts less than the national median, limits were increased by one-third of the difference between their amount and the national median. The cap for new HHAs (as defined by the BBA) was increased from 98 to 100 percent of the national median. Further, HHAs that opened after October 1, 1998, have per-beneficiary limits equal to 75 percent of the national median, reduced by 2 percent. The following year, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (P.L. 106-113, sec. 302) increased the per-beneficiary limits by removing the 2 percent reduction for all providers, thus increasing Medicare payments.

average cost per Medicare beneficiary below its per-beneficiary amount. It can do this by delivering visits more efficiently, changing the mix or reducing the number of visits provided to each user, increasing the proportion of lower-cost patients it treats, or some combination of these strategies.

Adapting to the IPS involves greater challenges for some agencies than others. HHAs that have provided more visits per beneficiary or that have higher per-visit costs than the average will have to change the way they deliver care. Agencies that treat few beneficiaries, agencies with few low-cost patients, or those with costly treatment patterns may find the adjustments more extensive and difficult. For agencies that have changed treatment patterns or their mix of patients since 1994, the limits, which are based on historical agency-specific costs, may not reflect current service provision. New agencies, particularly those located in high-cost regions, may be disadvantaged compared with established agencies because their aggregate revenue caps are based on the national median per-beneficiary amount.

The IPS may not adequately protect beneficiaries from underservice or the Medicare program from paying more than is warranted in the longer term. The revenue caps are based on each HHA's historical costs, which is intended to account for the differences in the mix of patients across agencies. An agency's historical patient mix, however, may not reflect the costs of the agency's current patients. Furthermore, the IPS does not mitigate the substantial cost differences across HHAs that may not have any relationship to patient needs.¹³ In addition, a system of cost-based payments subject to limits does not incorporate incentives for providers to reduce costs below the limits, thus it may not curb Medicare spending on lower-cost patients.

**PPS Design Determines
Incentives for Service
Provision and Cost Controls**

Under a PPS, payments are established in advance of service delivery. Payments may vary with patient characteristics or other factors that affect costs. The payment is divorced from an individual provider's actual cost of delivering care. Providers that on average deliver care for less than the

¹³The IPS is intended to account for historical differences in treatment patterns and patient mix through the use of each HHA's own historical costs. This may result in inefficient or inappropriate service use being incorporated in the payments. In addition, the IPS' use of the national median for new agencies means that there is no adjustment for differences in these agencies' own treatment patterns or patient mix.

payment amount profit; conversely, providers lose if their average service costs are higher than the payment.

HHA efforts to control the cost of service delivery can result in unacceptable reductions in the quantity or quality of care. Features of the PPS—including the unit of payment, the level of payments, and the method of adjusting payments for differences in patients' needs—should therefore be designed to minimize inappropriate provider responses to the financial incentives of the payment system. Risk-sharing arrangements between the payer and provider that limit providers' profits and losses may be added to the PPS to temper incentives to either over- or underserve. Other strategies outside the payment mechanism, such as medical review and examination of utilization patterns, could be used to monitor provider responses to the payment system and to design modifications to the PPS to help ensure the delivery of medically appropriate and necessary services.

The unit of payment defines the bundle of services covered by the payment—for example, it could be a home health visit or all of the visits during a course of treatment (an episode of care) that may span many days. Selecting between smaller and larger units involves trade-offs between control over the volume of services provided and beneficiary protections against underservice. With individual services as the unit of payment, providers have an incentive to deliver more services to increase their revenues, and, as a result, concerns about underservice are minimized. Defining an episode as the unit may encourage providers to focus on being more efficient by changing the intensity and mix of services delivered to patients during each episode, but it may also create incentives to stint on care.

The level of payment for each unit can affect access and the adequacy of services as well as overall program spending. The level is usually based on a historical average cost of a unit, either nationally or regionally, or by provider. Because information to identify the costs of efficiently delivering only appropriate services is generally not available, an average amount is assumed to be adequate to ensure that sufficient numbers of providers will continue to supply services. More generous payments would tend to ensure that more providers continue to serve Medicare beneficiaries if access proves to be a problem. When the payment level equals a national or regional average, providers with higher-than-average costs will need to lower their costs by, for example, shortening the length of visits, changing the mix of visits within an episode, or reducing the number of visits in an episode. Such changes may improve efficiency but also could reduce the

quality of care. However, the lack of standards for home health care means that distinguishing between added efficiency and reduced quality will often be difficult.

Under a PPS, adjusting payments to reflect expected resource needs for individual patients is critical to maintaining appropriate access and sufficient service provision while ensuring that payments and program expenditures are not unnecessarily high. The proposed PPS design incorporates a case-mix adjustment method to accomplish these objectives. A case-mix adjustment method has two parts, both of which must be reasonably precise to result in appropriate payment adjustments. First, categories are developed to group patients with comparable levels of expected resource use. Patients are usually assigned a category on the basis of clinical, functional, and other characteristics that are predictive of service costs. It is important that these categories not be subject to manipulation, such that providers could inappropriately assign patients to a particular group simply to boost payments.

Second, a relative weight is associated with each patient category. Each relative weight reflects the average costliness of the patients in that case-mix group compared with the costliness of all patients. To determine the payment for a given patient, therefore, requires first assigning the patient to the appropriate case-mix group and then multiplying the relative weight for that group by the average payment amount. Thus, how well the case-mix groups categorize patients with similar resource needs and how well the relative weight adjusts the payment will determine the fairness and adequacy of the payments under the PPS.

A PPS may be combined with a risk-sharing arrangement that limits the losses and gains a provider can experience over a period of time. Risk-sharing involves considering the provider's actual cost of delivering services in determining the final payment.¹⁴ Although risk-sharing reduces incentives to eliminate inefficient or inappropriate service use, it still may be appropriate because of the protections it affords beneficiaries against underservice and to the program against excessive payments, particularly when other mechanisms do not provide these safeguards.

¹⁴One such method would compare a provider's total Medicare payments with its actual allowable Medicare costs. For example, if payments exceed actual costs by 10 percent or more, these profits would be shared with Medicare. But if costs exceeded payments by 10 percent or more, a portion of these losses would be shouldered by Medicare.

Proposed PPS Design

HCFA published its proposed PPS design in a proposed rule in the *Federal Register* on October 28, 1999. The basic unit of payment would be a 60-day episode of care. An episode would begin with a beneficiary's first visit and end on the 60th day after that visit. For beneficiaries requiring additional care, a second episode would begin on day 61 and end on day 120. There would be no limits on the number of episodes for any beneficiary. The basic 60-day episode payment would cover all of a beneficiary's home health care during that period, regardless of the actual days of care or visits provided.

The basic 60-day episode payment would incorporate two adjustments—a case-mix adjustment based on a clinical classification system and a wage adjustment to reflect the variation in labor costs across geographic areas. The case-mix adjustment method would assign patients to one of 80 home health resource groups (HHRG) on the basis of patient assessment data from the Outcome and Assessment Information Set (OASIS)¹⁵ and the projected number of therapy visits in the patient's plan of care. The wage adjustment would be based on the geographic area in which the beneficiary received services and would be applied to the labor portion of the episode payment.

In cases in which the basic episode of care is interrupted, payments would be prorated.¹⁶ Interruptions occur when a beneficiary elects to transfer to another HHA, when a beneficiary is discharged when treatment goals are attained but then returns to the same HHA, or when a significant change in the beneficiary's condition (SCIC) results in a new OASIS assessment. For beneficiary-elected transfers or a discharge and return to the same agency during a 60-day episode, the payment would be adjusted to reflect the actual length of time the beneficiary remained under the agency's care before the intervening event. In the case of an SCIC, payments would have two prorated components: one for the portion of care before the SCIC and one for the care provided after a second OASIS assessment triggered a new HHRG.

¹⁵OASIS contains patient-level data on medical condition; demographic characteristics; supportive assistance; sensory, neurological, emotional, and behavioral status; activities of daily living; and instrumental activities of daily living. All agencies were required to begin using OASIS effective July 19, 1999.

¹⁶The proration calculations assume that costs are evenly distributed throughout an episode.

The level of aggregate agency payments was established in the BBA. PPS rates are to be set so that Medicare expenditures are equivalent to what would have been spent under the IPS, with those limits reduced by 15 percent.¹⁷ The base episode payments are to be set at the national average cost of providing the average number and mix of services within an episode.

