Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HOME HEALTH AGENCIES: ALTERNATIVE COVERAGE AND PAYMENT POLICIES

JUNE GIBBS BROWN
Inspector General

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection is to provide information to Health Care Financing Administration (HCFA) on how selected other payers structure and manage their home health benefit.

BACKGROUND

Title XVIII of the Social Security Act, Section 1861, authorizes Medicare payments for home health services under certain conditions. The care must be provided by certified home health agencies (HHAs), which may be either freestanding or facility-based. The Medicare home health benefit coverage includes the following items and services: 1) part-time or intermittent nursing care; 2) physical, occupational, or speech therapy; 3) medical social services; 4) part-time or intermittent services of a home health aide; and 5) medical supplies other than drugs and biological.

The HCFA has convened a task force to examine its home health benefit. One of the reasons for this examination is the significant increase in expenditures in this category of service. Between 1988 and 1992, they rose from $2.3 billion to $7.1 billion. During this time, the number of Medicare beneficiaries who used these services increased almost 65 percent. The number of services per beneficiary also increased by the same amount.

We selected twenty three payers of home health services. Our final list include fifteen respondents; three Medicaid agencies; five private insurance companies; five Health Maintenance Organizations; the Department of Veterans Affairs (DVA); and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). We conducted telephone interviews with each of the fifteen respondents using a focused discussion guide.

We asked each private payer to describe their policies as a general matter and to reflect in their responses what constituted the "rule," rather than the "exception." Each offers many different products, and their policies can and do differ among their insured population.

FINDINGS

Home Health Benefits in Other Health Plans are Generally Structured Similar to Medicare's

Other payers are similar to Medicare in their criteria for eligibility; requirements placed on home health agencies; services covered under their basic home health benefit; quality monitoring processes and how they pay providers.

Other Plans Approaches to Controlling Home Health Expenditures are Different from Medicare's

Other payers differ from Medicare in setting limits on home health benefits or moving more intensive and special needs patients to targeted programs; and in their utilization control mechanisms.

POINTS OF FURTHER ANALYSIS

The practices of other payers could provide potential ideas for reforming or managing Medicare's home health benefit. We believe that HCFA might study the merits of some of these approaches as it determines how best to control utilization and expenditures while assuring the appropriate delivery of high quality care to Medicare beneficiaries. Among those approaches which might hold promise for Medicare are:

- **Targeting Needs.** Rather than a "one size fits all" home health benefit, Medicare might wish to channel different patients into different home health "programs" where the benefit could better conform to different patient needs and program management. In addition, controls could be designed more effectively.

- **Case Management.** Case managers might be particularly appropriate for certain classes of beneficiaries who are expected to require services over a specified period of time (e.g. patients with chronic care needs).

- **Beneficiary Participation.** The use of Explanation of Benefits (EOBs) (perhaps on a monthly basis to avoid unnecessary administrative burden) and imposition of copayments, previously proposed in various legislative initiatives are avenues to increase the beneficiary's stake in their own health care and identify potential overutilization, abuse or quality problems.

- **Limitations on Coverage.** Caps on number of visits allowed each year, or some other kinds of limitations, would not only be consistent with the policies of some other payers but also with Medicare's own policies with regard to skilled nursing care, hospital benefits, and other categories of service.

As HCFA considers these ideas, it must struggle with a number of questions, including the impact of such changes on beneficiaries. To assist HCFA in answering some of these important questions, the Office of Inspector General is currently engaged in a home health initiative to examine payments made to home health agencies on behalf on Medicare beneficiaries. This initiative involves the OIG's investigations, audit, and evaluation staffs. Among the upcoming products emanating from this initiative are reports on provider audits and validation of claims; the physician's role in home health services; and an overall assessment of payment made to HHAs and the relationship of those payments to HHA characteristics, beneficiary characteristics, and other potentially relevant factors.

COMMENTS ON THE DRAFT REPORT AND OIG RESPONSE

The HCFA indicated that the report would be useful in assessing possible changes to the home health benefit. However, HCFA stated that our report appears to assume that other agencies are more effective than Medicare in controlling costs. Further, HCFA pointed out that there are no data in the report comparing the average number of visits or expenditures per beneficiary. The HCFA speculated that age, health status, and income could explain differences in utilization if they exist, as well as plan characteristics and benefit management.

