Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

VARIATION AMONG HOME HEALTH AGENCIES IN MEDICARE PAYMENTS FOR HOME HEALTH SERVICES

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EXECUTIVE SUMMARY

PURPOSE

To describe variation among home health agencies in reimbursement for home health services paid for by Medicare and assess potential causes of the variation.

BACKGROUND

Expenditures for Medicare home health care are increasing at an extraordinary rate. Medicare payments will total an estimated $14.4 billion in 1995, up from $3.3 billion in 1990, an increase of over 4 fold in only 5 years.

The Health Care Financing Administration (HCFA) is involved in a concerted effort to examine the home health care benefit. As part of that initiative, the Office of Inspector General (OIG) has developed a coordinated action plan to integrate investigations, audits, and inspections involving Medicare home health care. This inspection is part of that OIG coordinated effort.

METHODOLOGY

We analyzed HCFA data on Medicare reimbursement for home health services in calendar year 1993. The HCFA data represented services provided by 6,803 HHAs to over 3 million beneficiaries. We arrayed the HHAs in ascending order based on their average reimbursement per beneficiary and divided them into four groups. We then analyzed a number of factors, including agency characteristics, beneficiary characteristics, and quality of services, and how those factors varied among the four groups. We called the groups lower, middle, high-1 and high-2.

To place this analysis into an appropriate broader context, we incorporated into this report findings from other recent OIG work on this subject. Our recommendations are based on the entire body of OIG analysis of home health services.

FINDINGS

The Highest Group Of Home Health Agencies Received, On Average, Five Times The Amount Of Medicare Reimbursement Per Beneficiary As The Lower Group

Average reimbursement per beneficiary among the groups varied significantly. In the high-2 group, the average reimbursement was $7,978. The average reimbursement in the lower group was $1,534. The HHAs in the high-1 and high-2 groups, which represented one third of all the HHAs analyzed, received more than half (51.5 percent) of the nearly $9.7 billion reimbursed by Medicare in 1993. The two thirds of the HHAs in the lower and middle groups provided home health services at or below the national average reimbursement per beneficiary of $2,957.

Average Reimbursement Per Visit Was Similar Among HHAs, But The Number Of Visits Varied Widely

The average number of visits nationally was 50 per beneficiary. The average number of visits per beneficiary by HHAs in the highest group was about five times greater than that by HHAs in the lower group. In the highest group that average was 141 visits, as compared to 27 visits in the lower group. Nearly two thirds of all the HHAs averaged 33 visits per beneficiary, well below the national average of 50.

The average reimbursement per visit nationally for all 6,803 HHAs in 1993 was $58.06. The average reimbursement per visit in each of the four groups of HHAs was within $2 of the national average.

Higher Group Home Health Agencies Tended To Be Proprietary For-Profit, Non-affiliated Organizations Which Provided Seven Times More Aide Visits As The Lower Group And Which Employed A Higher Percentage Of Total FTEs As Aides

Some agency characteristics, such as ownership and affiliation status, were good predictors of which HHAs received higher reimbursement per beneficiary. Higher-reimbursement HHAs also had twice as many staff and four times the number of home health aides, on average, as lower group agencies.

Quality Of Service And Beneficiary Characteristics Were Similar Among All Four Groups Of HHAs And Did Not Appear To Explain The Variation In Average Reimbursement

HHAs which provided home health services at a higher level of reimbursement per beneficiary did not have fewer deficiencies or complaints than lower reimbursement agencies. In fact, the percentage of HHAs in the highest group that had at least one complaint was more than three times the percentage of HHAs in the lower group. Agencies in the higher-reimbursement groups were also less likely to be accredited.

Beneficiary characteristics such as age, gender, race, qualifying conditions and principal diagnostic codes did not explain the wide variation in average reimbursement per beneficiary.

DISCUSSION

The work performed in this inspection must be placed into the broadest context, including the battery of OIG work in home health performed over the past year. The findings from this inspection and all other OIG work in home health present a picture of a Medicare benefit which is vulnerable to fraud and abuse. For example, over the past year, we have identified numerous instances of inappropriate home health payments through audits of provider claims in Florida and Georgia.

- In one case we found that 75 percent of the claims submitted by one HHA did not meet Medicare guidelines.

- In another project we found that 26 percent of randomly reviewed claims in Florida did not meet Medicare guidelines. These claims were for beneficiaries who were not homebound, unnecessary visits, and visits that were never provided.

We have also found several types of fraud among HHAs around the nation. Some of the fraud we found includes excessive services, services not rendered, use of unlicensed staff, cost report fraud, falsified plans of care, forged physician's signatures, and kickbacks. Between 1990 and 1994, OIG investigations have led to 25 successful criminal prosecutions of HHAs or their employees and the imposition of 3 criminal penalties. In 1993 and 1994 alone, 39 HHAs or their employees were excluded from participating in the Medicare or Medicaid program.

We have also looked at how other payers manage home health benefits. For example, other payers tend to limit the benefit by capping the number of visits or services allowed per beneficiary. They also emphasize case management and use copayments.

RECOMMENDATIONS

HCFA Should Explore Ways to Address Excessive Utilization and Inappropriate Variation in Reimbursement Among HHAs.

The work of the OIG's audit and investigations staff have identified instances of medically unnecessary care and inappropriate or fradulent billing by specific HHAs. The data in this report describes more broadly patterns of billing by certain HHAs which may indicate fraud or abuse. As such, we believe it is prudent for HCFA to take steps to investigate such patterns and place systematic controls on the home health benefit to prevent abuse.

First, HCFA Should Intensify its Efforts to Scrutinize Claims Submitted by High Cost Agencies.

HCFA has already begun this effort through its activities under Operation Restore Trust. We have provided information to HCFA about the agencies in our analysis which had higher than average per beneficiary reimbursement, for the purposes of targeting agencies for further review.

Second, HCFA Should Explore Ways in Which to Prevent Unscrupulous Agencies from Engaging in Abusive Practices.

In addition to targeting certain agencies for review, HCFA should work to develop mechanisms to prevent agencies from engaging in practices which result in inappropriate use of the home health benefit.

This can be done in a variety of ways. For example:

- Involving Beneficiaries in Detecting and Reporting Unscrupulous Behavior: through the use of Explanation of Medical Benefits (which HCFA is currently testing), confirmation of visits received, and certification of need and eligibility for home health care.

- Involving Physicians in Detecting and Reporting Unscrupulous Behavior: now that HCFA is paying physicians for case management services delivered to home health patients, it is in a good position to use physicians to monitor the care provided to beneficiaries, report unscrupulous providers, and refer patients to agencies with a record of good practice. This will require educational outreach to the physician community.

- Setting Higher Standards for Participation in the Medicare Program: HCFA is now considering its policies with regard to how agencies enter the Medicare program and obtain permission to bill for services, and under what conditions certain entities may be suspended or dropped from the program.

HCFA Should Continue Its Efforts To Improve The Home Health Benefit and To Control Fraud, Waste and Abuse.

We support HCFA's efforts in developing potential long term solutions towards benefit reform which will assist in preventing fraud and abuse by unscrupulous providers. These HCFA efforts include:

- Outcome Measures: We urge HCFA to continue their work in developing outcome measures which can be used to assess the performance of individual home health agencies.

- Prospective Payment System: We believe that a home health prospective payment system might be the most effective long term model for restructuring the benefit and we encourage HCFA to continue their work in testing such a system. We believe, however, that it is important that a new system not "grandfather" in utilization patterns of the higher-reimbursement agencies. It is worth noting that this was an important issue when a prospective payment system was being developed for hospitals.

Additional structural reform might also assist in preventing fraud, waste and abuse. As we indicated in a prior report, "Home Health Agencies: Alternative Coverage and Payment Policies," issued in May 1995, HCFA may wish to consider adopting certain practices of other third party payers.

We also believe that the use of aides deserves further examination, based on the data presented in this report.

We plan to work together with HCFA and the Assistant Secretary for Planning and Evaluation (ASPE) on further analysis which can help shape these alternatives.

Budget Implications

The elimination of fraud, waste and abuse in the home health benefit can create significant cost savings for the program. Such an elimination would ultimately reduce the average number of visits for beneficiaries overall, while ensuring that appropriate services are still delivered to beneficiaries in need. To estimate the potential impact of effective action, we developed the following calculations.

- We estimated Medicare expenditures based on different levels of average number of visits per beneficiary nationwide. For example, if the national average number of visits had been 45 instead of 50, Medicare would have saved over $1 billion in 1993 in Medicare payments for home health services.

- The average number of visits per Medicare beneficiary for almost two-thirds of home health agencies (the lower and middle groups) in 1993 was 33. If the average number of visits by the remaining one-third of HHAs had also been 33 visits per beneficiary, Medicare cost would have decreased by about $3.3 billion in 1993.

- However, based on HCFA actuarial figures, the average number of visits per beneficiary is increasing annually. Based on our calculations for 1993 data, each time the national average number of visits per beneficiary increases by one, it costs the Medicare program an additional $191.4 million. If this upward trend in the number of visits were to continue unabated, the potential increase in the cost to Medicare would be substantial.

- Using HCFA projections of $14.4 billion in Medicare home health care expenditures for 1995, an average number of 33 visits per HHA would result in a savings of nearly $5.0 billion.

AGENCY COMMENTS

We received comments on the report from HCFA and ASPE. HCFA concurred with our recommendations, but felt that the report did not fully distinguish between variation that is appropriate and variation that suggests excessive utilization or inappropriate reimbursement levels. HCFA concluded, however, that when considered with the other OIG work in home health over the last several years, the findings in this report do suggest enough of a pattern to recommend that HCFA examine, and address where appropriate, excessive utilization and inappropriate variation in reimbursement among HHAs.

ASPE concurred that the study showed clear evidence of patterns in home health agency practices, and that such patterns should be investigated and more thoroughly

understood. Noting that our data were limited, ASPE stated that recommendations for change should be approached cautiously. ASPE expressed concern for the welfare of beneficiaries, and stated that any recommendations which would directly impact them be eliminated. ASPE suggested two follow-up reviews to our study -- one a regression analysis on potential causes of variation in cost, and two an intensive review to target high-cost HHAs.