HCFA's PPS design incorporates two additional features to adjust payments for beneficiaries with unusual costs. For beneficiaries with exceptionally high costs, an HHA would receive an "outlier" payment. The outlier payment is not intended to cover the full cost of the case, but it raises the payment above the standard episode amount. For beneficiaries with extremely low service use within an episode (four or fewer visits), HHAs would receive a low-utilization payment adjustment. Instead of the per-episode payment, payments would be on a per-visit basis, without a case-mix adjustment, but adjusted for geographic differences in labor costs.

New HHA data reporting requirements, while not available in time to affect the initial PPS design, may prove useful for subsequent refinements. As part of an assessment requirement, agencies must report OASIS and therapy service provision data on all patients, which will be used to assign a patient to an HHRG. In addition, the BBA required agencies to report the duration of visits in 15-minute increments. The OASIS, therapy, and visit time information will help in understanding what services are provided and what resources are needed during visits and episodes of care and in developing patient outcome indicators.

PPS Design Questions Remain, Despite HCFA Research

HCFA has sponsored a number of research and demonstration projects, at a total cost of \$27 million over 12 years, to better understand the nature of home health care, the characteristics of its users, and how these factors should be reflected in the payment system (see table 1). (For more detail on funded projects, see app. II.) The Home Health Agency Prospective Payment Demonstration involved six different projects in two phases at a cost of \$14.9 million. In both demonstration phases, Medicare tested

¹⁷The Medicare, Medicaid and SCHIP Refinement Act of 1999 delays the 15 percent reduction in the payments required under the PPS by the BBA until 12 months after implementation of the PPS. It also requires the Secretary of Health and Human Services to report to the Congress within 6 months of implementation of the PPS on the need for the 15 percent or other reduction.

limited features of a PPS, paying agencies prospective rates for visits in phase I and episodes of care in phase II and adjusting payments to limit the profits and losses of an agency. Phase II yielded valuable information on the effect of episode-based payments on costs and service use. The tested models did not, however, yield information about the appropriate level of payments. Furthermore, a case-mix adjustment method was not tested in either phase. Eight other HHA payment projects were funded at a cost of \$12.1 million. An ongoing project developed the case-mix adjustment method that will be used in the PPS and will continue to refine this method as more data become available. Other projects investigated determinants of and variation in home health utilization and expenditure growth to address questions about quality of care and appropriate service delivery.

Table 1: HCFA-Funded HHA Research Spending, 1988-99, by Project Category

Project category	Expenditure
Home Health Agency Prospective Payment Demonstration, phase I	\$6.5 million
Home Health Agency Prospective Payment Demonstration, phase II	8.3 million
Case-mix research	3.9 million
Related home health research	8.2 million
Total	\$26.9 million

Source: GAO analysis of data from *Active Projects Report: Research and Demonstrations in Health Care Financing*, eds. 1988-98.

HHA PPS Demonstration Provides Limited Guidance on PPS Design

The Omnibus Budget Reconciliation Act of 1987 directed HHS to conduct a demonstration project on prospective payment methods for HHAs. The demonstration tested only selected PPS features. In the two phases of the demonstration, alternative units of payment were evaluated; however, other key PPS design features were not. The PPS models tested in the demonstration were shaped, in part, by the need to minimize the financial risk placed on HHAs in order to secure their participation.

Phase I, conducted from 1990 to 1995, tested the effect of per-visit prospective payments on agency costs and patterns of care. HHAs in the test group were paid a fixed, prospective rate per visit based on each agency's historical costs. Payments were not subject to a case-mix

adjustment method to account for patient cost differences that were due to variation in resource needs. Retrospective payment adjustments were made so that gains and losses for each test agency were limited to 5 percent of Medicare-allowable costs. The evaluation of this demonstration concluded that prospective per-visit payments did not affect agency costs or the provision of care when the HHA was at little financial risk.

Phase II of the demonstration is testing the effect of prospective episode-based payments on HHA costs and service delivery. Phase II started in 1995 and will continue until the PPS is implemented. Test agencies are paid a single prospective rate for the first 120 days of services to a patient and a prospective per-visit rate for any additional visits. As in phase I, payment rates are based on each agency's historical costs. Therefore, HHAs with higher historical costs continue to receive higher payments. The rates may be adjusted at year-end if the cost patterns of the agency's current patient mix do not match its historical costs. Agency losses are shouldered primarily by HCFA and agency profits over 5 percent of Medicare-allowable costs are shared with Medicare.¹⁸ Preliminary evaluation of phase II suggests that HHAs respond to an episode-based PPS by controlling their per-episode costs by reducing the number of visits provided.¹⁹ This is notable, given the demonstration's risk-sharing arrangement, which limited an agency's financial losses and gains and thus reduced the incentives to change the way care was delivered. That is, HHAs controlled their costs even though their financial losses or gains were restricted. The evaluation will continue to monitor the demonstration's effect on patient outcomes and access and on the use of other health services.

Phase II of the demonstration showed that expanding the unit of payment for home health care from a visit to a 120-day episode can change the way HHAs provide services, resulting in lower per-episode spending. The risk-sharing arrangements incorporated into the demonstration mitigated any large swings in payment to HHAs. Phase II did not continue to pay for long-term patients on a per-episode basis—instead it switched to per-visit

¹⁸HCFA reimburses each test agency for 99 percent of its losses in the first demonstration year, 98 percent of its losses in the second year, and 97 percent in the third and subsequent demonstration years, subject to total payments being no greater than Medicare-allowable costs. HCFA retains 25 percent of an agency's profit, if it is between 5 percent and 15 percent of the HHA's total allowable costs, and 100 percent thereafter.

¹⁹First-year results from phase II showed a 17 percent reduction in the number of visits provided by study agencies, compared with agencies in the control group.

payments after 120 days. Neither phase of the demonstration adjusted payments for differences in expected beneficiary resource use, so they did not yield a case-mix adjustment method for use in a PPS. Finally, neither phase tested alternative levels of payment for services across agencies, as payments were based on agency-specific historical payments.

HCFA also funded research to measure and monitor the quality of care provided by HHAs participating in the demonstration. Both phase I and phase II of the demonstration evaluated the effect of prospective payment on the quality of care. Results indicate that a PPS may not negatively affect the measured patient outcomes and that HHAs can reduce costs for home health services without compromising quality or outcomes. Furthermore, the effects of the payment approach tested in the demonstration on the quality of care may be understated because outcome measures to evaluate care, especially for chronically ill patients, are not fully developed.

Case-Mix Research is Ongoing

HCFA has been researching a case-mix adjustment method for home health services for some time, although the demonstration did not test one. An early research project to develop patient categories was completed in 1991. It entailed a significant primary data collection phase because available claims data contained little of the patient-level information necessary to adequately group patients to reflect their expected resource needs. The study concluded that service-dependent descriptors such as nursing treatments were more predictive of patient resource use than measures like functional status or medical diagnosis. Service-dependent patient descriptors, however, are vulnerable to provider manipulation (that is, providers can add services to increase payments) and therefore are not ideal for use in a payment system. Furthermore, the project's data were collected before the issuance of revised coverage guidelines in 1989, so they do not reflect current treatment patterns for many patients.

In 1996, HCFA funded a major study to develop a case-mix adjustment method to be used in the HHA PPS.²⁰ The resulting preliminary method will be based on 20 patient descriptors from the OASIS assessment instrument and a measure of patients' therapy use during the home health episode. These data elements, measuring clinical severity, functional status, and therapy service use, are used to assign a patient to one of 80 HHRGs. Each HHRG is assigned a relative weight that reflects the costliness of the

²⁰This study is scheduled to be completed by April 2000.

beneficiaries in that category relative to the other case-mix groups. The case-mix adjustment method will continue to be refined as the research project is completed.

Related Research Projects Contribute to Understanding Home Health Care

Six other HCFA-funded research projects, at a total cost of \$8.2 million, were initiated to contribute to the design of the PPS or to understand its potential effect on service delivery. The majority of these studies addressed the quality of home health care, which could be affected by PPS payment incentives to reduce costs. HCFA funded efforts to develop home health care quality measures and monitoring methods. The projects did not, however, establish who should receive home health care or any appropriate standards of care. Given the continued lack of agreement, the quality measures and monitoring methods may not be adequate to assess changes in home health care quality associated with new payment policies.

Other studies were designed to explain factors contributing to variation in service mix and costs. Research on the regional variation in costs found that only a portion of these differences in service use could be explained by patient characteristics. Some of the differences appeared to be due to variations in practice patterns unrelated to patient needs, indicating that policies to reduce service use would not necessarily constrain needed care. Another study examined the growth in home health expenditures. It found that spending increases were fueled by rising utilization, not higher costs per visit. This suggests that an episode-based payment method, rather than a per-visit approach, would be more promising in controlling Medicare home health outlays.