We appreciate HCFA's comments. We recognize that there are no data in the report comparing the number of visits or expenditures per beneficiary; however, this was beyond the scope of our inquiry. The purpose of this report was to describe how selected payers structure and manage their home health benefit as compared to Medicare. Our analysis indicated that other payers limit the benefit and use a variety of techniques to control utilization more than Medicare. Whether these techniques actually result in lower per capita costs is subject to further analysis. It is clear, however, that other payers have many more opportunities to manage utilization of the benefit and control costs compared to Medicare coverage and payment policies for home agencies.

The full text of HCFA's comments can be found in appendix A.

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INTRODUCTION

PURPOSE

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BACKGROUND

Medicare

Title XVIII of the Social Security Act, Section 1861, authorizes Medicare payments for home health services under certain conditions. The care must be provided by certified home health agencies (HHAs) which may be either freestanding or facility-based. They can be voluntary not-for-profit, proprietary or governmental in nature.

Virtually all Medicare reimbursements for home health care are made under Part A, (hospital insurance). Beneficiaries pay no coinsurance or deductibles for home health care covered under Part A or Part B, except for durable medical equipment (DME) furnished by a home health agency, nor do they receive an Explanation of Medicare Benefits (EOMBs). Home health care may be covered under Part B (supplementary medical insurance) if a beneficiary has only Part B coverage. Claims are submitted to one of nine fiscal intermediaries known as Regional Home Health Intermediaries.

The Medicare home health benefit coverage includes the following items and services:
1) part-time or intermittent nursing care; 2) physical, occupational or speech therapy;
3) medical social services; 4) part-time or intermittent services of a home health aide; and
5) medical supplies other than drugs and biological.

To qualify for home health benefits under either Part A or Part B of Medicare, a beneficiary must: be considered homebound, except to receive services that due to special equipment needs, can not be provided in the patient's home; need care on an intermittent basis; and receive services under a plan of care established and periodically reviewed by a physician. Skilled care includes: skilled nursing services, physical therapy, or speech therapy services. In addition, only after the patient receive one of these qualifying services may he or she then receive the services of an occupational therapist, a medical social worker, or a home health aide. Home health aides provide hands-on personal care of beneficiaries which must be necessary to the treatment of the beneficiary's illness or injury. Home health aide services include: 1) personal care services, 2) simple dressing changes, 3) assistance with some medications, 4) activities to support skilled therapy services, and 4) routine care of prosthetic and orthotic devices. A beneficiary whose sole need is for custodial care does not qualify.

Medicare beneficiaries who are eligible for home health services may receive care as long as it is reasonable and necessary; there are no limits to the number of visits or length of

coverage. Medicare does not require copayments or deductibles for home health care, except for durable medical equipment. In addition, the courts have limited Medicare's ability to deny home health coverage. In the case, Dugan vs. Sullivan, Medicare was instructed that sufficient evidence in the medical record was necessary to deny a claim. This high standard has led to a decrease in home health denials. To ensure that payments for home health services are appropriate, Medicare requires intermediaries to conduct post-payment reviews of home health claims and monitor those providers that appear to have high utilization rates that are unexplainable.

Medicare reimburses home health agencies on a reasonable cost basis (subject to limits) for costs related to visits for patient care. "Visit costs" include all incurred costs related to making the visits such as preparation for the visits, telephone calls, conferences about the patient and maintaining patient records.

The Medicare program addresses the quality of home health services through: annual beneficiary satisfaction surveys, certification requirements for home health agencies, and, agency surveys conducted at least once every 15 months.

The HCFA has convened a task force to examine its home health benefit. One of the reasons for this examination is the significant increase in expenditures. Between 1988 and 1992, they rose from $2.3 billion to $7.1 billion. During this time, the number of Medicare beneficiaries who used these services increased almost 65 percent. The number of services per beneficiary also increased by the same amount.

METHODOLOGY

We selected twenty-three payers of home health services. We made initial telephone calls to verify that those we planned to interview provided such services. Our final list includes fifteen respondents; three Medicaid agencies; five private insurance companies; five Health Maintenance Organizations; the Department of Veterans Affairs (VA); and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). We conducted telephone interviews with each of them using a focused discussion guide and later followed up to collect any missing data.