We plan to work with HCFA and ASPE concerning additional efforts in this area, and have so indicated in the report. We have also made some revisions to the text of the report based on their comments, particularly in the focus of our recommendations.

The full text of HCFA and ASPE comments is contained in appendix C.

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INTRODUCTION

PURPOSE

To describe variation among home health agencies in reimbursement for home health services paid for by Medicare and assess potential causes of the variation.

BACKGROUND

Home Health Care

Home health care is nursing, therapeutic, medical social, or aide services which are provided in a patient's home. Home health care allows people with limited mobility to live independently while still receiving professional health care services. Section 1861, Title XVIII of the Social Security Act authorized Medicare Part A payments for home health care services. If a beneficiary does not have Part A entitlement, home health services may be covered by Medicare Part B.

To receive Medicare reimbursement, home health agencies (HHAs) must provide a skilled care service to a homebound beneficiary. Beneficiaries who need intermittent skilled nursing services, physical therapy, speech therapy, and occupational therapy may qualify for home health services under Medicare. Registered nurses and licensed therapists must provide or supervise skilled services. Nursing and home health aide services must be provided on an intermittent (i.e., not daily) or part-time (less than 8 hours per day) basis.

Beneficiaries may receive an unlimited number of home health visits. However, Section 1861 of the Social Security Act authorizes the Department to set limits on allowable costs incurred by a provider of services for which payment may be made under the Medicare program. Under this authority, the Department has maintained limits on HHA per-visit costs since 1979.

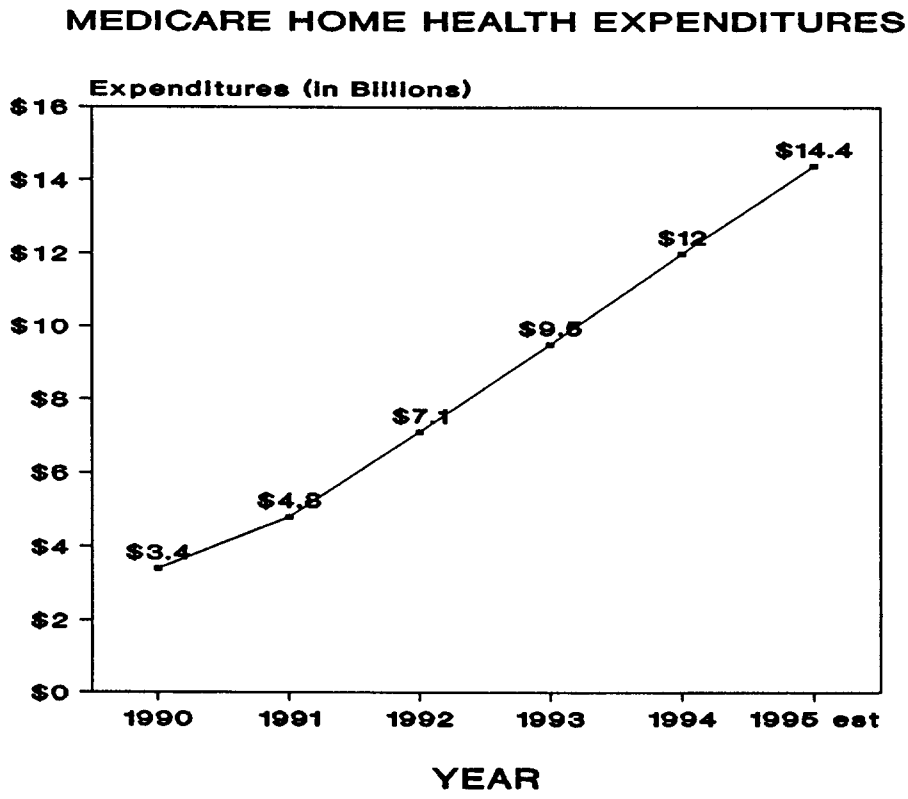
Home health agencies may supplement skilled services with medical social services and home health aide services. Medical social services are provided by a qualified medical social worker or a social work assistant under the supervision of a qualified medical social worker. Medical social services are necessary to resolve social or emotional problems which are expected to be an impediment to effective treatment of a beneficiary's medical condition. Home health aide services are hands-on personal care or services which are needed to maintain a beneficiary's health or to facilitate treatment. Home health aide services include personal care (bathing, changing bed linens, feeding, etc.), changing dressings for simple wounds, assistance with medications, assistance with some therapy activities, and routine care of prosthetic and orthotic devices.

All home health services must be specified in a plan of care which a physician must sign. Physician certification must be updated every 62 days. According to current Medicare rules, physicians who sign a plan do not have to actually see the patient for whom the plan was written. This holds true for both the initial plan as well as subsequent updates.

Growth Of Home Health Care

Home health care spending by all insurers nationwide is skyrocketing. It is increasing at a greater rate than any other type of health care in the United States. In 1993, expenditures for home health care increased 23.8 percent over the previous year, according to HCFA's Office of the Actuary. During that time, expenditures for all types of health care increased by 7.8 percent. Hospital and physician care increased by 6.7 percent and 5.8 percent respectively in 1993.

Expenditures for home health care paid for by Medicare are also increasing at an extraordinary rate, beginning in 1989 with the settlement of a major court case, Duggan v. Sullivan, as illustrated by the following graphic. In this case, Medicare beneficiaries and others sued the Department claiming that the Department's interpretation of "part time and intermittent" was in conflict with the intent of Congress and the wording of the law. The Department settled the litigation and revised the coverage guidelines as a result.



Home health care is one of the fastest growing segments of health care paid for by Medicare. Medicare payments will total an estimated $14.4 billion in 1995, up from $3.3 billion in 1990, an increase of over 4 fold in only 5 years. The Health Care Financing Administration predicts that expenditures will continue to rise even more dramatically, reaching an estimated $18.8 billion in 1996.

Health Care Financing Administration Reviews of Home Health Care

The Health Care Financing Administration (HCFA) administers the Medicare program, and has funded a number of studies in recent years to examine home health care services. For example, HCFA has a demonstration study underway to test a prospective payment system for home health care. Another HCFA research team is developing and testing a set of outcome-based quality measures for home health care. This team expects to examine quality from the perspectives of providers, patients, regulators, and payers. HCFA is also sponsoring a three-year study to test a nurse-managed model of home health care. Finally, HCFA conducts an annual survey to determine satisfaction of Medicare beneficiaries.

The Administrator of HCFA also convened a task force to complete a comprehensive examination of home health care from both a policy and an operations perspective. The task force consists of staff from all HCFA components that deal in some way with home health.

Other Home Health Studies

Considerable work has been done toward analyzing and understanding variations in the use of and reimbursement for home health services. For example, in a report to Congress in 1994, the Prospective Payment Assessment Commission (PROPAC) examined the variation in home health agency costs and the relationship between costs and Medicare reimbursement. [1] That report found that many factors affected agency costs, such as geography, economies of scale, and local market characteristics. The report concluded that, "...the current payment system may not be rewarding efficiency and may be overcompensating the less efficient agencies."

Authors Henry Goldberg and Robert Schmitz in their article "Contemplating Home Health PPS: Current Patterns of Medicare Service Use," analyzed home health care episodes as part of a HCFA prospective payment demonstration project. They found that, in general, rural agencies, proprietary agencies, larger agencies, new agencies and free-standing agencies had longer episodes than agencies that were urban, not-for-profit, small, older or hospital-based. They also found that the number of visits per beneficiary was the cause of the variation in reimbursement per episode.

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[1] "Interim Analysis of Payment Reform for Home Health Services," Congressional Report C-94-02. Prospective Payment Assessment Commission. P. 31.

Other OIG Work In Home Health

Because of the phenomenal growth in Medicare home health expenditures and concerns about possible fraud, waste and abuse, the HCFA Administrator asked the Office of Inspector General to join HCFA and its task force in a concerted examination of home health care. Accordingly, we developed a strategic home health plan that incorporated audits, investigations, and inspections of Medicare home health care policies and operations.

This report describes the extent of the variation in average reimbursement per beneficiary among 6,803 home health agencies in 1993 and the relationship between a number of factors which could potentially cause that variation.

METHODOLOGY

To measure the variation in reimbursement for home health services to Medicare beneficiaries, we used average reimbursement per beneficiary. We used average reimbursement per beneficiary because use of averages is a recognized and easily-understood method of mathematically representing a large number of data elements.

To determine the extent of variation among HHAs in Medicare average reimbursement per beneficiary for home health services, we first identified all HHAs in the United States that were certified to participate in the Medicare program. We used HCFA's On-line Survey and Certification Reporting System (OSCAR) for 1993 and identified 6,803 HHAs.

We then identified all episodes of care reported by the 6,803 HHAs for Medicare beneficiaries. We used HCFA's National Claims History data file and identified 3,263,100 episodes of home health care in 1993. For our calculations of variations in HHA average reimbursement and visits per beneficiary, we considered each episode of home health care to be equivalent to one beneficiary.

Next we attempted to divide the HHAs into three groups of approximately equal numbers of agencies, which we called lower, middle and higher (See Table 1). We arrayed the 6,803 HHAs in ascending order based on average reimbursement. We arbitrarily selected three groups as a basis for comparing agencies. However, using SAS software, we observed a skewed distribution for our dependent variable -- average reimbursement per beneficiary. Accordingly, we then divided the 6,803 HHAs into four groups for analysis. We called the four groups lower, middle, high-1, and high-2.

We performed various statistical analyses on the 6,803 HHAs, including a univariate analysis and analysis of variance. Our use of the analysis of variance procedure was not as robust as it could have been because we could not assume the population variance among the four groups was equal. We did not validate the data obtained from HCFA data bases.

The four groups are shown in table 1. Also displayed in table 1 are the percentage of the 6,803 HHAs in each of the four groups and the percentage and number of all the beneficiaries in the four groups.