Additional Research and Analysis Required to Refine PPS

Although HCFA has used information from its research efforts to shape the design of the PPS, the PPS is based on incomplete knowledge and will likely require modifications as more data become available. Given the wide variation in patients and service use, the 60-day episode unit of payment will not reflect the service patterns of many beneficiaries. Because the episode length does not closely match many beneficiaries' service needs, the PPS will rely heavily on the case-mix adjustment to calibrate payments to different types of patients. In addition, payments based on national average costs and service provision will redistribute payments across providers and may result in over- or underpayments. Furthermore, because of widely varying service patterns, it has been difficult to develop a case-mix adjustment method that adequately describes resource use, particularly for long-term users. The proposed method relies heavily on

therapy treatments for its classification of patients into payment groups, which may contribute to inappropriate care if providers change therapy regimens for financial reasons. Therefore, although the PPS is intended to affect provider behavior and thereby moderate Medicare spending, the limited research evidence on the appropriate payment design, the broad range of beneficiaries, and the lack of standards for care make it likely that the HHA PPS will have unintended consequences for beneficiary access, quality of care, and Medicare spending.

Proposed Unit of Payment May Not Be Suitable for All Patients

HCFA has proposed a 60-day episode of care as the unit of payment in the PPS, rather than the per-visit payment or the 120-day episode tested in the demonstration. HCFA believes that the 60-day episode has several advantages because it conforms to Medicare physician certification requirements for home health care and the OASIS reassessment schedule. In addition, the majority of beneficiaries historically have received services for fewer than 60 days and thus one episode payment would cover their care.

While a 60-day episode is logical for administrative reasons, it may not be appropriate for all beneficiaries, and the case-mix adjuster may not be robust enough to adequately calibrate payments under these circumstances. Although for the majority of beneficiaries care is completed within 60 days, care for many patients is completed in a much shorter period. Medicare's home health benefit is broadly defined, and different groups of home health users have unique care needs. For example, prior research has demonstrated that the health status and patterns of care of long-term users of home health care, as described by functional limitations, differ substantially from those of short-term users. It is possible that a single payment unit, combined with the limitations of the case-mix adjuster, may not reflect the variation in these distinct groups of beneficiaries.

The effect of HCFA's designation of 60-day episodes as the unit of payment attempts to balance competing concerns about level of service to Medicare beneficiaries and Medicare outlays. The proposed unit of payment will impose more discipline on HHAs to lower total costs of caring for short-term users than a shorter unit such as a visit. It also may not be as easy for providers to increase the number of units of service to augment revenues. The 60-day episode payment, however, creates incentives to lower the intensity or cost of services in the episodes—by shortening visit lengths or by reducing the number of visits provided within the episode. This

anticipated response to the episode payment may not negatively affect patient care, given the questionable appropriateness of previous utilization. However, because there is a lack of accepted standards of home health care, it will be difficult to assess the effect of any changes in service patterns. Furthermore, if HHAs merely delay services in order to extend care over multiple episodes to increase provider payments, Medicare expenditures will rise inappropriately.

HCFA has anticipated that the payments for patients who receive few visits could be too high under a 60-day episode amount. Thus, as one refinement, it has developed a specific payment policy for low-cost patients—the low-utilization payment adjustment. This policy would result in lower payments for these beneficiaries than would be made under a case-mix adjusted episode amount and is intended to partially counter the incentive to generate additional low-cost episodes. Agencies, however, will have strong financial incentives to ensure that all beneficiaries receive enough services to qualify for the full episode payment. If agencies do increase the number of episodes provided, Medicare expenditures will increase.

Payments Based on Averages May Inappropriately Raise or Lower HHA Payments

HCFA used the most recent available cost data (fiscal year 1997) to develop the HHA payment rates. The rates reflect the national average number of visits in an episode and the national average cost per visit, by type of visit. Because the prospective rates reflect national average service use and visit costs, the PPS will result in considerable redistribution of payments across providers.

The proposed rule includes HCFA's estimates of the effect of the PPS on HHAs. Payments to rural, freestanding, for-profit HHAs are expected to fall 17 percent when the PPS is implemented, but payments are expected to increase 46 percent to rural, freestanding, government HHAs. Payments to urban for-profit agencies would decrease 18 percent compared with a 20 percent increase to urban nonprofit agencies. The appropriateness of these estimated changes in payment and resulting provider responses are not known. Higher revenues may lead some HHAs to provide more services, while others may not change their patterns of care, thus leaving little justification for the higher Medicare payments. Conversely, lower payments may encourage some providers to increase their efficiency or to provide fewer services. Because there are no established treatment guidelines or outcome measures for home health care, it will be difficult to evaluate the effect of any service changes on quality of care.

Case-Mix Adjustment Method May Not Adequately Account for Differences in Patient Needs

A case-mix adjustment method for home health care must be robust to adequately predict resource use for the wide range of types of patients who receive care. Without a good measurement system, payments will be too high for some types of patients and too low for others, creating provider incentives to seek or to avoid certain types of patients for financial reasons. The proposed case-mix adjustment method, based on HCFA-funded research, predicts patient resource use about as well as methods used in PPSs for other services, but it is heavily dependent on therapy services delivered during the HHA episode for its ability to do so. Therefore, providers have incentives to manipulate therapy treatments to maximize their Medicare revenues.²¹ This could be a particular problem in home health care because the patterns of care are so variable and the standards of care are so ill-defined.

Given the diversity of patients receiving care, the large variation in practices, and the lack of standards for appropriate care, the case-mix adjustment method may not closely track resource use, resulting in large over- and underpayments for certain types of patients. In particular, HCFA's analysis indicates that resource use of long-term users may not be adequately accounted for by the case-mix adjustment method. This is because the variable measuring therapy use is the major predictor of costs, yet these patients generally use fewer of these services. As a result, the PPS payments for long-term patients in subsequent episodes may be consistently too high or too low, which could distort provider incentives regarding beneficiary treatment.

Anticipating the occasional exceptionally costly patient, HCFA has proposed outlier payments to cushion the losses an HHA would incur on a particular beneficiary. Moreover, an outlier policy should counter the incentive to avoid certain types of patients that can be identified prior to treatment. Outlier payments, however, may not adequately protect beneficiary access or address HHA concerns about losses if the basic case-mix adjustment method, which affects payments for all beneficiaries, is not robust.

²¹ *Balanced Budget Act: Implementation of Key Medicare Mandates Must Evolve to Fulfill Congressional Objectives* (GAO/T-HEHS-98-214, July 16, 1998) and *Medicare Post-Acute Care: Better Information Needed Before Modifying BBA Reforms* (GAO/T-HEHS-99-192, Sept. 15, 1999).

Risk-Sharing Arrangements Would Counter Large Degree of Uncertainty

Substantial variation in patient service needs and costs of care, combined with the 60-day episode unit of payment and the potential limitations of the case-mix adjustment method, could result in inappropriately high or low payments for particular beneficiaries or certain HHAs. Risk-sharing arrangements that limit HHA losses or gains from Medicare could be incorporated into the PPS design to adjust aggregate payments to account for actual agency costs. Such arrangements could moderate the effects of inadequate payments, the incentives to manipulate services to maximize profits, and the uncertainties associated with payment rates that are based on averages when so little is known about appropriate patterns of home health care. On the other hand, risk-sharing dampens the incentive of the PPS to provide care more efficiently.

A risk-sharing arrangement that limits the amount an HHA can lose or gain would involve a year-end settlement that compares an HHA's actual Medicare-allowed costs with its total Medicare payments. Payments above the costs would be constrained to a specific percentage, as would agency losses. Both phases of the demonstration included this form of risk-sharing, but HCFA's proposed PPS does not.

Although the PPS is intended to provide incentives to HHAs to deliver care more efficiently by allowing them to earn profits while risking losses on treating Medicare beneficiaries, extreme gains or losses could have unintended consequences. For example, the possibility of large gains might encourage providers to underserve beneficiaries because the HHA could retain all payments in excess of costs. Conversely, unlimited losses could undermine the quality of care and could eventually lead to reduced access for Medicare beneficiaries. These potential problems are compounded by the lack of standards for appropriate home health care that preclude effective monitoring of these HHA behaviors.

Conclusions

Over the past 12 years, HCFA has sponsored several research projects related to the use of home health care and payment policy for HHAs. These projects have provided valuable insights into the appropriate design of the PPS. Yet, questions about key PPS design components and their effect on service delivery and costs remain. The research offered little to explain the variation in service costs and patterns of care that is not tied to therapy service use, which is valuable information to have to help evaluate the effects of the PPS on beneficiary access and quality of care.