We asked each private payer to describe their policies as a general matter and to reflect in their responses what constituted the "rule," rather than the "exception." Each offers many different products, and their policies can and do differ among their insured population.

We also collected information from officials in Australia and the province of Ontario, Canada. Because of the basic dissimilarity in health care systems between the United States and these countries, a strict comparison is not useful. Instead, we are providing a description of our discussions with those officials under separate cover to HCFA.

FINDINGS

HOME HEALTH BENEFITS IN OTHER HEALTH PLANS ARE GENERALLY STRUCTURED SIMILAR TO MEDICARE'S

Other payers are similar to Medicare in their criteria for eligibility; the requirements they place on home health agencies, the services covered under their basic home health benefit, their quality monitoring processes, and how they pay providers.

Other Payers Have Similar Eligibility Requirements to Medicare.

Medicare's requirements for eligibility are similar to those used by the private payers we interviewed, as demonstrated below.

CONDITIONS OF COVERAGE FOR HOME HEALTH BENEFIT
Medicare and Private Payers

	MEDICARE	PRIVATE PAYERS (Total = 10)
Homebound	X	6
Prior Hospitalization		1
Require Skilled Care	X	9
Intermittent Care	X	9

Like Medicare, six of the ten private payers have a homebound requirement. The four private payers who do have some requirement that patients be confined to the home, also consider different patient needs and circumstances when making coverage decisions. For example, patients with AIDS may be employed full-time and still receive home health care benefits.

Similarly, nine of the ten private insurers do not require prior hospitalization in order to receive home health benefits. These same nine private payers require that skilled care be needed as a precondition for receiving other home health services.

One plan mandates that a completed home health care plan be completed within seven days following the end of a hospital confinement, and that the care be for the same or related condition which caused the hospitalization. Rather than having an explicit skilled care requirement, this plan requires that the physician certify that, in the absence of the home health care services, the proper treatment of the injury or illness would require continued hospitalization.

All but one of the private payers require that care be provided to patients on an intermittent basis.

The three Medicaid programs we interviewed have slightly less restrictive eligibility requirements. Two of the three do not require that patients need skilled care or rehabilitative therapy in order to receive the benefit, nor do they have a strict homebound requirement.

The U.S. Department of Veterans Affairs (VA) and CHAMPUS are also slightly less restrictive than Medicare. Unlike Medicare, they do not require that patients be homebound in order to be eligible for home health services. The VA does not set an explicit "intermittent" standard for its beneficiaries; care may be authorized as long as it is necessary or appropriate for effective and economical treatment. The VA allows care to be provided on a daily basis as long as the total costs in one month do not exceed the costs that would have been incurred in an institution. The CHAMPUS program does require the care be intermittent to qualify for its basic home health benefit. Both programs require that patients need skilled care in order to be covered.

Other Payers Place Similar Requirements on Home Health Agencies for Care to be Covered.

All of the private payers require a formal plan of care established for the home health care patients. Most payers use plans of care similar to Medicare's, though there are some variations. One indemnity plan, for example, uses a formal plan of care for catastrophic cases only.

All three Medicaid agencies require use of a formal plan of care which must be ordered and signed by a physician.

The VA requires a physician's statement be completed in order for care to be authorized. Such a statement must include the specific medical services required, the duration authorized, frequency of visits by providers, and estimated total monthly costs of providing home health services. The VA's physicians (either employed by the VA hospital or with staff privileges) are responsible for ordering the care and following the patient's progress. Similarly, CHAMPUS requires that services be ordered by a physician and have a treatment plan describing the frequency and duration of therapies, procedures and medication, and the prognosis for the patient.

Most payers require that HHAs be Medicare-certified, or accredited in lieu of certification, in order to receive payment.

Benefit Packages Offered by Other Payers are Similar to Medicare's.

Generally, services covered by other payers as part of their basic benefit packages are similar to Medicare's, including coverage of skilled nursing care, therapy services, and aide services. Only two differences emerged:

- A number of other payers also offer a drug benefit in conjunction with their home health benefit or as a general benefit in their insurance program. The availability of this benefit in the private market might vary from employer to employer. For Medicaid, prescription drug coverage is an optional offering but is currently included in all State Medicaid programs.