TABLE 1					
FOUR GROUPS OF HOME HEALTH AGENCIES					
	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Totals
			High-1	High-2	
Number of HHAs	2,270	2,262	1,930	341	6,803
Number of Beneficiaries	843,833	1,347,085	948,826	123,356	3,263,100
Percent of HHAs	33.4%	33.3%	28.3%	5.0%	100%
Percent of Beneficiaries	25.8%	41.3%	29.1%	3.8%	100%

With few exceptions, only two factors primarily influence average reimbursement per beneficiary. They are the cost per visit and the number of visits. We looked at both of these.

Since these agencies differ in a variety of ways, we also examined other factors which helped explain why the variation exists. We identified these factors through discussions with HCFA staff, fiscal intermediary staff, and provider staff. These discussions were supplemented by reviewing statutes, regulations, and policies which govern the delivery of home health. In addition, we studied existing research reports, audits, and other publications which focussed on home health.

Our objective in examining the other factors was to determine statistical relationships between these factors and the HHAs' average reimbursement per beneficiary. These factors are characteristics of the beneficiaries served (including principal diagnoses for those beneficiaries), characteristics of the HHAs, and quality of home health services provided. All of the analysis of these data, however, needed to be considered in the broader context of recent OIG work performed on this subject. We, therefore, drew from recent OIG work on home health in developing the findings and recommendations in this report.

Data Limitations and Future Work

We recognize that there are numerous potential data elements which could be used to measure the effect of beneficiary characteristics, agency characteristics, and quality of home health services on average HHA reimbursement per beneficiary. The data used

in this report are inherently descriptive. As such, they do not purport to show causal relationships relating to the variation in average reimbursement among HHAs.

For purposes of this report we used only those measures that were readily available through existing HCFA data sets. For example, in the absence of outcome measures, which we understand are being developed, we had to use available data. Those data were numbers of complaints and numbers of Survey and Certification deficiencies, as recorded by HCFA. We also used data from the two accrediting organizations to identify HHAs which were accredited. Though complaints, deficiencies and accreditation status may not be optimal, we believe they are reasonable proxies for quality.

There were no readily available data on other factors which could influence average reimbursement per beneficiary. For example, the lack of readily available data on case mix, the presence of a caregiver in the home of the beneficiary, and the use of other services in lieu of home health (such as SNFs), did not allow us to use those factors as possible influences on reimbursement or to establish their statistical relationship to reimbursement.

In addition, there are other factors that may be important to consider in explaining HHA variation which are not discussed in this report. Factors such as geographic location and operations of fiscal intermediaries may play a role. We will consider these potential influences in future OIG home health activities.

We conducted our inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

THE HIGHEST GROUP OF HHAs RECEIVED ON AVERAGE FIVE TIMES THE AMOUNT OF MEDICARE REIMBURSEMENT PER BENEFICIARY AS THE LOWER GROUP

Average Reimbursement For Home Health Agencies Varied Widely Among The 6,803 Home Health Agencies

- The average reimbursement per beneficiary for the four groups ranged from $1,534 to $7,978.

- Table 2 shows significant variation in average reimbursement per beneficiary among the four groups of HHAs. The average reimbursement per beneficiary for the high-2 group was about 5.2 times greater than the average reimbursement for the lower group. The average reimbursement to HHAs in the high-1 and middle groups were 2.7 and 1.6 times greater than in the lower groups.

TABLE 2

AVERAGE MEDICARE REIMBURSEMENT PER BENEFICIARY BY HOME HEALTH AGENCY

HHAs Arrayed into Four Groups Based on Their Average Medicare Reimbursement per Beneficiary

	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
Average Reimbursement per Beneficiary	$1,534	$2,514	$4,198	$7,978	$2,957
Range of Average Reimbursement per Beneficiary	<$1,982	$1,982 to $3,163	$3,164 to $6,484	>$6,484	

- The HHAs which comprised the two high groups represented one third of all the agencies, served one third of the beneficiaries, but received 51.5 percent of the $9.65 billion reimbursed by Medicare in 1993 for home health services. In addition, the 341 HHAs in the high-2 group, which represented only 5 percent

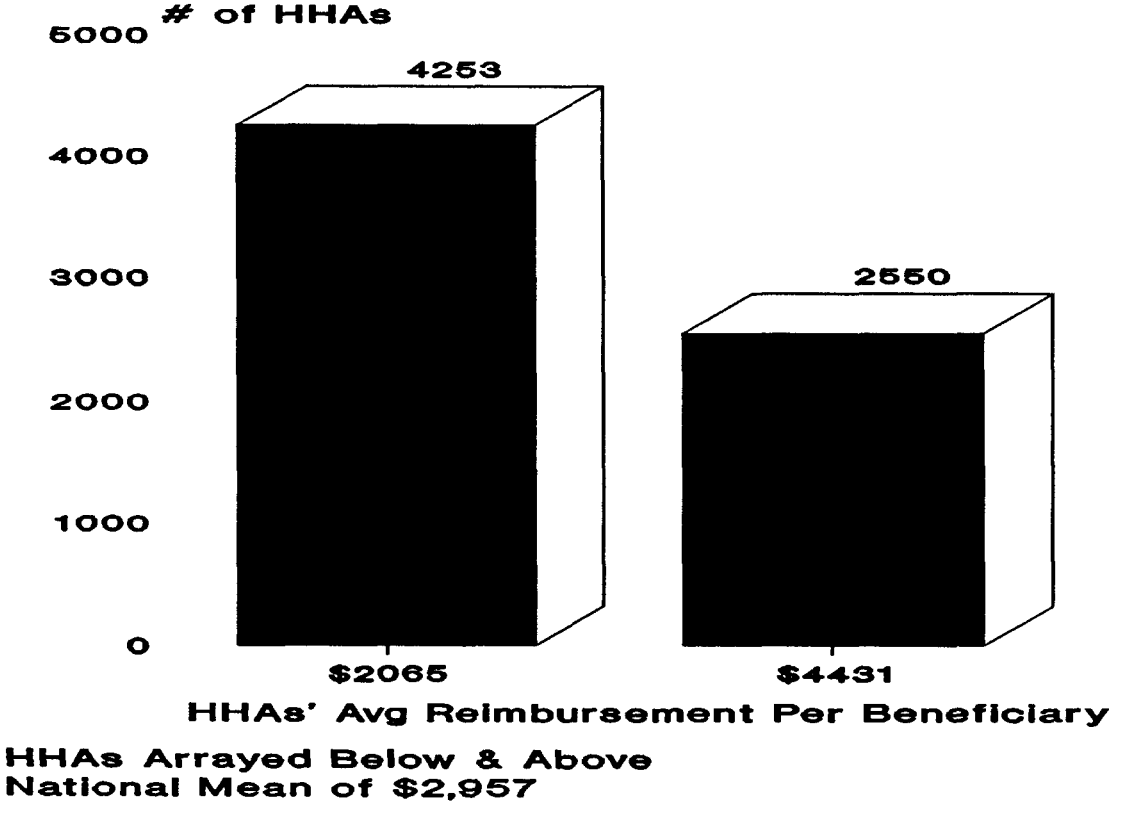
of all the HHAs, received 10 percent of the total Medicare reimbursement for home health services in 1993. The two-thirds of the HHAs in the lower and middle groups received 48.5 percent of the 1993 Medicare reimbursement.

Most HHAs Provided Home Health Care At Less Than The National Average Reimbursement Per Medicare Beneficiary

- The chart below shows that sixty-three percent (4,253) of the HHAs provided home health services at or below the national average reimbursement of $2,957 per beneficiary.

- Thirty-seven percent (2,550) of the HHAs provided home health services above the $2,957 national average reimbursement per beneficiary.

Almost Two-Thirds Of HHAs Provided Home Health Services For Less Than The National Average Reimbursement Per Beneficiary



AVERAGE REIMBURSEMENT PER VISIT WAS SIMILAR AMONG HHAs, BUT THE NUMBER OF VISITS VARIED WIDELY

Average Number Of Visits By HHAs In The Highest Group Was About Five Times Greater Than That By HHAs In The Lower Group

- In 1993, the 6,803 HHAs provided 164.5 million home health visits to 3.26 million Medicare beneficiaries. The average number of visits per beneficiary for all 6,803 HHAs was 50. See table 3.

- The average number of visits ranged from 27 visits per beneficiary in the lower group of HHAs to 141 visits per beneficiary in the high-2 group of HHAs.

TABLE 3

AVERAGE NUMBER OF VISITS PER BENEFICIARY BY HOME HEALTH AGENCY

	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		All HHAs
			High-1	High-2	
Average Number of Visits Per Beneficiary	27	41	72	141	50

- Table 4 shows that the ratio of average visits by the top 3 groups of HHAs to the visits by the lower group is directly correlated to the ratio of average reimbursement by the top 3 groups to that in the lower group. To illustrate, HHAs in the high-2 group averaged 5.2 visits per beneficiary to every one visit by HHAs in the lower group. Likewise, average reimbursement for high-2 HHAs was $5.2 for every $1 received by HHAs in the lower group.