The proposed HHA PPS would create strong financial incentives to providers to change the way they deliver care that could compromise quality of care and could result in unintended increases in Medicare home health spending. It is likely that extensive monitoring of home health service delivery will be required to ensure that HHAs do not respond to these financial incentives either by inappropriately reducing care within an episode or by providing care that is not medically necessary in order to gain payments for additional episodes. Such monitoring is complicated by the current lack of accepted standards for home health care against which changes may be measured.

Uncertainties about the appropriate specification of key design features and provider responses to the PPS suggest moderating the effect of a largely untested PPS. Until data are available to refine the PPS to ensure appropriate beneficiary access and payment levels, a risk-sharing approach could moderate unintended changes. Although risk-sharing may dampen the PPS incentive to provide care more efficiently, we believe such a trade-off is appropriate to protect beneficiaries, HHAs, and the Medicare program.

Finally, key PPS features may need to be modified as experience is gained with the system and more data become available. While such revisions are common when major changes are made to payment methods, the current gaps in information mean that HCFA should be prepared to develop and implement substantial improvements. OASIS, therapy service, and visit length data should help define what services beneficiaries receive for specific clinical conditions. These data should be analyzed to determine whether the unit of payment, the level of payments, and the case-mix adjustment method need refinement. These data could also be used to assess the relationship between service use and appropriate patient outcomes.

Recommendations

In order to minimize unintended consequences on beneficiaries, HHAs, and Medicare, and to narrow information gaps in the PPS design, the Administrator of HCFA should take the following actions:

- Ensure that adequate resources are devoted to utilization monitoring and medical review to ensure that Medicare does not make inappropriate payments for home health services and that quality of care is not compromised.

- Incorporate a risk-sharing arrangement into the PPS design, consistent with methods tested in the demonstration, until available analyses indicate that it is no longer needed to protect beneficiaries, HHAs, or the Medicare program.
- Modify the PPS design, as appropriate, on the basis of continued study of the variations in service use and patient needs and the effects of the change in payment method on service use.

Agency Comments

In commenting on a draft of this report, HCFA agreed overall with our exposition of Medicare's home health care benefit; the research and findings funded by HCFA; the difficulties inherent in changing Medicare's payment method; and that careful monitoring of HHA, beneficiary, and program experience will be needed under the PPS. The agency agreed with two of our recommendations but raised concerns about our recommendation to incorporate a risk-sharing arrangement into the payment system. It also commented about some of our concerns regarding the overall design of the PPS. HCFA also made one technical comment, which we have incorporated.

HCFA agreed with our first recommendation to ensure that adequate resources are devoted to utilization monitoring and medical review. In its comments, HCFA outlined its planned efforts to (1) ensure that patient classification and billing data are accurate and payments are appropriate and (2) provide quick feedback on beneficiary outcomes and impacts for use in future PPS refinements. Its activities include using OASIS data to check the accuracy of data reporting and payments and ensure that HHA services properly address the identified needs of beneficiaries; conducting medical reviews of claims; and creating an aggressive surveillance system to assess the impact of the payment changes. It plans to compile claims information on a real-time basis to improve its ability to identify significant changes in provider behavior. Furthermore, it will target its investigative efforts on areas identified as potential vulnerabilities to ensure that the payment system is being implemented correctly and that agencies are responding to it appropriately. We support HCFA's efforts to ensure data and payment accuracy; nevertheless, we urge HCFA to devote sufficient resources to review efforts to detect unnecessary episodes and flag underservice within episodes on an ongoing basis as well as at the start of the PPS.

HCFA raised two major concerns with our second recommendation to incorporate risk sharing into the PPS design. First, it believes that such a

policy is not needed, given the adjustments included in the PPS that, in combination with its monitoring activities, it believes will be sufficient to protect agencies, beneficiaries, and the program. These adjustments include a case-mix measurement system to calibrate payments on the basis of patient needs, unlimited episode payments to account for long-term patients, outlier payments for extraordinarily high-cost episodes, and significant change in condition (SCIC) policies that vary payments when a beneficiary's condition changes substantially during the episode. HCFA's second concern was that implementing a risk-sharing arrangement would be operationally difficult and could threaten meeting its deadline for the PPS. HCFA stated that a risk-sharing arrangement would be more costly for HHAs and HFCA to administer because it would require comparisons of payments and provider-specific costs and require auditing of HHA costs to determine allowable costs. Such an arrangement would also make it more difficult to estimate payment levels to achieve budget neutrality.

While we agree with HCFA that the four payment adjustments included in the proposal are all important to calibrate payments for individual episodes, we believe that, given the incentives under a PPS and the historically substantial variation in utilization of the benefit, they are insufficient by themselves. These episode-level adjustments will help ensure that payments for certain beneficiaries are not too extreme, but they will not be sufficient to ensure that agencies with treatment patterns that are very different from the average are protected from extraordinary losses or do not gain inappropriately from extreme profits. This moderation to agency-level losses or gains is needed until HCFA better understands geographic and agency differences in treatment and agrees on appropriate HHA service so that PPS payments can be calibrated appropriately and underservice can be avoided. A risk-sharing mechanism would temper the incentives of the proposed PPS, protect beneficiaries from underservice, and shield HHAs from large losses that high-cost cases may engender if not adequately addressed by the outlier policy. Coupled with the inadequacies of the proposed case-mix adjustment method, we believe this moderation is critical to protect beneficiaries from inadequate care and safeguard the Medicare program from paying for services that were not needed or were not provided. We are sympathetic to HCFA's concerns that a risk-sharing method adds complexity to the payment calculations, and we do not believe that the implementation of the PPS should be delayed in order to incorporate one. However, we believe that the magnitude of potential overpayments to some HHAs and underpayments to others warrants this added complexity. Furthermore, we believe that the Medicare program already has experience in administering

each component of a risk-sharing approach. For example, for many providers, Medicare has estimated current-year costs to adjust current payments. In addition, HCFA has used payment methods that blend prospective rates with provider-specific costs, and it has implemented complex budget neutrality requirements in other payment policies. Though HCFA may need to proceed with its plans so that it can expedite replacing the IPS, we believe it should consider incorporating a risk-sharing arrangement in the future.

HCFA agreed with our third recommendation to modify the PPS design, as appropriate, on the basis of experience under the PPS and continued research on the variation in service use and patient needs. HCFA will continue to refine its case-mix measurement system and will evaluate whether the 15-minute billing data could be used in this refinement. Likewise, examination of data on users with multiple episodes may suggest different episode lengths or case-mix groupings for the population of long-term users.

HCFA also discussed some of our general concerns expressed in the report:

- We noted that the proposed case-mix adjustment method is heavily dependent on the level of therapy services provided, which can be manipulated by HHAs to boost payments. In its discussion of the case-mix adjustment method, HCFA notes that therapy services are an important component of home health care and that these home health patients are likely to fall into two groups—those who need significant amounts of therapy and those who do not. We agree that distinguishing among patients on the basis of their service need is appropriate. However, this case-mix adjustment method distinguishes between those who use therapy services and those who do not. We caution against relying on therapy service use to designate home health case-mix categories because of the financial incentives this creates for inappropriate service provision. We agree that the payment system needs to appropriately account for therapy services; therefore, we urge HCFA to refine the case-mix adjustment method so that it reflects patient needs, not service provision. We also agree that it will be important to monitor and assess how well the case-mix adjustment method accounts for the costs of long-stay patients. These beneficiaries make up a substantial share of all users, yet because they use fewer therapy services than other patients and their experience was not used in developing the case-mix adjustment method, refinements may be needed.

-
- We also raised concerns that using 60 days as the length of the episode may not be appropriate for patients with shorter lengths of stay. HCFA noted that many such stays are not predictable; that the 60-day length is appealing from an administrative perspective; and that a shorter period would undermine the notion of an “episode,” while a longer period would result in overpayments for many patients. We agree that beneficiary needs for services are not always predictable from the outset and that longer episode lengths would be likely to result in considerable overpayments for many cases. However, because the majority of home health episodes last 60 days or less, and a considerable share of stays are under 30 days, we believe that HCFA needs to evaluate current service patterns and make refinements to the episode length if necessary.
 - We are also concerned that agencies will have an incentive to provide enough visits to qualify for the full episode payment rather than the low-utilization payment adjustment. HCFA agrees that the low-utilization payment adjustment policy is likely to increase service provision and proposes a behavioral offset, not discussed in the proposed rule, that would decrease payments for all cases to account for added spending resulting from an increased number of episodes. HCFA also indicates that this will be a payment area that will be closely monitored. We concur that this is a vulnerability in the PPS and that this situation warrants monitoring, but we are unsure whether reducing the average payment through a behavioral offset adjustment is appropriate.
 - Finally, HCFA said that the report did not adequately discuss that historical utilization is not necessarily an appropriate basis for setting PPS rates because of services that were not medically necessary or lacked supporting documentation. We agree and have noted this in the text. Moreover, because historical utilization was used as the basis for the PPS, we believe this is further support for incorporating risk sharing into its design.