- The VA does not cover aide services as part of its basic home health benefit, which is limited to medical services. The VA has determined that homemaker, domestic-type services (such as house cleaning, meal preparing, companion) are not medical services and cannot be authorized under its home health program. Veterans may qualify for another program which would provide those services.

Like Medicare, other payers rely on beneficiary surveys, complaint programs and provider audits and reviews to ensure quality; none reported using outcome measures.

Like Medicare, most of the private payers' beneficiary surveys are conducted as part of a larger satisfaction survey on all services covered and not specifically on home health services. The HMOs, in particular, emphasized this practice, reporting that they conduct such surveys several times a year. Indemnity plans vary more in their use of beneficiary surveys. One plan conducts quarterly surveys; two other plans survey only when there is a case manager involved; another does not survey beneficiaries at all. Many payers also reported using various types of internal audits, complaint monitoring programs, and provider reviews, as a means of ensuring that necessary services are rendered and beneficiary abuse does not occur.

The VA also conducts surveys to monitor beneficiary satisfaction with all covered services. In addition, VA medical centers have quality assessment committees which sample patients from their outpatient centers to ask them about the care they receive.

Although we asked about the use of outcome measures, none of the payers report using these to measure the quality of home health services. A few report they are developing some measures for future use.

Like Medicare, Most Other Payers Reimburse Providers on a Per Service Basis; HMOs Use a Capitated Approach

All of the private indemnity plans pay for services by visit or by hour depending on the service. Payers often negotiate rates with home health agencies using the Medicare fee schedule as the basis for negotiation. Rates frequently are determined locally, taking cost-of-living and other local factors into consideration. One plan pays a flat $40 per visit with a visit defined as an eight-hour shift from a nurse or aide, one therapy session, or one social worker visit.

The HMOs negotiate capitated rates with home health agencies. One common practice is to negotiate a capitated rate for nurses and home health aides and hourly payments for therapists

or other services. Under this scenario, HMOs pay agencies a flat sum per enrollee with agencies providing all necessary nursing and aide care to enrollees as needed. Rates are established based on prior payments and can be adjusted if necessary.

Medicaid agencies generally pay providers on a per-visit or per unit basis.

Agencies are paid by the VA on a per visit basis, either under contract or on a "usual and customary" basis. When the cost of care at home begins to exceed nursing home care, the VA will authorize placement in an institution.

OTHER PLANS APPROACHES TO CONTROLLING HOME HEALTH EXPENDITURES ARE DIFFERENT FROM MEDICARE'S

Other payers differ from Medicare in setting limits on home health benefits; moving more intensive and special needs patients to targeted programs; and in their utilization control mechanisms.

Several Payers Place Limits on Their Home Health Benefits.

Some payers structurally limit their home health benefit through limits, or caps, on the number of services allowed for any one beneficiary. Three of the five indemnity plans who use service caps either cap the number of visits allowed per year or limit the amount of time per visit (in programs that pay by the hour). Two HMOs limit the amount of physical and occupational therapy services delivered.

The VA limits coverage of home health services to six months for veterans without service-connected injuries.

One of the Medicaid agency officials we interviewed specifically mentioned service caps. This State limits beneficiaries to 50 skilled nursing and aide visits annually, although exceptions are allowed.

Other Government Payers Supplement Their Basic Home Health Programs with Targeted Efforts Devoted to the Care of Special Populations.

Our conversations with other government payers yielded information regarding special efforts to target certain populations and develop special programs to meet their requirements, rather than relying on their basic home health benefit to address those needs.

Medicaid

Medicaid can cover home health care for needs beyond "part-time" or "intermittent" with State-only dollars. States can pay for home health services up to the equivalent cost of the State's share of a nursing home stay. Long-term home-based care to special populations (frail elderly, disabled children, AIDS patients) can also be provided under Medicaid waivers with both Federal and State dollars.

Department of Veterans Affairs

The VA has a special "aide and attendant" program for those with severe disabilities, including veterans with service-connected spinal cord injuries. This program provides a cash benefit to purchase needed services (to pay the salary of an aide, for example); the cash benefit may be supplemented by skilled services under the home health benefit.