TABLE 4

CORRELATION OF AVERAGE NUMBER OF VISITS TO AVERAGE REIMBURSEMENT PER BENEFICIARY

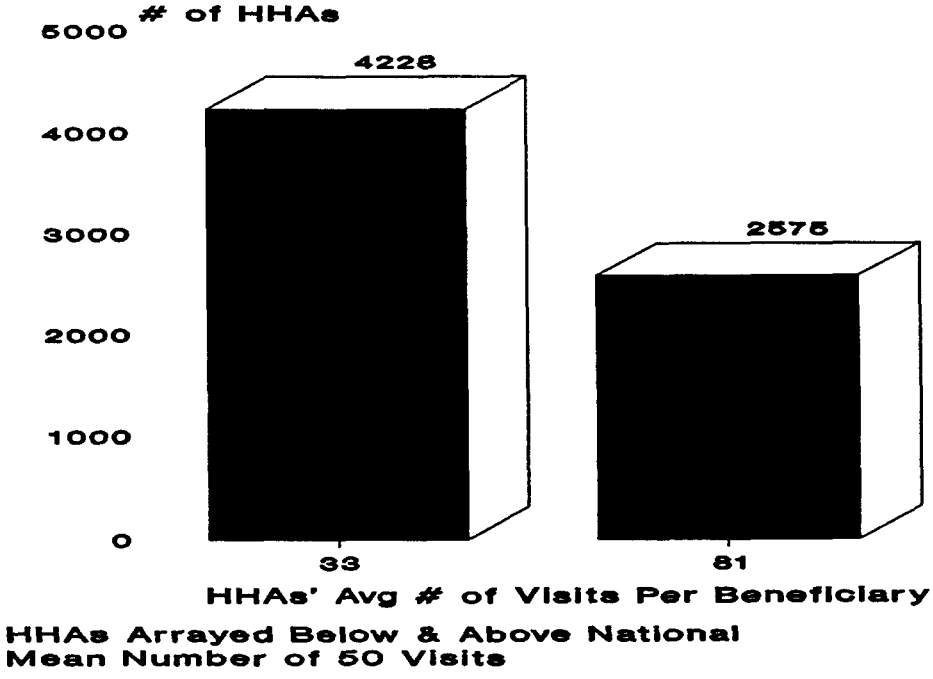
GROUPS OF HHAs	REIMBURSEMENT		VISITS	
	Average	Ratio	Average	Ratio
High-2	$7,978	5.2	141	5.2
High-1	$4,198	2.7	72	2.6
Middle	$2,514	1.6	41	1.7
Lower	$1,534	1	27	1

Over 60 Percent Of HHAs Made Less Than The National Average Number Of Visits Per Beneficiary

- The chart below shows that 62 percent (4,228) of the HHAs averaged 33 visits per beneficiary. This average is well below the national average of 50 visits per beneficiary.

- Thirty-eight percent (2,575) of the HHAs averaged 81 visits per beneficiary -- well above the national average of 50.

Almost Two-Thirds Of HHAs Provided Fewer Than The National Average Number Of Visits Per Beneficiary



The Average Reimbursement Per Visit Was Fairly Consistent Across All Four Groups

As illustrated in table 5, the average reimbursement per visit varied among the four groups by only about $2 to $4.

TABLE 5					
AVERAGE REIMBURSEMENT PER VISIT BY HOME HEALTH AGENCY					
	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
Average Reimbursement per Visit	$56.06	$60.82	$58.28	$56.71	$58.66

HIGHER GROUP HHAs TENDED TO BE PROPRIETARY FOR-PROFIT, NON-AFFILIATED ORGANIZATIONS

Some Agency Characteristics Were Good Predictors Of Which HHAs Received Higher Reimbursement And Provided Higher Numbers Of Visits

- The percentage of proprietary for-profit agencies rose from 27 percent in the lower group to 85 percent in the high-2 group, as illustrated in table 6.

- The percentage of voluntary non-profit and public/government HHAs decreased from the lower and middle groups to the higher groups.

TABLE 6				
TYPE OF OWNERSHIP				
Type of Ownership	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs	
			High-1	High-2
Proprietary For-Profit	26.7%	37.5%	65.4%	85.4%
Voluntary Non-Profit	43.8%	44.8%	24.1%	11.7%
Public/Government	29.5%	17.7%	10.5%	2.9%
TOTALS	100%	100%	100%	100%

- The majority of HHAs in the two higher groups were non-affiliated. Only a small percentage of HHAs in the higher groups were affiliated with a hospital, skilled nursing facility or other medical service organization. See page A-2.

- The percentage of non-affiliated HHAs rose from the lower group to the higher groups. See page A-3.

- Over 41 percent of high-2 agencies had branches, as compared to 12.8 percent of the lower group HHAs. See page A-4.

The Two Higher Groups Provided Seven Times More Aide Visits As Lower Group Agencies And Employed A Higher Percentage Of Total FTEs As Aides

- HHAs in the high-2 group provided 7 times more aide visits per beneficiary and four times more skilled nursing visits as those in the lower group, as table 7 below illustrates.

TABLE 7

TYPE OF VISIT PROVIDED BY HOME HEALTH AGENCIES TO MEDICARE BENEFICIARIES

	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
Types of Home Health Visits	Average Number of Visits per Beneficiary				
Home Health Aides	10.4	17.6	37.0	77.5	23.6
Skilled Nursing	13.3	18.5	29.0	52.9	21.5
Physical Therapy	2.8	3.9	4.4	7.3	3.9
All Other Types	0.8	1.4	1.6	3.0	1.4
Average Number for All Types of Visits	27.4	41.3	72.0	140.7	50.4

- Over half of all visits performed by high-2 group agencies were aide visits. See page A-5.

- High-2 group HHAs averaged 25 home health aides (representing 40 percent of their work force) as compared to an average of about 7 for the lower group (representing 28 percent of their work force). See page A-6.

Home Health Agencies Generally Provided The Same Types Of Services

- All HHAs in all four groups and 98 percent of HHAs in all four groups provided nursing services and home health aide services, respectively. See page A-7.

- The majority of the agencies provided therapy services, regardless of group. See page A-7.

QUALITY OF HHA SERVICES DID NOT APPEAR TO EXPLAIN THE VARIATION IN AVERAGE REIMBURSEMENT PER BENEFICIARY

In the absence of outcome measures for Medicare home health services, we used several proxies for quality. Those proxies were the number of deficiencies and complaints recorded by the HCFA Survey and Certification Branch, and an HHA's accreditation status. While we recognize that accreditation is an alternative to certification through the State survey mechanism, we believe that the popular perception is that agencies which are accredited hold the promise of providing better services. This may or may not be the case.

HHAs That Provided Services At A Higher Level Of Reimbursement Did Not Have Fewer Deficiencies

To participate in the Medicare program, HHAs must agree to be surveyed annually to determine if they are in compliance with Medicare conditions of participation. Conditions of participation are health, quality and personnel standards and are prescribed in the Code of Federal Regulations. There are 12 conditions of participation. Annual surveys of compliance with the conditions are performed by State survey agencies under contract with HCFA. HCFA expects HHAs to correct deficiencies identified by a State survey within 60 days of being notified of them, or sooner if a question of "adequate and safe care" is raised.

When we arrayed HCFA's Survey and Certification data on HHA deficiencies, we found no significant difference among the agencies in the four groups. This is illustrated by table 8. The rows which refer to deficiencies contain data about both types of deficiencies, that is, conditions deficiencies and standards deficiencies. Conditions are broad, refer to systems, or address jeopardy to a beneficiary's health or safety. Standards are components of conditions.

TABLE 8				
HHA SURVEY AND CERTIFICATION DEFICIENCIES				
Deficiency Status	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs	
			High-1	High-2
% HHAs With No Deficiencies	46.4%	45.3%	40.6%	40.8%
% HHAs With 1 To 6 Deficiencies	45.5%	43.8%	46.8%	42.8%
% HHAs With 7 Or More Deficiencies	8.1%	11.0%	12.5%	16.4%
% HHAs with Current *Condition* Deficiencies	3.3%	3.5%	4.3%	7.0%
% HHAs with Current *Standards* Deficiencies	53.4%	54.6%	59.2%	58.7%

The Percentage Of HHAs In The Highest Group That Had At Least One Complaint Was More Than Three Times The Percentage of HHAs In The Lower Group

- Nearly 60 percent of HHAs in the high-2 group had at least one complaint, as compared to about 17 percent of HHAs in the lower group. See page A-8.

Agencies In The Highest Group Were Much Less Likely To Be Accredited Than Those In The Lower Groups

- Both average reimbursement and average number of visits per beneficiary of all accredited HHAs were lower than the average reimbursement and average number of visits of non-accredited HHAs. See pages A-9 through A-11.

CHARACTERISTICS OF BENEFICIARIES SERVED BY HHAs WERE SIMILAR AMONG ALL FOUR HHA GROUPS

- Little difference existed among the four groups of HHAs in the age of beneficiaries served. See page A-12.

- There was a slight increase in the percentage of episodes for female beneficiaries and nonwhite beneficiaries from the lower group to the higher groups. See pages A-13 and A-14.

- The percentage of deaths while in care of an HHA increased slightly from the lower group to the higher groups. See page A-15.

- The percentage of episodes for beneficiaries who were Medicare-eligible because they were aged, disabled or in end-stage renal disease was quite similar among the four groups. See page A-16.

- Lastly, an analysis of principal diagnostic codes, a proxy for medical condition, did not suggest that beneficiaries in the higher groups were any sicker or in any greater need of medical services than those beneficiaries in the lower and middle groups. See pages A-17 through A-21.

DISCUSSION

This report shows wide variation among 6,803 home health agencies (HHAs) in the average reimbursement per Medicare beneficiary in 1993. The major reason for the variation was the average number of visits per beneficiary that HHAs provided. Some HHAs made substantially more visits per beneficiary, on average, than others.

The work performed in this inspection must be placed in the broadest context, including the battery of OIG work in home health which has been performed over the past year. The findings from this inspection coupled with the findings from other OIG work present a picture of a Medicare benefit which is vulnerable to fraud and abuse. While variation in reimbursement among HHAs is not inherently bad, our analyses certainly suggest that excessive numbers of visits are being provided by some HHAs in some cases. Again, this conclusion is strengthened when considered with other OIG findings regarding abuse of the benefit and outright fraud. Examples of findings from other OIG work will make this clearer.

Over the past year, we have identified numerous instances of inappropriate home health payments through audits of provider claims in Florida and Georgia. For example, an audit of one HHA in Florida revealed that of $45.4 million claimed in 1993, well over half, $25.9 million, did not meet reimbursement requirements. Seventy five percent of the claims submitted did not meet Medicare guidelines. We found:

- visits claimed were never made;
- visits were made to persons who were not homebound;
- visits which physicians denied having authorized were made; and
- visits were made to beneficiaries who did not want the services.