HCFA’s comments appear in their entirety as appendix III.

We are sending copies of this report to the Honorable Nancy-Ann Min DeParle, the Administrator of HCFA; interested congressional committees; and other interested parties. We will also make copies available to others upon request.

If you have any questions about this report, please call me or Laura Dummit, Associate Director, at (202) 512-7114. Major contributors to this report included Carol Carter, Jean Chung, and James E. Mathews.

A handwritten signature in black ink that reads "William J. Scanlon". The signature is written in a cursive style with a large, prominent initial "W".

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

List of Addressees

The Honorable William V. Roth, Jr.
Chairman
The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Arlen Specter
Chairman
The Honorable Tom Harkin
Ranking Minority Member
Subcommittee on Labor, Health and
Human Services, and Education
Committee on Appropriations
United States Senate

The Honorable Tom Bliley
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

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

The Honorable John Edward Porter
Chairman
The Honorable David R. Obey
Ranking Minority Member
Subcommittee on Labor, Health and
Human Services, Education and
Related Agencies
Committee on Appropriations
House of Representatives

Scope and Methodology

To develop the information for this study, we examined contracts awarded as described in HCFA's Active Projects Reports from 1987 through 1998.¹ We included research projects that were conducted as part of the Home Health Agency Prospective Payment Demonstration and projects that addressed issues related to home health payment, such as quality assurance, case-mix measurement and adjustment, and the relationship between service volume and patient outcome. We excluded home health research projects that did not have direct implications for a payment system (see app. II). We summarized the research and demonstration findings and tabulated the costs of these projects but did not evaluate the scope, methodology, or findings of the projects.

Our analysis of HCFA's proposed PPS was based on the proposed rule² and briefings and discussions with HCFA officials. We also examined the project reports prepared by Abt Associates, Inc., on the case-mix measurement system and followed up on several methodological issues.

¹*Active Projects Report: Research and Demonstrations in Health Care Financing* is produced annually and summarizes active intramural and extramural projects.

²"Medicare Program: Prospective Payment System for Home Health Agencies," Proposed Rule, *Federal Register*, Vol. 64, No. 208 (Oct. 28, 1999).

HCFA Projects to Develop a Prospective Payment System for Home Health Agencies

Project	Expenditures	Description
Home Health Agency Prospective Payment Demonstration		
Implementation of the Home Health Agency Prospective Payment Demonstration. Project No.: 500-90-0024 Contractor: Abt Associates, Inc. Period: 1990-95	\$1,608,319 ^a	This project implemented and monitored the design of phase I of the demonstration. The demonstration tested prospectively set payments per visit by type of discipline (that is, skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services). HHAs that agreed to participate were randomly assigned to either the per-visit prospective payment group or the control group, which was paid according to existing Medicare payment rules. HHAs paid on a per-visit basis shared the financial risks and rewards with Medicare—agencies were reimbursed for any losses greater than 5 percent of their Medicare-allowable costs and gave back any profits greater than 5 percent of that amount. Forty-seven agencies participated in the demonstration for 3 years.
Evaluation of the Home Health Prospective Payment Demonstration Project No.: 500-90-0047 Contractor: Mathematica Policy Research, Inc. Period: 1990-95	\$3,406,668 ^a	This project evaluated the results of phase I of the demonstration. The findings indicated that a per-visit PPS had no significant effect on quality of care, selection and retention of patients, cost per visit, visit volume, use of non-Medicare services, and use and reimbursement of Medicare-covered services.
Quality Review for Phase I of the Home Health Agency Prospective Payment Demonstration Project No.: 500-91-0096 Contractor: New England Research Institute, Inc. Period: 1991-94	\$1,499,085 ^a	This project reviewed the quality of care provided by HHAs participating in phase I of the demonstration. Nurses reviewed patient records for a sample of Medicare beneficiaries. They found that quality of care was unaffected by per-visit prospective payment. Patient access to care was also unaffected by the payment method. Patients treated by agencies paid on a per-visit basis were generally similar to patients treated by control agencies.
Phase II Implementation of the Home Health Agency Prospective Payment Demonstration Project No.: 500-95-0011 Contractor: Abt Associates, Inc. Period: 1995-2000	\$1,811,184 ^b	This project, implementing and monitoring phase II of the demonstration, tests a per-episode prospective payment approach. Agencies are paid a prospective amount for a patient's first 120 days of care and a per-visit amount for subsequent care during the episode. Payment rates are based on each agency's costs in a base year. Loss protection and profit-sharing provisions mitigate the financial risks for participating agencies. Ninety-one agencies from 5 states—CA, FL, IL, MA, and TX—were randomly assigned to either the prospective payment or the control group. At the participating agencies' request, phase II has been extended until the HHA PPS is implemented in October 2000.

Continued

**Appendix II
HCFA Projects to Develop a Prospective
Payment System for Home Health Agencies**

Project	Expenditures	Description
Evaluation of Phase II of the Home Health Agency Prospective Payment Demonstration Project No.: 500-94-0062 Contractor: Mathematica Policy Research, Inc. Period: 1994-99	\$3,732,642 ^b	This program evaluation addresses two key issues relating to a per-episode payment system: program impact and HHA decisions and operations. The evaluation estimates the effect of the demonstration PPS on cost, service use, access, and quality. Evaluation results to date are based on first-year data from 51,000 home health episodes from 85 demonstration agencies. On average, the cost per episode was lower in PPS HHAs by \$419, or 13 percent; however, the cost per visit was higher than in the control HHAs. The number of visits in the 120-day period was 17 percent lower for patients in PPS agencies, and there was little change in the proportion of visits across health disciplines. The average length of episodes under the PPS decreased by 15 percent. The evidence suggests that there were no increases in the use of other health care services and that patient outcomes were not compromised.
Quality Assurance for Phase II of the Home Health Agency Prospective Payment Demonstration Project No.: 500-95-0028 Contractor: Center for Health Policy Research Period: 1995-2000	\$2,799,265 ^b	This project provides for the development and implementation of a quality review mechanism for use by HHAs participating in phase II of the demonstration. All participating agencies are required to collect patient status data at prescribed intervals. Data on patient outcomes are provided to individual agencies that, in turn, may use this information to make adjustments to treatment protocols. In addition, the project will compare patient outcomes for PPS and control agencies.
Subtotal	\$14,857,163	
Related research projects		
Develop and Demonstrate a Method for Classifying Home Health Patients to Predict Resource Requirements and to Measure Outcomes Project No.: 17-C-98983/3 Contractor: Georgetown University School of Nursing Period: 1987-91	\$967,836 ^a	This project developed a method for classifying patients to predict resource requirements and measure treatment outcomes of Medicare patients in HHAs. Data on 73 variables were collected from the medical records of about 9,000 recently discharged Medicare home health patients. The analysis indicated that home health care was primarily provided to a white, suburban, young-elderly population. Less advantaged and higher-risk patients were more likely to receive care in nursing homes. Findings on resource use suggested that nursing diagnoses and nursing interventions were better predictors of home health utilization than were functional status or medical diagnosis.
Analysis of Home Health Costs and Service Utilization Issues Project No.: 99-C-99169/5 Contractor: University of Minnesota Research Center Period: 1991-92	\$189,607 ^c	This project synthesized the research literature on prospective payment and examined outlier cases and possible volume adjustments using Medicare claims. Findings suggested that a 120-day home health episode was appropriate for the demonstration. The study also found significant regional variation in the average length of episodes. This study helped shape phase II of the Home Health Agency Prospective Payment Demonstration.
Development of Outcome-Based Quality Measures for Home Health Services Project No.: 500-88-0054 Contractor: Center for Health Policy Research Period: 1988-94	\$2,699,298 ^a	This project developed and tested outcome-based measures or indicators of quality for Medicare home health services. Outcomes were developed according to different types of patient care needs defined by patient condition taxonomy termed Quality Indicator Groups. Using longitudinal data collected on about 3,000 patients, the investigators tested the reliability, validity, and utility of each outcome measure.