CHAMPUS

For CHAMPUS, patients who need more intensive care than can be provided through its basic home health benefit can be enrolled in one of three demonstration projects.

- The first demonstration project identifies patients with catastrophic, complex needs and develops home and community-based treatment plans, with case managers helping patients gain access to sophisticated, cost-efficient care. Patients share in the costs, with active-duty families paying 20 percent of CHAMPUS's allowable charge (limited to $1000 out-of-pocket) and other families paying 25 percent (limited to $7500).

- The second demonstration project is designed to keep patients at home in lieu of hospitalization when such care is cost effective. This demonstration focuses on high-cost patient populations including children, hospice patients, and patients with AIDS, those who have had transplants, or those who require intense rehabilitation efforts. The physician must sign a detailed treatment plan, including an estimate of the length of time the patient would spend in an institution if the home health care were not provided. An itemized comparison of the costs of hospitalization versus the costs of home care is required.

- The third demonstration provides financial assistance to active-duty families with a severely-handicapped family member. The family pays initial costs based on the active-duty personnel's pay grade; CHAMPUS pays up to $1000 a month. If more than one family member qualifies, CHAMPUS pays all allowable costs for the additional handicapped persons. Covered services include nursing, physical, occupational and speech therapy, durable medical equipment, hearing aids, and schooling or residential care.

In all these demonstrations, the goal is to convert the patient to the regular benefit plan. This transition would take place when the patient no longer needs the care provided under the demonstration, when such care is no longer cost effective, or when the "policy holder" is no longer on active duty. The transition is achieved through following the plan of care, stabilizing the patient, and training the caregivers. The case management coordinator follows patients' progress after they have left the demonstration, to ensure that they are stable and to prevent rehospitalization.

Case Management, Post Payment Utilization Review, and Beneficiary Participation Through Copayments and Explanation of Benefits (EOBs) are Used by Other Payers to Ensure Appropriateness of Services and Detect Fraud and Abuse.

When asked, about what techniques they used to manage and control utilization of their home health benefit, respondents indicated that the methods used in any plan depends largely on the terms of the contract negotiated with employers, these payers generally reported a variety of techniques in common use.

METHODS USED TO CONTROL UTILIZATION OF HOME HEALTH BENEFITS
Medicare and Private Payers

	MEDICARE	PRIVATE PAYERS (Total = 10)
Case Management		9
Utilization Reviews	X	10
Copayment/Deductibles	*	9
Explanation of Benefits		6

* Medicare requires a 20 percent coinsurance charge for DME.

Case Management

Almost all payers used some form of case management to ensure quality of service and to act as gatekeeper. Indemnity plans tend to target their case management efforts. For example, one plan focuses its case management efforts on its catastrophic and chronic patients. Another plan hires case managers only in major urban areas to work with local physicians and nurses with a goal of helping patients access other community services. All of the HMOs use case managers and primary care physicians to monitor and manage patients' care.

The VA also reports using case managers. For that program, because of its link to its hospital system, the hospital social workers acts as a case manager and is responsible for reauthorizing care if appropriate. The CHAMPUS also reports using case managers under one of its three home health demonstration programs.

Utilization Review

The payers cite a number of utilization review measures including: intensive interaction with physicians, review of physician referral rates, post-pay edits, prior approval, utilization profiling combined with physician education, and active fraud units. One HMO conducts an analysis of the cost of providing care in the home compared to skilled nursing facilities (SNFs). The patient and family may then choose whether to contribute the difference in cost, supplement professional care with volunteers, or admit the patient to the SNF.

The three Medicaid programs cite a post-payment utilization review measures such as post pay edits, "exception" reviews where high use cases are identified for close monitoring, and verification of incoming claims against the plan of care.

Copayment and Deductibles

Almost all of the private payers report that they commonly require some level of financial participation by the beneficiary. Two of the five indemnity plans mention a coinsurance charge of 20 percent was common in their plans. Two other indemnity plans contract with a network of home health providers, and when used, require no copayment; otherwise they also require a copayment. The other indemnity plan requires a copayment after 90 days of full coverage. The HMOs either have no copayment charges at all, or charge some nominal amount (e.g. one HMO charges $5.00 per visit). Two of the four HMOs require either a copayment or deductible for durable medical equipment only. None of the Medicaid agencies we interviewed require copayments (although this is not true for all Medicaid programs).