In another project in Florida, we randomly selected HHA claims in the state and found that 26 percent of claims did not meet Medicare guidelines. Inappropriate claims included:

- visits to beneficiaries who were not homebound;
- visits to beneficiaries who did not need the services that were delivered; and
- visits claims for services not provided.

Based on these audit findings, we recommended that HCFA require physicians to have knowledge of beneficiaries' condition prior to certifying a plan of care, require fiscal intermediaries which review Florida claims to notify beneficiaries when claims are paid

on their behalf, and require fiscal intermediaries to perform in-depth reviews of claims from HHAs in Florida.

In an audit of an HHA based in Georgia, we found the agency claimed approximately $14 million in unallowable costs during one cost reporting year. Those unallowable costs included expenses for

- theater tickets,
- alcoholic beverages,
- bags of Vidalia onions for legislators, and
- gourmet popcorn for physicians.

We have found several types of fraud among HHAs, including

- cost report fraud,
- excessive services,
- services not rendered,
- use of unlicensed staff,
- falsified plans of care,
- forged physicians' signatures, and
- kickbacks.

Our investigative work has led to indictments and possible exclusions from the Medicare program. Between 1990 and 1994, OIG investigations led to 25 successful criminal prosecutions of HHAs or their employees and the imposition of 3 civil money penalties. In 1993 and 1994 alone, 39 HHAs or their employees were excluded from participating in the Medicare or Medicaid program.

We have also looked at how other payers manage home health benefits. In our inspection report, "Home Health Agencies: Alternative Coverage and Payment Policies," we describe mechanisms used by other payers. For example, other payers tend to structurally limit their benefit by capping the number of services or visits allowed per beneficiary. They also emphasize case management, post payment review, and ensure beneficiary participation through copayments. In addition they encourage beneficiaries to report cases of inappropriate services, abuse and fraud.

RECOMMENDATIONS

HCFA Should Explore Ways to Address Excessive Utilization and Inappropriate Variation in Reimbursement Among HHAs.

The work of the OIG's audit and investigations staff have identified instances of medically unnecessary care and inappropriate or fradulent billing by specific HHAs. The data in this report describes more broadly patterns of billing by certain HHAs which may indicate fraud or abuse. As such, we believe it is prudent for HCFA to take steps to investigate such patterns and place systematic controls on the home health benefit to prevent abuse.

First, HCFA Should Intensify its Efforts to Scrutinize Claims Submitted by High Cost Agencies.

HCFA has already begun this effort through its activities under Operation Restore Trust. We have provided information to HCFA about the agencies in our analysis which had higher than average per beneficiary reimbursement, for the purposes of targeting agencies for further review.

Second, HCFA Should Explore Ways in Which to Prevent Unscrupulous Agencies from Engaging in Abusive Practices.

In addition to targeting certain agencies for review, HCFA should work to develop mechanisms to prevent agencies from engaging in practices which result in inappropriate use of the home health benefit.

This can be done in a variety of ways. For example:

- Involving Beneficiaries in Detecting and Reporting Unscrupulous Behavior: through the use of Explanation of Medical Benefits (which HCFA is currently testing), confirmation of visits received, and certification of need and eligibility for home health care.

- Involving Physicians in Detecting and Reporting Unscrupulous Behavior: now that HCFA is paying physicians for case management services delivered to home health patients, it is in a good position to use physicians to monitor the care provided to beneficiaries, report unscrupulous providers, and refer patients to agencies with a record of good practice. This will require educational outreach to the physician community.

- Setting Higher Standards for Participation in the Medicare Program: HCFA is now considering its policies with regard to how agencies enter the Medicare program and obtain permission to bill for services, and under what conditions certain entities may be suspended or dropped from the program.

HCFA Should Continue Its Efforts To Improve The Home Health Benefit and To Control Fraud, Waste and Abuse.

We support HCFA's efforts in developing potential long term solutions towards benefit reform which will assist in preventing fraud and abuse by unscrupulous providers. These HCFA efforts include:

- Outcome Measures: We urge HCFA to continue their work in developing outcome measures which can be used to assess the performance of individual home health agencies.

- Prospective Payment System: We believe that a home health prospective payment system might be the most effective long term model for restructuring the benefit and we encourage HCFA to continue their work in testing such a system. We believe, however, that it is important that a new system not "grandfather" in utilization patterns of the higher-reimbursement agencies. It is worth noting that this was an important issue when a prospective payment system was being developed for hospitals.

Additional structural reform might also assist in preventing fraud, waste and abuse. As we indicated in a prior report, "Home Health Agencies: Alternative Coverage and Payment Policies," issued in May 1995, HCFA may wish to consider adopting certain practices of other third party payers.

We also believe that the use of aides deserves further examination, based on the data presented in this report.

We plan to work together with HCFA and the Assistant Secretary for Planning and Evaluation (ASPE) on further analysis which can help shape these alternatives.

Budget Implications

The elimination of fraud, waste and abuse in the home health benefit can create significant cost savings for the program. Such an elimination would ultimately reduce the average number of visits for beneficiaries overall, while ensuring that appropriate services are still delivered to beneficiaries in need. To estimate the potential impact of effective action, we developed the following calculations.

- We estimated Medicare expenditures based on different levels of average number of visits per beneficiary nationwide. For example, if the national average number of visits had been 45 instead of 50, Medicare would have saved over $1 billion in 1993 in Medicare payments for home health services.

- The average number of visits per Medicare beneficiary for almost two-thirds of home health agencies (the lower and middle groups) in 1993 was 33. If the average number of visits by the remaining one-third of HHAs had also been 33

visits per beneficiary, Medicare cost would have decreased by about $3.3 billion in 1993.

- However, based on HCFA actuarial figures, the average number of visits per beneficiary is increasing annually. Based on our calculations for 1993 data, each time the national average number of visits per beneficiary increases by one, it costs the Medicare program an additional $191.4 million. If this upward trend in the number of visits were to continue unabated, the potential increase in the cost to Medicare would be substantial.

- Using HCFA projections of $14.4 billion in Medicare home health care expenditures for 1995, an average number of 33 visits per HHA would result in a savings of nearly $5.0 billion.

AGENCY COMMENTS

We received comments on the report from HCFA and ASPE. HCFA concurred with our recommendations, but felt that the report did not fully distinguish between variation that is appropriate and variation that suggests excessive utilization or inappropriate reimbursement levels. HCFA concluded, however, that when considered with the other OIG work in home health over the last several years, the findings in this report do suggest enough of a pattern to recommend that HCFA examine, and address where appropriate, excessive utilization and inappropriate variation in reimbursement among HHAs.

ASPE concurred that the study showed clear evidence of patterns in home health agency practices, and that such patterns should be investigated and more thoroughly understood. Noting that our data were limited, ASPE stated that recommendations for change should be approached cautiously. ASPE expressed concern for the welfare of beneficiaries, and stated that any recommendations which would directly impact them be eliminated. ASPE suggested two follow-up reviews to our study -- one a regression analysis on potential causes of variation in cost, and two an intensive review to target high-cost HHAs.

We plan to work with HCFA and ASPE concerning additional efforts in this area, and have so indicated in the report. We have also made some revisions to the text of the report based on their comments, particularly in the focus of our recommendations.

The full text of HCFA and ASPE comments is contained in appendix C.

APPENDIX A

DETAILS REGARDING POSSIBLE CAUSES OF THE VARIATION IN AVERAGE REIMBURSEMENT PER BENEFICIARY AMONG HOME HEALTH AGENCIES

ORGANIZATIONAL AFFILIATION

THE MAJORITY OF AGENCIES IN THE TWO HIGHER GROUPS WERE NON-AFFILIATED HHAs

When we compared organizational affiliation, we found that the distribution of agencies affiliated with various types of larger, umbrella health care-related organizations was quite similar from one group to the next, except for the high-2 group. In the high-2 group, nearly twice the percentage of agencies are in the "other" category, which is the non-affiliated category.

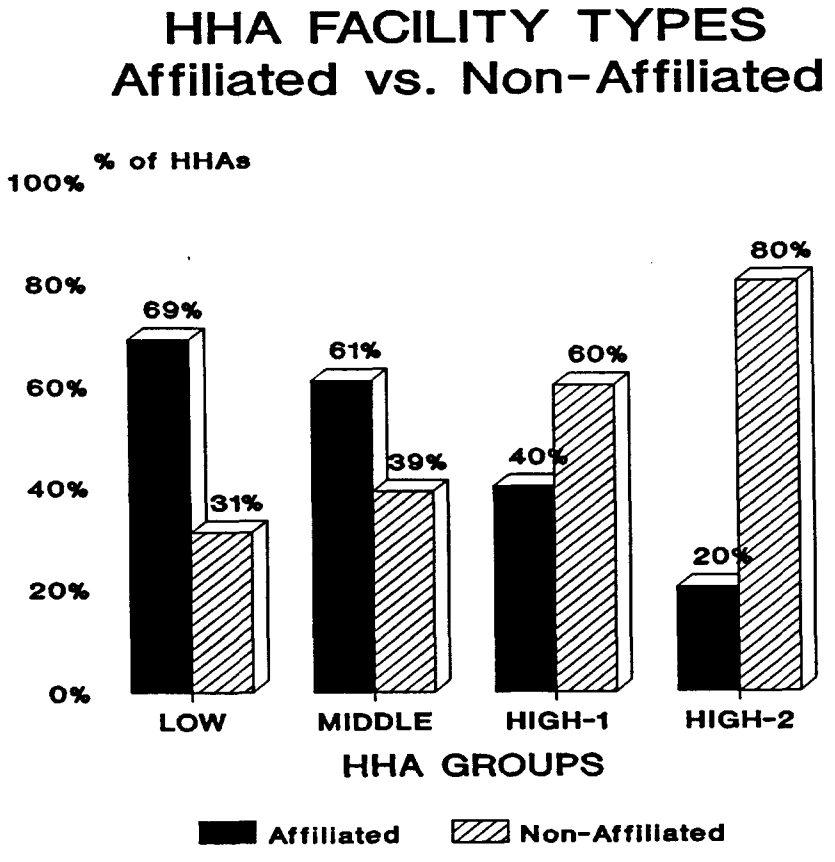
ORGANIZATIONAL AFFILIATION HHAs Arrayed into Four Groups Based on Their Average Medicare Reimbursement per Beneficiary				
FACILITY TYPE	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs	
			High-1	High-2
Visiting Nurse Association	8%	10%	6%	2%
Government & Voluntary*	1%	1%	1%	1%
Official Health Agency**	23%	13%	12%	12%
Rehabilitation	0%	0%	0%	0%
Hospital-Based	35%	36%	20%	4%
SNF-Based	2%	1%	1%	1%
Other/Non-affiliated	31%	39%	60%	80%
TOTALS	100%	100%	100%	100%

* Government and voluntary is a type of official health agency which is a governmental HHA that also receives voluntary support.