Continued from Previous Page

**Appendix II
HCFA Projects to Develop a Prospective
Payment System for Home Health Agencies**

Project	Expenditures	Description
Regional Variation in Home Health Episode Length and Number of Visits per Episode Project No.: 500-89-0047/38 Contractor: Lewin/VHI, Inc. Period: 1993-94	\$168,600 ^c	This study addressed regional differences in the utilization of home health services. The authors examined factors such as patient characteristics, supply of home health agencies and staff, and availability of alternatives to home health care across high-use regions and low-use regions. In the highest-use regions, HHAs served very frail patients who may not have access to alternative sources of care and few resources to purchase those available. By contrast, agencies in low-use regions served much less frail and less chronically ill patients who may have better access to alternative sources of care.
Sources of Medicare Home Health Expenditure Growth: Implications for Control Options Project No.: 17-C-90107/1 Contractor: Brandeis University/Heller Graduate School Period: 1992-95	\$385,764 ^a	The objective of this project was to develop and consider options for controlling home health expenditures. The first phase of the project used secondary data to examine the composition of the Medicare home health expenditures from 1985 to 1989 and 1989 to 1991 (that is, growth in number of people served, visits per person, mix of visits, and visit charges; and attributing growth to types of agencies by auspice and scale). The second phase examined data from the Regional Home Health Intermediary database to measure variation in types of patients served. Results indicated that the rise in home health expenditures was primarily driven by an increase in the number of home health visits received per patient.
Design and Implementation of Medicare Home Health Quality Assurance Demonstration Project No.: 500-94-0054 Contractor: Center for Health Policy Research Period: 1994-99	\$3,234,881 ^b	This demonstration is to develop outcome-oriented quality assurance measures and promote continuous quality improvement in HHAs. It is designed to serve two purposes: to increase HCFA's capacity to assess the quality of Medicare home health care services and to improve HHAs' outcomes. The quality assurance approach would complement existing home health certification and review programs and could be used with current survey and certification approaches. The study's conceptual framework is based on home health outcome measures developed under the HCFA-funded study entitled "Development of Outcome-Based Quality Measures in Home Health Services."
Maximizing the Cost Effectiveness of Home Health Care: The Influence of Service Volume and Integration With Other Care Settings on Patient Outcomes Project No.: 17-C-90435/8 Contractor: Center for Health Policy Research Period: 1994-99	\$1,496,245 ^b	This study examines the relationship between the volume of home health services provided by HHAs and patient outcomes. The study will determine whether upper- and lower-volume thresholds exist that can be used to define the range of services most beneficial to patients. In addition, the study will test whether it is possible to improve patient care and control costs by strengthening the role of the physician and better integrating home health care with other services during an episode of care. Interim findings have not been released.

Continued from Previous Page

Appendix II
HCFA Projects to Develop a Prospective
Payment System for Home Health Agencies

Project	Expenditures	Description
Case-Mix Adjustment for a National Home Health Prospective Payment System Project No.: 500-96-0003/02 Contractor: Abt Associates, Inc. Period: 1996-99	\$2,966,524 ^b	This project will develop a case-mix classification system for the national home health PPS. The resulting case-mix system will be based on serial 60-day episodes. The Outcome and Assessment Information Set (OASIS), which was developed for outcome-based quality assurance and improvement for Medicare HHAs, will be examined to determine whether the data elements can be used to construct a case-mix classification system. Significant features of this project include its measurement of resource use and emphasis on easily understandable patient groupings.
Subtotal	\$12,108,755	
Total	\$26,965,918	

Continued from Previous Page

^aAmount represents actual expenditures.

^bAmount represents amount allocated for an ongoing project.

^cNumber represents amount allocated for project. HCFA could not provide actual expenditures for this project.

Sources: *Active Projects Report: Research and Demonstrations in Health Care Financing* (1987-98); *Report to the Congress from the Secretary of Health and Human Services* (Washington, D.C.: Jan. 4, 1999); and discussions with HCFA officials.

Comments From the Health Care Financing Administration



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: MAR -9 2000

TO: Laura Dummit
Associate Director
Health Financing and Public Health Issues
General Accounting Office (GAO)

FROM: Nancy-Ann Min DeParle *Nancy-Ann DeParle*
Administrator
Health Care Financing Administration (HCFA)

SUBJECT: GAO Draft Report: "Medicare Home Health Care: Prospective Payment System Will Need Refinement as Data Become Available"
GAO/HEHS/00-09

Thank you for the opportunity to review the above-referenced report.

Home health care is an important benefit that enables Medicare beneficiaries to receive many services in their homes as covered under Medicare. HCFA is committed to protecting this critical benefit for those who qualify for it. The home health prospective payment system (PPS) will help strengthen this benefit for Medicare beneficiaries by appropriately paying home health agencies (HHAs) according to the health condition and care needs of each beneficiary.

In the Balanced Budget Act of 1997 (BBA), Congress significantly reformed the payment system and other rules for HHAs. The BBA eliminated cost-based reimbursement that encouraged agencies to provide more visits and to increase costs up to the set limits. As a first step toward giving HHAs incentives to refocus their efforts on providing care efficiently, this older system was replaced by the interim payment system. This interim system is to operate until the PPS is developed and implemented on October 1, 2000.

HCFA believes it is imperative --for both HHAs and the beneficiaries they serve-- that the home health PPS be implemented on October 1, 2000, as Congress has directed. Payments to agencies must be adjusted to reflect patient acuity and resource needs quickly --something that can only be done under the PPS. At the same time, we share the GAO's concerns that HCFA must be alert and respond to possible unintended consequences of the PPS. As you will read below and in the attachment, HCFA has taken steps to address these important concerns.

**Appendix III
Comments From the Health Care Financing
Administration**

The home health PPS is the product of over ten years of research on case mix and HHA payment issues. Even prior to the passage of the BBA, HCFA used numerous demonstration projects and worked with outside research organizations, such as Mathematica Policy Research, to help lay the groundwork for PPS. Although work on home health PPS has intensified since the passage of BBA, HCFA agrees with the GAO that research should continue. That is why HCFA concurs with GAO's recommendation that the home health PPS (like all new prospective payment systems) must be closely monitored and refined based on experience and the findings of future research. This is critical for protecting beneficiaries, agencies, and the Medicare Trust Fund. HCFA has taken, and will continue to take, actions to ensure that beneficiaries have access to the quality home health care guaranteed to them under Medicare.

As you will see in the attached response, HCFA is continuing to build on these earlier research activities. In fact, consistent with the GAO's recommendation, HCFA has already developed plans to pursue on-going research and refinements to the home health PPS. This will include intensive monitoring of PPS claims, payments, cost report data, and quality/outcome data from the Outcome and Assessment and Information Set (OASIS) system. HCFA will also conduct additional research, both internally and with Abt Associates, on case mix. This aggressive monitoring effort, coupled with the research effort, will serve as the basis for future improvements that HCFA will make to the PPS. HCFA has also taken steps to ensure that beneficiaries are protected from the major risk inherent in all PPS systems --underutilization-- and to ensure that all HHAs are paid appropriately for the services provided.

In the report, the GAO also recommends that the final rule contain a risk sharing provision in order to help protect beneficiaries and HHAs from unintended consequences caused by the PPS. As mentioned earlier, we share the GAO's concerns for beneficiaries and HHAs. Therefore, in addition to the commitment to conduct further research and implement adjustments to the PPS as needed, HCFA has proposed features in the PPS that would help protect beneficiaries and HHAs as the GAO recommends. Some of these proposed features include the following:

- *Case mix* system that would provide higher payments for high care need patients;
- *Unlimited episodes* that would aid agencies that care for beneficiaries with longer term needs (agencies will be able to receive as many as 7 episode payments for a beneficiary who is cared for throughout a year with no limit on program payment);
- *Outlier payment system* for extraordinarily costly patients; and,
- *Significant Change in Condition (SCIC) feature* that would permit an HHA to receive higher or lower payments when a beneficiary's condition changes substantially.

At this point, HCFA is concerned that implementation of a proposal such as risk sharing would complicate, and delay beyond the statutory deadline, the implementation of the home health PPS. Beyond consideration of the significant activities that would need to be completed in order to implement the proposal (development of regulations and

**Appendix III
Comments From the Health Care Financing
Administration**

computer systems programming), HCFA is also concerned that substantive policy barriers exist. As explained in detail in the attachment, it is questionable whether meeting the statute's budget neutrality requirement under risk sharing would be achievable. This is because HCFA would need precise estimates of how much each agency gains or loses under PPS in order to determine whether the standardized payment amount would need to be reduced. The new system would also be less predictable for providers under risk sharing.