Explanation of Benefits

Four of the five indemnity plans provide beneficiaries with an explanation of benefits (EOBs); one provides them only upon request. The HMOs were mixed in their use of EOBs. None of the Medicaid programs we interviewed use EOBs.

Recertification of Need/Reauthorization of Services

Most private payers have a formal program in place for reauthorization or recertification of need. Generally they follow Medicare's practice of recertification every 60 days. Medicaid agencies also review cases every 60 days, according to statutory requirements.

The VA has a 12-month review process in place for all veterans receiving home health benefits under the fee for service program. This redetermination process assesses whether care should continue in the home or another alternative employed. The VA also submits all cases whose authorizations are to expire in the next three months to VA officials, who consult with the home health provider, review the veteran's medical record, and consider alternatives and costs of alternatives.

POINTS OF FURTHER ANALYSIS

Due to the rapid increase in home health care costs and the need to ensure the quality of services delivered in the home, HCFA has initiated efforts to improve Medicare's home health benefit. We are supporting HCFA in that effort by providing this report as well as others focusing on a variety of home health issues.

Despite the small number of other payers that we examined during the course of this review, their practices could provide potential ideas for reforming or managing Medicare's home health benefit. The HCFA might study the merits of some of these approaches as it determines how best to control utilization and expenditures while assuring the appropriate delivery of high quality care to Medicare beneficiaries. Among those approaches which might hold promise are:

- **Targeting needs.** Rather than a "one size fits all" home health benefit, Medicare might wish to channel different patients into different home health "programs" where the benefit could better conform to different patient needs and program management. In addition, controls could be designed more effectively.

- **Case Management.** Case managers might be particularly appropriate for certain classes of beneficiaries who are expected to require services over a specified period of time (e.g. patients with chronic care needs).

- **Beneficiary Participation.** The use of EOBs (perhaps on a monthly basis to avoid unnecessary administrative burden) and imposition of copayments, previously proposed in various legislative initiatives, can increase the beneficiaries' stake in their own health care and identify potential overutilization, abuse or quality problems.

- **Limitations on Coverage.** Caps on number of visits allowed each year, or some other kinds of limitations, would not only be consistent with the policies of some other payers but also with Medicare's own policies with regard to skilled nursing care, hospital benefits, and other categories of service.

Our additional work ongoing and planned in the home health area will assist HCFA in testing out some of these ideas. Some of the questions that would need to be answered in assessing the validity of these approaches for Medicare include:

- What have been the patterns of utilization and health care consumption for beneficiaries in plans with experience with these approaches, as compared to Medicare?

- What impact would such changes have on Medicare beneficiaries?

- What impact would such changes have on the fiscal soundness of the Medicare program?

One of the factors that makes assessment of impacts difficult is the lack of outcome measures. While many of the payers we spoke to told us that they are interested in and/or developing outcome measures for their programs, we found they had little to offer on this subject at the current time. Therefore, we support any efforts by HCFA to address the issue of developing methods to measure and monitor the quality of home health services.

Additional OIG Work

The OIG is currently engaged in a home health initiative to examine payments made to home health agencies on behalf on Medicare beneficiaries. This initiative involves the OIG's investigations, audit, and evaluation staffs. Among the upcoming products emanating from this initiative are reports on provider audits and validation of claims; and on the physician's role in home health services; an overall assessment of payment made to HHAs and the relationship of those payments to HHA characteristics, beneficiary characteristics, and other potentially relevant factors.

COMMENTS ON THE DRAFT REPORT AND OIG RESPONSE

The HCFA indicated that the report would be useful in assessing possible changes to the home health benefit. However, HCFA stated that our report appears to assume that other agencies are more effective than Medicare in controlling costs. Further, HCFA pointed out that there are no data in the report comparing the average number of visits or expenditures per beneficiary. The HCFA speculated that age, health status, and income could explain differences in utilization if they exist, as well as plan characteristics and benefit management.