** Official health agency is usually a county or local public health department.

THE PERCENTAGE OF NON-AFFILIATED HHAs RISES FROM THE LOWER TO HIGHER GROUPS

The array of affiliated versus non-affiliated agencies is visually summarized in the following bar charts. Affiliated HHAs are those that are run by or are part of a visiting nurses association, a government or voluntary agency, an official health agency, a rehabilitation facility, a hospital, or a skilled nursing facility. Non-affiliated agencies are those defined by the HCFA as "other."



4 Groups of HHAs by Average Reimbursement per Beneficiary

BRANCHES

FORTY-ONE PERCENT OF THE HHAs IN THE HIGHEST GROUP HAD BRANCHES, OVER 3 TIMES THE PERCENTAGE OF HHAs IN THE LOWER GROUP

HHA WITH BRANCHES				
HHAs Arrayed into Four Groups Based on Their Average Medicare Reimbursement per Beneficiary				
	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs	
			High-1	High-2
Percent of HHAs with Branches	12.8%	20.7%	30.4%	41.4%

TYPE OF HHA VISIT

OVER HALF OF ALL VISITS PROVIDED BY HIGHER GROUP HHAs WERE HOME HEALTH AIDE VISITS

HHAs in the lower group provided nearly sixty percent of all their visits as skilled nursing and physical therapy visits while higher group agencies provided less than half of their visits in those categories.

TYPE OF VISIT PROVIDED BY HOME HEALTH AGENCIES TO MEDICARE BENEFICIARIES					
HHAs Arrayed into Four Groups Based on Their Average Medicare Reimbursement per Beneficiary					
Type of Visit Listed in Descending Order by Utilization	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
	Percentage of Total Visits				
Home Health Aides	38.1%	42.6%	51.4%	55.1%	46.9%
Skilled Nursing	48.6%	44.8%	40.3%	37.7%	42.7%
Physical Therapy	10.2%	9.3%	6.1%	5.2%	7.7%
Occupational Therapy	1.4%	1.5%	0.8%	0.5%	1.1%
Speech Pathology	0.9%	0.7%	0.5%	0.5%	0.6%
Social Services	0.8%	1.1%	0.9%	1.0%	1.0%
TOTALS	100%	100%	100%	100%	100%

PROFILE OF FTEs

HIGHER GROUP AGENCIES HAD A DISPROPORTIONATELY HIGHER NUMBER OF HOME HEALTH AIDES

PROFILE OF FTEs				
HHA STAFFING PROFILE BY NUMBER OF FTEs				
Average Number of FTE by Categories	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs	
			High-1	High-2
Registered Nurses	9.5 (41%)	14.8 (38%)	16.0 (31%)	15.6 (25%)
Licensed Practical Nurses	2.0 (9%)	2.0 (5%)	5.2 (10%)	8.9 (14%)
Physical Therapists	0.9	1.8	1.7	1.2
Occupational Therapists	0.2	0.5	0.4	0.4
Speech Therapists	0.1	0.3	0.3	0.3
Social Workers	0.5	0.8	0.8	1.2
Aide Workers	6.5 (28%)	12.9 (33%)	19.2 (37%)	25.1 (40%)
Pharmacists	0.02	0.04	0.03	0.03
Dieticians	0.05	0.06	0.06	0.20
All Other Staff	3.4	5.9	7.9	9.6
Average Total FTEs Per HHA In Each Group	23.2	39.0	51.5	62.5

TYPES OF SERVICES

HHAs IN ALL FOUR GROUPS ARE PROVIDING, IN GENERAL, THE SAME TYPES OF SERVICES

HHAs in all four groups provided nursing services and over 98 percent of all HHAs provided home health aide services. Well over half of all the agencies provided different types of therapy services, that is, physical, occupational, and speech, as well. Details of the percentage of each type of service provided by all four groups, both by HHA employees and by contract, are in the following table.

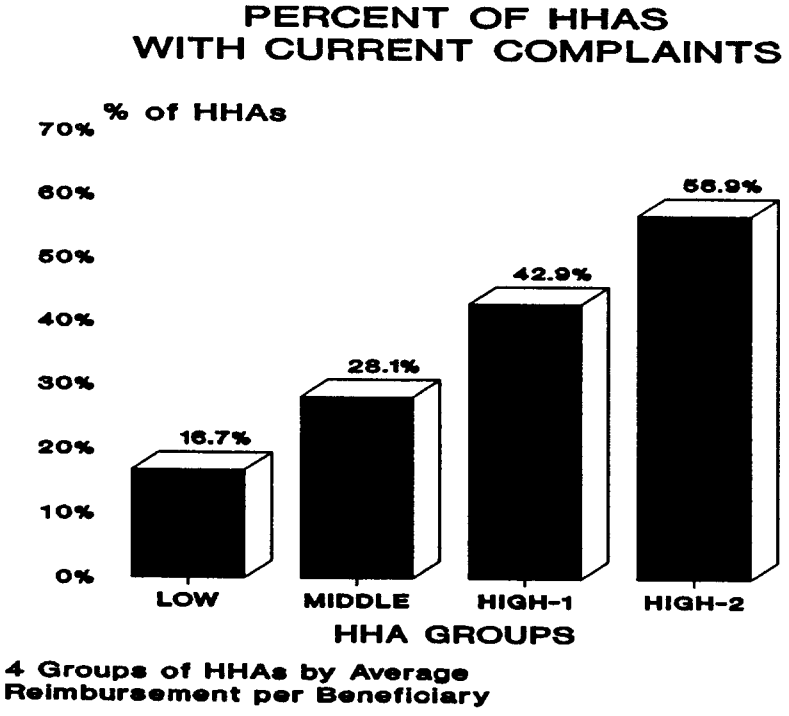
TYPES OF HOME HEALTH SERVICES PROVIDED BY HHAs HHAs Arrayed into Four Groups Based on Their Average Medicare Reimbursement per Beneficiary				
Type of Service HHAs Provide	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs	
			High-1	High-2
	Percentage of HHAs Providing Service			
Nursing	100%	100%	100%	100%
Physical Therapy	86.6%	93.8%	90.8%	90.9%
Occupational Therapy	64.0%	74.8%	71.7%	66.6%
Speech Therapy	71.7%	83.1%	74.5%	76.5%
Medical Social Worker	62.7%	78.5%	81.5%	82.4%
Home Health Aide	98.4%	99.5%	99.3%	98.8%
Interns & Residents	1.0%	1.0%	1.2%	1.5%
Food Services	25.5%	27.3%	20.5%	21.1%
Pharmacy	12.8%	15.7%	13.2%	12.0%
Medical Equipment	17.3%	16.2%	15.7%	15.8%
Vocational	1.8%	1.4%	1.5%	2.6%
Laboratory	13.9%	16.5%	16.7%	20.5%
Other	23.2%	22.7%	26.7%	29.9%

COMPLAINTS

THE PERCENTAGE OF HHAs IN THE HIGHEST GROUP THAT HAD AT LEAST ONE COMPLAINT WAS THREE TIMES THE PERCENTAGE OF HHAs IN THE LOWER GROUP

Anyone may lodge a complaint against an HHA. That is, the beneficiary, a friend or family member of the beneficiary, or an employee of an HHA is free to lodge a complaint. HHAs are required by Medicare regulations to inform all home health recipients of a hotline telephone number they or any other interested party may use to complain.

As the following figure illustrates, the percentage of HHAs with current complaints against them was nearly 57, as compared to nearly 17 percent in the lower group of HHAs.



ACCREDITATION

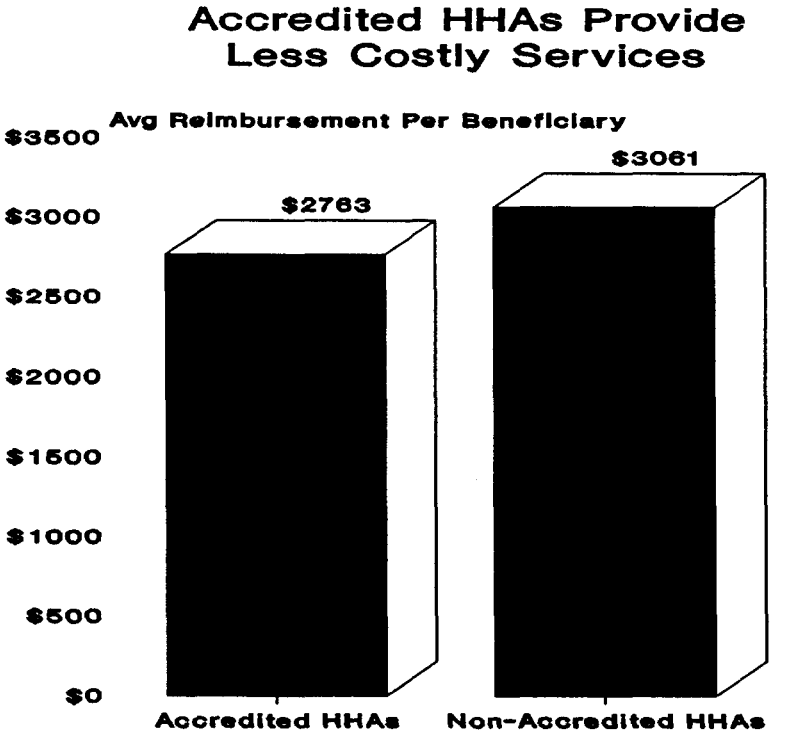
AGENCIES IN THE HIGHEST GROUP WERE MUCH LESS LIKELY TO BE ACCREDITED THAN THOSE IN THE LOWER GROUPS

An HHA may choose to achieve or continue their Medicare certification either through participation in a State agency survey or through a process called "deeming." Two not-for-profit organizations have been granted authority by HCFA to deem HHAs through an accreditation process. The two organizations are the Community Health Accreditation Program (CHAP), a subsidiary of the National League for Nursing, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Agencies that achieve accreditation from CHAP or JCAHO will be "deemed" compliant with Federal standards, that is the conditions of participation.