The GAO report on the proposed home health PPS accurately captures the salient information about the background of the home health benefit, the HCFA's research, and the features of the proposed PPS. HCFA is looking forward to continuing our work with the GAO on this critical payment issue. Again, thank you for the opportunity to comment on this thoughtful and detailed report.

Attachment

**Comments of the Health Care Financing Administration (HCFA) on
General Accounting Office (GAO) Draft Report:
“Medicare Home Health Care: Prospective Payment System Will Need Refinement
as Data Become Available”
GAO/HEHS/00-09**

Home health care is an important benefit that enables Medicare beneficiaries to receive many services in their homes as covered under Medicare. We are committed to protecting this critical benefit for those who qualify for it.

The home health prospective payment system (PPS) will strengthen the home health benefit for Medicare beneficiaries by appropriately paying home health agencies (HHAs) according to the health condition and care needs of each beneficiary. The purpose of PPS is to create incentives for providers to give appropriate care in the most efficient manner. Of course, we must closely monitor to make sure that underutilization does not occur and that unnecessary payments are precluded. More specifically, under the proposed system:

- Medicare would pay HHAs for each covered 60-day episode of care. Beneficiaries would receive as many episodes of care as they need.
- Medicare would make reimbursements more fair than the interim system by paying HHAs to provide care according to the health condition and needs of each beneficiary. Nurses and other clinical workers at Medicare-certified agencies already use a standardized tool to assess the care needs of patients. Payment rates would be based on relevant data from the assessment. Agencies would be paid at a higher rate to care for those beneficiaries with greater needs.
- To help adjust payments for risk, the new system would provide additional payments for an individual beneficiary if the costs of care were significantly higher than the specified payment rate. These “outlier” payments would account for the unusual needs of specific beneficiaries.
- Medicare would require agencies to provide at least five visits to beneficiaries to receive the full payment for each Medicare-covered episode of care. For fewer visits, Medicare would rely on a different methodology to ensure appropriate payments.

Recommendation One

Ensure that adequate resources are devoted to utilization monitoring and medical review to ensure that Medicare does not make inappropriate payments for home health services, and that quality of care is not compromised.

Response

We concur. As with all new prospective payment systems, it is absolutely essential for HCFA to monitor payment and to conduct utilization review of the services provided under the home health PPS. This is needed to ensure that intermediaries are properly administering, and agencies are adapting to, the new system. Close monitoring is also needed so that the impact of the new system on beneficiaries and agencies can be assessed quickly and accurately. This is critical to ensure that problems are addressed in a timely manner.

As a result, HCFA is taking a number of steps to: 1) ensure that data reporting is accurate and payment amounts are appropriate, and 2) provide quick feedback on outcomes and impacts for use in possible refinements. These steps include:

- Using the Outcome and Assessment and Information Set (OASIS) to gather information;
- Conducting medical review of claims; and,
- Creating an aggressive surveillance system to assess impacts in the short term and long term.

OASIS

OASIS is a critical patient assessment tool in ensuring that the data reporting and payments are accurate and that HHA services address properly the identified needs of patients. Last year, HCFA required agencies to complete OASIS and report the data to state agencies. We are very pleased with the high degree of compliance among agencies. State survey agencies have identified HHAs that were not meeting the OASIS requirements and have engaged in educational efforts to obtain a higher degree of reporting. HCFA has also conducted a substantial outreach campaign to the home health industry on OASIS; we are now moving into an environment where sanctions for non-collection and non-reporting will be applied.

To ensure the integrity of the OASIS data, we have contracted with Abt Associates to develop protocols that can help assess the accuracy of these data. Survey agencies will be able to apply these protocols in conducting surveys of HHAs. At the same time, however, we believe that we need an ongoing, system-wide monitoring effort to ensure that OASIS data, as a whole, are accurate and that individual providers are reporting OASIS data accurately. As a result, we are developing a task order for competition among the entities on our schedule of program safeguards contractors to conduct this monitoring. The

2

**Appendix III
Comments From the Health Care Financing
Administration**

selected program safeguard contractor will conduct random, statistically valid assessments of OASIS reporting to ensure that the data are reported accurately. This contractor will also perform such assessments for selected agencies that are identified for medical reviews by fiscal intermediaries. The Home Health Outcome Based Quality Improvement (OBQI) System is being implemented as a pilot project in five states through the Peer Review Organization (PRO) program. The OBQI System will explore the feasibility of providing assistance to HHAs in their efforts to implement and manage new programs for quality improvement.

We will use all of this information as part of our through analysis of the impact of the PPS on beneficiaries and HHAs.

Conducting Medical Review

As with the Skilled Nursing Facility (SNF) PPS, HCFA's primary approach to safeguarding payment and ensuring the accuracy of payments under the home health PPS will be to conduct random review of claims at the start of the payment system. HCFA will be able to better assess, through random review, where payment errors are occurring and what responses are appropriate. We will be instructing contractors to conduct sufficient random reviews in the first quarter of the new PPS system to provide robust feedback to us and to the provider community on common errors, vulnerabilities, and trends.

We have developed a matrix outlining where possible payment vulnerabilities may occur under the new system. This will enable HCFA to test the results of our review in the first quarter against our theories of what may occur. It will also serve to educate the provider community on where to conduct special assessments within their own operations to ensure compliance.

Aggressive Monitoring and Analysis Effort

At the same time, HCFA must expand monitoring beyond the already substantial challenges of ensuring that data and payments are accurate. This will involve building a surveillance system to assess impact of home health in the short and long term. To accomplish this, we plan to conduct intensive monitoring of OASIS data, combined with other monitoring systems. Our surveillance system will include the following action steps.

- *Analyzing data regarding home health payment data gathered from HCFA's PULSE system.* The PULSE system, developed during HCFA's successful effort to address the Y2K problem, provides real time data to HCFA on the number of claims processed

**Appendix III
Comments From the Health Care Financing
Administration**

by the Regional Home Health Intermediaries (RHHIs) and also the payments made by the RHHIs. Therefore, on an ongoing basis, HCFA should be able to detect significant changes in the volume of claims.

- *Gathering additional information from the home health industry.* HCFA will collect data from our regional offices regarding a targeted group of at least 100 HHAs. HCFA will identify at least ten agencies in each of our ten regions, representing rural, suburban, urban, non-profit, for-profit agencies, to partner with HCFA in providing feedback on their operations and experience under PPS. We will ask for their cooperation in providing us information from beneficiaries receiving services or discharged from those agencies.
- *Developing operational analysis capacity to look across Medicare+Choice plans, providers, and physicians to evaluate the impact of payment system changes.* HCFA's Center for Health Plans and Providers (CHPP) will use the standard Medicare data that is available, as well as other information sources such as PULSE and the State Health Insurance Programs (SHIPs), to gain a better understanding of the impact of PPS on HHAs and beneficiaries. The goal will be to have an analytic focal point with the responsibility for analyzing a wide variety of data, including those related to home health PPS. HCFA will analyze the home health claims data and cost report data when it becomes available. (It should be noted that cost report data will not be available for at least two years after the implementation of PPS.)
- *Creating a workgroup chaired by the Executive Associate Administrator to review data regarding home health PPS.* Using all data available, information will be accumulated and reviewed by senior HCFA officials responsible for quality, integrity, payment, beneficiary affairs, and claims processing. Senior HCFA staff will meet at least monthly following the implementation of PPS and take any appropriate actions needed to ensure access and quality of care under the PPS and to help monitor the accessibility of services to patients.

Generally, we believe that the issues raised in the report are ones that can be effectively addressed after gaining program experience based on appropriate monitoring efforts. We expect that implementation and operation of the system will produce national utilization data, as well as OASIS data, that will enable us to fine-tune our patient classification system and other policies. We also expect that our initial medical review efforts will moderate some of the incentives noted in the report and will reveal the need for other reviews and edits. These are all actions that should occur in the natural course of program implementation and refinement. We believe that it is this process that should be used to address any unintended consequences that may be identified in implementation.

4

Recommendation Two

Incorporate a risk-sharing arrangement into the PPS design, consistent with the methods tested in the demonstration, until available analyses indicate that it is no longer needed to protect beneficiaries, home health agencies, or the Medicare program from unintended consequences of the PPS.

Response

HCFA shares your concerns regarding the unforeseen consequences that may affect beneficiaries and agencies. That is why, as discussed in the GAO report, the home health PPS would incorporate several features that protect beneficiaries from the risk that is inherent in all prospective payment systems, namely under-service, by providing appropriate payment to agencies.