We appreciate HCFA's comments. We recognize that there are no data in the report comparing the number of visits or expenditures per beneficiary; however, this was beyond the scope of our inquiry. The purpose of this report was to describe how selected payers structure and manage their home health benefit as compared to Medicare. Our analysis indicated that other payers limit the benefit and use a variety of techniques to control utilization more than Medicare. Whether these techniques actually result in lower per capita costs is subject to further analysis, as indicated in the report. It is clear, however, that other payers have many more opportunities to manage utilization of the benefit and control costs compared to Medicare coverage and payment policies for home agencies.

The full text of HCFA's comments can be found in appendix A.

APPENDIX A

AGENCY COMMENTS TO THE DRAFT REPORT

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

DATE MAR 27 1995

FROM Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General Draft Reports: "The Physician's Role in Home Health Care," (OEI-02-94-00170) and "Home Health Agencies: Alternative Coverage and Payment Policies," (OEI-12-94-00180)

TO June Gibbs Brown
Inspector General

We reviewed the subject draft reports which examine home health care provided under the Medicare program. Our comments are attached for your consideration.

Thank you for the opportunity to review and comment on these reports. Please advise us if you would like to discuss our position on the recommendations.

Attachment

Comments of the Health Care Financing Administration (HCFA) on Office of Inspector General (OIG) Draft Reports: "The Physician's Role in Home Health Care," (OEI-02-94-00170) and "Home Health Agencies: Alternative Coverage and Payment Policies," (OEI-12-94-00180)

OIG Recommendations on "The Physician's Role in Home Health Care"

1. The HCFA should continue its efforts to change the plan of care to ensure it conveys critical information to caregivers and relieves unnecessary burden from physicians.

2. The HCFA should further communicate its expectations about physician involvement and take steps to assure that it is more clearly understood by home health agencies and physicians.

HCFA Response

HCFA defers action on the above recommendations at this time. We are in the process of examining issues related to plans of care and the physician's role and recognize the importance of both recommendations. However, we believe it would be premature to make immediate changes.

Clearly one of the most important problems facing the Medicare home health benefit is utilization. OIG is commended for its attempts to better understand the appropriate role of the physician in monitoring utilization and appropriateness and duration of care.

HCFA has addressed the issue of physician involvement through regulations. In the December 8, 1994 Federal Register, HCFA issued a new regulation providing separate payment for physician care plan oversight services. Reimbursing physicians for care oversight services should lead to greater physician involvement and prudent utilization of the home health benefit.

HCFA has also established a Medicare Home Health Care Work Group which is currently drafting revised Home Health Agency Conditions of Participation. HCFA is also developing a Core Standard Assessment Instrument. Requirements for the assessment instrument could significantly impact the information requirements on the plan of care. The work group expects to develop recommendations after it completes its research. Until then our operational plans are to continue using HCFA Forms 485 and 486 (Medicare Collection of Medical Information on Home Health Services).

We note that the report recommendations do not address the two main questions listed on page 3: "Are physicians effectively fulfilling their gatekeeper role in initiating and monitoring the plan of care?" "Do physicians rubber stamp the plan of care?" While the report recognizes that there are discrepancies in how physicians and agencies view the

physician's role in coordinating care, it does not address whether physicians are an effective gatekeeper. Perhaps the study might more effectively address "Does greater physician involvement result in a more cost-effective utilization of the home health benefit?"

Additionally, we would be interested in any specific suggestions OIG may be able to offer on the following:

- After interviewing both agencies and physicians, does OIG have any specific suggestions of ways the plan of care can be changed?
- Does OIG have specific suggestions on how the role of physicians should be better communicated?
- Does OIG feel that, after talking to agencies and physicians, there is a consensus on what the physician role ought to be?

Comments on "Home Health Agencies: Alternative Coverage and Payment Policies"
The report appears to assume that other agencies are more effective than Medicare in controlling costs. However, there are no data in the report comparing the average number of visits or expenditures per beneficiary. While the report identifies other plans' limits on utilization, there may be other factors, such as age, health status, and income, that could explain differences in utilization, if they exist.

We are in the process of developing our approach to revitalizing the coverage and payment policies for home health agencies. The Points of Further Analysis in this report raise interesting alternatives that will be considered by HCFA as it formulates its plan to revitalize the home health benefits.