JCAHO AND CHAP ACCREDITED HHAs				
HHAs Arrayed into Four Groups Based on Their Average Medicare Reimbursement per Beneficiary				
TYPE OF ACCREDITATION	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs	
			High-1	High-2
Percent of HHAs JCAHO Accredited	19.3%	24.3%	15.8%	8.5%
Percent of HHAs CHAP Accredited	1.3%	1.8%	1.1%	.6%

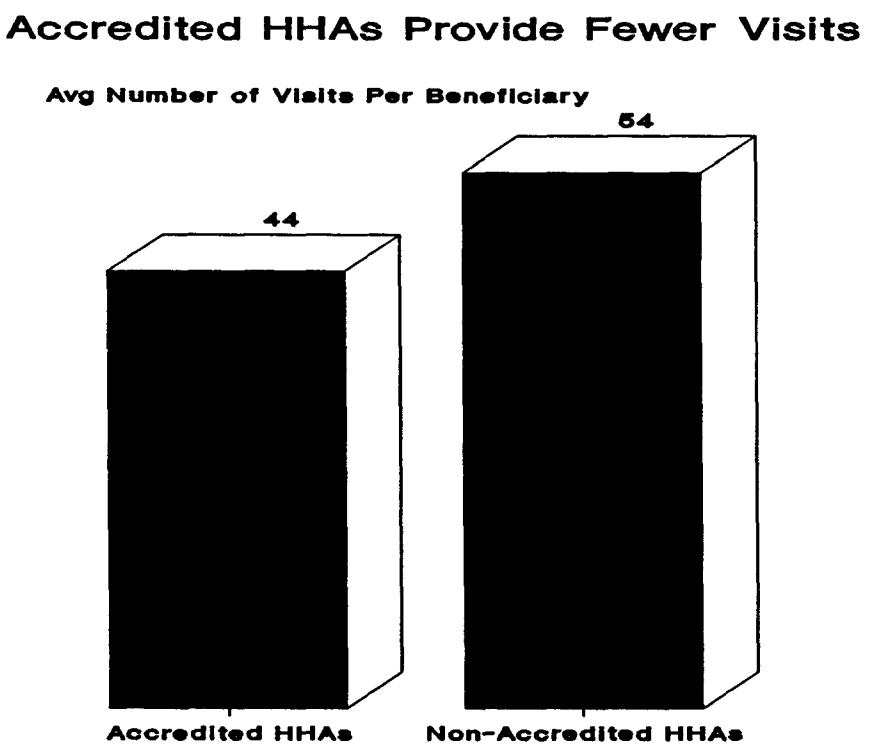
AVERAGE REIMBURSEMENT PER BENEFICIARY OF ALL ACCREDITED HHAs WAS LOWER THAN THE AVERAGE REIMBURSEMENT PER BENEFICIARY OF NON-ACCREDITED AGENCIES

One might assume that, due to the expense incurred for accreditation, agencies which elect to seek accreditation would have a higher average reimbursement per beneficiary than agencies which are not accredited. In other words, agencies which seek accreditation might tend to fall in the higher groups of HHAs. We found, however, that the average reimbursement per beneficiary receiving home health services in accredited HHAs was $300 less than beneficiaries receiving services from a non-accredited HHA.



AVERAGE NUMBER OF VISITS PER BENEFICIARY OF ALL ACCREDITED HHAs WAS LOWER THAN AVERAGE NUMBER OF VISITS PER BENEFICIARY OF NON-ACCREDITED AGENCIES

The average number of visits per beneficiary receiving home health services from an accredited HHA was 44. The average number of visits per beneficiary receiving home health services from a non-accredited HHA was 54. The mean for the entire 6,803 HHAs was 50 visits per beneficiary.



LITTLE DIFFERENCE EXISTED AMONG THE FOUR GROUPS OF HHAs IN THE AGE OF THE BENEFICIARIES THEY SERVED

When we compared the average age of beneficiaries being served by the HHAs in the four groups, we found a very small variation among the groups.

AGE OF MEDICARE BENEFICIARIES RECEIVING HOME HEALTH SERVICES					
HHAs Arrayed into Four Groups Based on Their Average Medicare Reimbursement per Beneficiary					
Percent of Home Health Episodes for Medicare Beneficiaries Who Are:	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
Age <65	6.3%	6.8%	7.5%	8.5%	7.0%
Age 65-79	53.1%	51.2%	49.7%	48.8%	51.1%
Age >79	40.6%	42.0%	42.8%	42.7%	41.9%
Total	100%	100%	100%	100%	100%
Average Age of Beneficiary When Home Health Service Began	76.4	76.7	76.5	75.7	76.5

GENDER OF BENEFICIARY

THERE WAS A SLIGHT INCREASE IN THE PERCENTAGE OF EPISODES FOR FEMALE BENEFICIARIES FROM THE LOWER GROUP TO THE HIGHER GROUPS

As illustrated by the table below, the percentage of females increased by about 3 percentage points from the lower group to the high-1 group and by about 4 percentage points from the lower group to the high-2 group. On the other hand, the percentage of males decreased by about 2 percentage points from the lower group to the high-1 group and by about 4 percentage points from the lower group to the high-2 group.

GENDER OF MEDICARE BENEFICIARIES RECEIVING HOME HEALTH SERVICES					
HHAs Arrayed into Four Groups Based on Their Average Medicare Reimbursement per Beneficiary					
Percent of Home Health Episodes for Medicare Beneficiaries	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
Females	63.8%	64.8%	66.0%	67.6%	65.0%
Males	36.2%	35.2%	34.0%	32.4%	35.0%
Total	100%	100%	100%	100%	100%

RACE OF BENEFICIARY

THE PERCENTAGE OF EPISODES FOR NON-WHITE BENEFICIARIES INCREASED FROM THE LOWER GROUP TO THE HIGHER GROUPS

The percentage of episodes for non-white beneficiaries nearly doubled from the lower group to the high-2 group, as illustrated by the following table. On the other hand, the percentage of episodes for white beneficiaries decreased by about 7 percentage points from the lower group to the high-1 group and by about 11 percentage points from the lower group to the high-2 group.

WHITE VS. NON-WHITE MEDICARE BENEFICIARIES RECEIVING HOME HEALTH SERVICES					
HHAs Arrayed into Four Groups Based on Their Average Medicare Reimbursement per Beneficiary					
Percent of Home Health Episodes for Beneficiaries	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total
			High-1	High-2	
White	88.4%	85.6%	81.3%	77.3%	84.7%
Non-White	11.8%	14.4%	18.7%	22.7%	15.3%
Total	100%	100%	100%	100%	100%

DEATHS WHILE IN CARE

THERE WAS A SLIGHT DIFFERENCE IN THE PERCENT OF DEATHS WHILE IN CARE OF A HOME HEALTH AGENCY BETWEEN THE LOWER GROUP AND THE HIGHER GROUPS

When we examined home health services that were truncated by death of the beneficiary, we found only a slight difference.

BENEFICIARIES WHO DIED WHILE IN CARE OF A HOME HEALTH AGENCY					
HHAs Arrayed into Four Groups Based on Their Average Medicare Reimbursement per Beneficiary					
	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total
			High-1	High-2	
Percent of Medicare Beneficiaries Who Died During a Home Health Episode	2.4%	2.7%	3.2%	3.5%	2.8%

ELIGIBILITY OF BENEFICIARY

THE PERCENTAGE OF EPISODES FOR BENEFICIARIES WHO WERE MEDICARE-ELIGIBLE BECAUSE THEY WERE AGED, DISABLED OR IN END-STAGE RENAL DISEASE WAS SIMILAR AMONG GROUPS

We found only a slight difference among the groups, as shown below.

ELIGIBILITY OF MEDICARE BENEFICIARIES RECEIVING HOME HEALTH SERVICES					
HHAs Arrayed into Four Groups Based on Their Average Medicare Reimbursement per Beneficiary					
Percent of Episodes for Beneficiaries Who Are:	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
Aged	93.2%	92.6%	92.0%	91.3%	92.5%
Disabled	5.1%	5.4%	6.1%	6.4%	5.6%
ESRD	1.7%	2.0%	1.9%	1.8%	1.9%
Total	100%	100%	100%	100%	100%

AVERAGE MEDICARE REIMBURSEMENT PER BENEFICIARY INCREASED GREATLY FROM THE LOWER GROUP AGENCIES TO THE HIGHER GROUP AGENCIES WITHIN EACH DIAGNOSTIC CODE

We arrayed all diagnostic codes by total reimbursement by the Medicare program to the 6,803 HHAs in our inspection. The following table shows the 15 diagnostic codes with the highest reimbursement amounts representing 52.4 percent of total Medicare expenditures for home health in calendar year 1993.