We believe that this home health PPS, which was published in a proposed rule in November 1999 and is being revised to reflect comments received, would be vastly superior to the interim payment system currently in effect. The most important features in the proposed system that would help ensure appropriate payment would be the:

- *Case mix* system that would provide higher payments for high care need patients;
- *Unlimited episodes* that would aid agencies that care for beneficiaries with longer term needs (agencies will be able to receive as many as 7 episode payments for a beneficiary who is cared for throughout a year with no limit on program payment);
- *Outlier payment system* for extraordinarily costly patients; and,
- *Significant Change in Condition (SCIC) feature* would permit an HHA to receive higher or lower payments when a beneficiary's condition changes substantially.

As already noted, HCFA will aggressively monitor the effects of the PPS, and HCFA is committed to making refinements to the system as soon as warranted (as discussed in our response to Recommendations 1 and 3.) While risk sharing, as discussed in your recommendation, is one method to address any unintended consequences of a new payment system, we believe that the combination of payment adjustments in the PPS coupled with the aggressive monitoring and commitment to refinement will enable us to address problems that arise.

At this point, HCFA is concerned that implementation of a proposal such as risk sharing could complicate, and delay, implementation of the home health PPS. HCFA is finalizing the final rule as a result of the comments received on the proposed rule, and HCFA is conducting extensive computer programming and testing for the PPS, as well as preparing instructions for the contractors on implementing PPS. The final rule must be published by August 1, 2000 in order to meet the statutory deadlines for implementing PPS. A shift to risk sharing would likely delay publication of the final rule and thus the implementation of the PPS beyond the statutory deadline.

5

There are other operational concerns. A payment system that embodied the suggested adjustments would be more costly and complex to administer than the cost reimbursement system has been. This is true not only for HCFA, but for HHAs as well because it requires extensive comparisons between costs and revenues. Such a system would also be less predictable for providers because HCFA would still be forced to conduct extensive audits of cost reports before allowable costs could be determined.

Risk sharing would require blending a provider-specific, cost-based system with the very different per episode PPS. Achieving the statute's budget neutrality requirement under risk sharing would be extremely difficult. This is because HCFA would need precise estimates of how much each agency gains or loses under PPS in order to determine whether the standardized payment amount would need to be reduced. For example, risk sharing could provide perverse incentives for agencies to increase costs so as not to be too profitable or to increase costs to assure risk sharing payments. These incentives would have to be factored into the estimate of budget neutrality. Thus, under a blended system, determination of budget neutrality is much more difficult. As such, we believe that the risks of not meeting budget neutrality are greater than under PPS.

Another method to mitigate the effects of a new payment system would be to create a transition period and phase the new system in over time. A transition that would blend reasonable costs paid and an estimated per visit amount with a 60-day episode payment would be difficult to operationalize. In our proposed rule, we did not propose the transition option given significant concerns about continuing with the interim payment system. Further, given the adverse impacts of the interim payment system on many HHAs, commenters did not support a transition that would continue payments partly on the basis of the interim system while also reducing the gains from the new PPS system.

Recommendation Three

Modify the PPS design as appropriate, based on continued study of the variations in service use and patient needs and the effects of the change in payments method on service used.

Response

We concur. Key in implementing and maintaining any prospective payment system is ongoing refinement as indicated by ongoing research into all aspects of the new payment system. HCFA is absolutely committed to refining the home health PPS in the future as we have done in the development of the other prospective payment systems, such as inpatient hospital PPS, and are currently doing for SNF PPS.

We have begun to put in place some of the structure to support future refinement. Our monitoring efforts will greatly assist in the refinement process. In an extension of the contract with Abt Associates under which the case mix system was developed, we will be undertaking a comprehensive reexamination of the case mix system using the latest data. We will also explore the accuracy of the 15-minute increment billing data and determine its relevance for future refinements to group weights. HCFA will also examine superimposing a diagnostic structure on the groupings to see if it is feasible and provides greater certainty as to the accuracy of the payments.

General Comments

Case Mix

The report questions the inclusion of therapy treatments in the case mix adjustment noting that it can be manipulated by an agency. We included therapy treatment because therapy services are an important and expensive component of home care. The predictive power of therapy services is so great that to leave it out, would be to ignore both its strong predictive power and the fact that the nursing/therapy dichotomy is at the heart of home care. That is, home health patients are likely to fall into two groups – those who need significant amounts of therapy and those who do not. If the home health PPS did not pay more for therapy than for non-therapy cases, then HHAs would have an incentive to not provide therapy in the home to Medicare beneficiaries. We understand the concerns raised by the GAO that this could be subject to gaming. As a result, it is an area that will be the focus of audit and review once the system is implemented.

Another concern raised by the report was that the resource use of long-term home health patients may not be adequately accounted for the by case-mix adjustment method because of the lesser use of therapy by long-term users. While this is an area that we will examine with an eye toward future refinement, we believe that agencies will benefit greatly from the PPS over the current system. Long-term users of home health services will be able to receive unlimited 60-day episodes. This means that an agency will be able to receive up to seven episode payments a year for those beneficiaries that continue to receive home care. In addition, to the extent the beneficiary's resource needs change from episode to episode, that will be reflected by their assignment to different home health resource groups as they are reassessed.

60-Day Episodes

The report questions the appropriateness of the 60-day payment unit for patients with shorter lengths of stay. We believe that in many cases, no one knows in advance how short or long a beneficiary's home health episode will be. While some patients will recover and be discharged well before the 60 days, other, apparently similar patients, will

remain under the agency's care for nearly the full 60-day period and offset the savings achieved by the early discharges. The 60-day episode has a number of features that make it an attractive period of time to use. First, it is the time period that agencies have traditionally used for care planning purposes and it is the time period established for the preparation of OASIS reports. Moreover, our demonstration showed that more than 60 percent of the cases received all their care within an episode. We believed that choosing a shorter period would weaken the concept of an "episode" and that a longer episode, based on the behavior change in the PPS demonstration, would result in overpayment for the majority (60 percent) of episodes and would increase administrative burdens.

Historical Utilization

We believe the report should acknowledge more clearly that the historical utilization of Medicare home health services cannot be taken as a benchmark of appropriateness of care. This report cites some of the historical variation between geographic areas and this variation has also been seen within geographic areas. GAO's past reports and reports of the Department of Health and Human Services Inspector General have indicated that much of the variation can be explained by factors such as whether the agency is proprietary or non-profit or the relative comprehensiveness of the State's Medicaid program. Epidemiological factors, while relevant to some extent, account for only a small degree of the variation. Both GAO and the Inspector General have also reported that a large number of the services for which payment was made were not covered under Medicare's rules. In a 1997 study, the Inspector General found that up to 40 percent of the services provided in the states studied should not have been covered. The Administration's efforts to combat waste, fraud and abuse appear to be fruitful - last November, the Inspector General issued a report showing that these improper home health payments had been cut in half.

Low Utilization Payment Adjustment (LUPA)

The report notes that the LUPA gives agencies a strong financial incentive to provide beneficiaries with just enough visits to qualify for a full episode payment, and thus could increase the number of episodes. We agree with this observation and the rule will contain a behavioral offset to ensure overall payments do not increase as a result of this incentive. Further, this will be a payment area that we will monitor closely once PPS is implemented and if changes are warranted will propose them as part of our on-going refinement effort.

**Appendix III
Comments From the Health Care Financing
Administration**

Technical Comment

OASIS and 15-Minute Increment

The report implies that OASIS and the 15-minute reporting requirement for HHAs is related to home health PPS. OASIS reporting began as an assessment requirement; it was joined with PPS only after the BBA required PPS and our research determined OASIS' usefulness for case mix. The 15-minute reporting requirement came from a Balanced Budget Act of 1997 provision and was not necessary for the PPS. At this point, HCFA plans to study the 15-minute increment information; if it provides useful information for PPS, then HCFA may incorporate it into a later refinement of PPS.

Ordering Information

The first copy of each GAO report is free. Additional copies of reports are \$2 each. A check or money order should be made out to the Superintendent of Documents. VISA and MasterCard credit cards are accepted, also.

Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

Orders by visiting:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders by phone:

(202) 512-6000
fax: (202) 512-6061
TDD (202) 512-2537

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

Orders by Internet:

For information on how to access GAO reports on the Internet, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web home page at:

<http://www.gao.gov>

To Report Fraud, Waste, or Abuse in Federal Programs

Contact one:

- Web site: <http://www.gao.gov/fraudnet/fraudnet.htm>
- e-mail: fraudnet@gao.gov
- 1-800-424-5454 (automated answering system)

**United States
General Accounting Office
Washington, D.C. 20548-0001**

**Official Business
Penalty for Private Use \$300**

Address Correction Requested

**Bulk Rate
Postage & Fees Paid
GAO
Permit No. GI00**