ANALYSIS OF TOP FIFTEEN DIAGNOSTIC CODES
Groups Arrayed by Average Reimbursement Per Beneficiary

ICD-9-CM Diagnostic Code	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
Diabetes Mellitus	$1,575	$2,752	$4,988	$8,386	$3,652
Heart Failure	$1,423	$2,172	$3,380	$6,047	$2,537
Chronic Ulcer of Skin	$2,714	$4,145	$5,981	$8,908	$4,610
Cerebrovascular Disease	$1,946	$2,798	$3,916	$5,831	$3,049
Hypertension	$1,177	$1,860	$2,959	$5,071	$2,513
Pulmonary Disease	$1,474	$2,215	$3,327	$5,103	$2,498
Osteoarthrosis	$1,027	$1,509	$2,273	$3,979	$1,692
Urinary System Symptoms	$2,461	$3,473	$4,815	$7,156	$3,685
Fracture of Neck of Femur	$1,327	$1,946	$2,691	$3,935	$2,056
Cardiac Dysrhythmias	$1,124	$1,723	$2,689	$4,352	$2,055
Other Urinary Tract Disorders	$1,486	$2,062	$3,001	$4,765	$2,501
General Symptoms	$1,224	$1,983	$3,035	$5,108	$2,287
Osteoporosis	$1,882	$2,984	$4,124	$7,083	$3,035
Other Forms of Heart Disease	$1,069	$1,558	$2,560	$4,710	$1,834
Pneumonia	$1,045	$1,523	$2,152	$3,045	$1,629

Even when adjusting for size of the HHA, such differences remain. For example, we analyzed patterns of payment for the three principal diagnoses which accounted for almost one quarter of all 1993 Medicare expenditures, diabetes, heart failure, and skin ulcers, concentrating only on large HHAs (those with at least 1,000 beneficiaries). These results were consistent with those shown on the previous page. Using the principal diagnosis of diabetes we found that large HHAs with over $5,000 average reimbursement per beneficiary were reimbursed an average of $7,174; large HHAs with an average reimbursement per beneficiary of $3,000 to $5,000 were reimbursed an average of $4,433; large HHAs with an average reimbursement per beneficiary of $1,000 to $3,000 were reimbursed an average of $2,293; and all other large HHAs were reimbursed an average of $1,481.

AVERAGE REIMBURSEMENT PER VISIT IN EACH DIAGNOSTIC CODE DID NOT VARY MUCH AMONG THE FOUR GROUPS OF HHAs

When we analyzed the average reimbursement per visit in the top 15 diagnostic codes, we found little variation.

AVERAGE REIMBURSEMENT PER VISIT PROVIDED BY HOME HEALTH AGENCIES
Groups Arrayed by Average Reimbursement Per Beneficiary

ICD-9-CM Diagnostic Code	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
Diabetes Mellitus	$52.29	$56.88	$57.51	$53.13	$56.16
Heart Failure	$55.39	$59.56	$55.26	$61.37	$57.33
Chronic Ulcer of Skin	$57.78	$64.02	$62.22	$58.65	$61.92
Cerebrovascular Disease	$56.07	$62.22	$60.20	$52.52	$59.66
Hypertension	$47.91	$52.55	$53.81	$55.65	$53.35
Pulmonary Disease	$54.79	$60.01	$58.42	$59.36	$58.50
Osteoarthrosis	$58.03	$64.62	$59.88	$56.72	$60.98
Urinary Systems Symptoms	$55.83	$61.19	$57.73	$60.44	$58.84
Fracture of Neck of Femur	$58.18	$65.34	$64.58	$52.06	$62.93
Cardiac Dysrhythmias	$55.35	$57.82	$57.01	$57.30	$57.11
Other Urinary Tract Disorders	$55.20	$58.79	$55.96	$57.19	$56.86
General Symptoms	$55.54	$59.25	$56.85	$56.57	$57.46
Osteoporosis	$56.21	$61.73	$59.68	$60.40	$60.05
Other Forms of Heart Disease	$56.62	$61.59	$58.83	$57.17	$59.29
Pneumonia	$58.26	$63.98	$61.31	$44.51	$60.38

THE NUMBER OF VISITS PER BENEFICIARY IN EACH DIAGNOSTIC CODE INCREASED GREATLY FROM THE LOW GROUP TO THE HIGHER GROUPS

We found that the average number of visits in the highest group HHAs was from 3 to 5 times greater than the average number of visits in the lower group agencies.

AVERAGE NUMBER OF VISITS PER BENEFICIARY PROVIDED BY HOME HEALTH AGENCIES
Groups Arrayed by Average Reimbursement Per Beneficiary

ICD-9-CM Diagnostic Code	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
Diabetes Mellitus	30	48	87	158	65
Heart Failure	26	37	61	99	44
Chronic Ulcer of Skin	47	65	96	152	75
Cerebrovascular Disease	35	45	65	111	51
Hypertension	25	35	55	91	47
Pulmonary Disease	27	37	57	86	43
Osteoarthrosis	18	23	38	70	28
Urinary Systems Symptoms	44	57	83	118	63
Fracture of Neck of Femur	23	30	42	76	33
Cardiac Dysrhythmias	20	30	47	76	36
Other Urinary Tract Disorders	27	35	54	83	44
General Symptoms	22	33	53	90	40
Osteoporosis	34	48	69	117	55
Other Forms of Heart Disease	19	25	43	82	31
Pneumonia	18	24	35	68	27

HIGH GROUP SERVED ONLY 5% OF THE BENEFICIARIES, BUT RECEIVED NEARLY 11% OF THE MEDICARE DOLLARS

The 15 diagnostic codes in this analysis had the highest reimbursement of all diagnostic codes and in the aggregate represented nearly 52 percent of Medicare reimbursement for home health care in 1993.

PERCENT OF BENEFICIARIES AND REIMBURSEMENT FOR 15 DIAGNOSTIC CODES

Groups Arrayed by Average Reimbursement Per Beneficiary

	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total
			High-1	High-2	
Percent of Beneficiaries Receiving Home Health Services in the Top 15 Diagnostic Codes	22.86%	39.75%	32.35%	5.04%	100%
Percent of Total Reimbursement to the HHAs for the 15 Top Diagnostic Codes	12.67%	33.64%	42.76%	10.93%	100%

APPENDIX B

CALCULATION OF ESTIMATED SAVINGS

The formula we used for estimating savings to Medicare that would result from reducing the average number of visits is illustrated with the following example. Our calculations are based on a universe of 3.26 million beneficiaries receiving care from 6,803 home health agencies in 1993. The average number of visits per beneficiary made by the HHAs was 50.

Our calculations show that decreasing the average number of visits per beneficiary nationally by one visit results in a savings of more than $190 million. In our example below, we used an average of 45 visits per beneficiary -- a reduction of about 5 from the national average of 50.4. By reducing the average number of visits from 50.4 to 45, Medicare would save over $1 billion.

Average Cost Per Home Health Visit:	$58.66
Average # of Visits Per Beneficiary Episode	x 45
Average Cost Per Beneficiary Episode	$2,639.70
Total Beneficiary Episodes	x 3,263,100
Total Reimbursement Cost @45 Visits	$8,613,605,070
Total Reimbursement Cost @50.4 Visits	$9,648,423,752
Annual Savings to Medicare	$1,034,818,682

APPENDIX C

AGENCY COMMENTS

- HEALTH CARE FINANCING ADMINISTRATION
- ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE JUN 28 1995

TO June Gibbs Brown
Inspector General

FROM Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General (OIG) Draft Report: "Variation Among Home Health Agencies in Medicare Payments for Home Health Services" (OEI-04-93-00260)

This draft report, which provides information on the extent and causes of variation in Medicare payments for home health care, helps to identify the problems we are addressing together as part of Operation Restore Trust.

We concur with OIG's recommendations with one comment: We believe the report should fully distinguish between variation that is appropriate and variation that suggests excessive utilization or inappropriate reimbursement levels.

Our specific comments on the report's recommendations are attached. Thank you for the opportunity to review and comment on this report. I look forward to working with you in the future on these issues.

Attachment

Health Care Financing Administration's (HCFA) Comments on Office of Inspector General (OIG) Draft Report: Variation Among Home Health Agencies (HHAs) in Medicare Payments for Home Health Services (OEI-04-93-00260)

OIG Recommendation 1

HCFA should explore ways to address excessive utilization and inappropriate variation in reimbursement among HHAs.

HCFA Response

We concur. Through the Medicare Home Health Initiative, HCFA is exploring ways to restructure the benefit and payment policy to address the problems identified by OIG and us. We will consider the suggestions offered by OIG to address excessive utilization.

HCFA currently has a demonstration that pays for home health prospectively, on a per episode basis. This method of payment would resolve the problem of overutilization of visits regardless of the type of visit. This payment method would also eliminate the need for agency limits, as suggested in the report. Even though we are a number of years from implementing this type of prospective payment system (PPS), any system which sets parameters for number of visits by specific condition would be as extensive a project as a per episode PPS.

OIG Recommendation 2

HCFA should continue its efforts to improve the home health benefit and to control fraud, waste, and abuse.

HCFA Response

We concur. As mentioned in the report, HCFA is striving to achieve a well managed home health benefit and to control fraud, waste, and abuse through the Medicare Home Health Initiative and various agencywide fraud and abuse detection and enforcement activities. We appreciate, and will pay heed to, OIG's advice to consider options that maintain the quality of services and that do not financially punish beneficiaries for abusive, excessive, or fraudulent practices of providers.

Additional Comments

Methodology

We do not believe that the OIG methodology allows one to firmly draw a conclusion that the variation in Medicare payments among HHAs, as found by OIG, is a result of inappropriate utilization, waste, fraud, and abuse. As OIG itself concedes:

- The data used in its report are inherently descriptive and, as such, do not purport to show causal relationships relating to the variation in reimbursement among HHAs.

- A host of other, nonobserved, factors may contribute to variation in reimbursement, including severity of illness and case mix, payer mix, and the role of other caregivers in the home.

Further, the report does not fully distinguish between variation that is appropriate and variation that suggests excessive utilization or inappropriate reimbursement levels.

Nevertheless, the report's findings, taken in conjunction with the battery of OIG work in home health performed over the past year, do suggest enough of a pattern to recommend that HCFA examine, and address where proper, excessive utilization and inappropriate variation in reimbursement among HHAs.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JUNE 22, 1995

TO: June Gibbs Brown
Inspector General

FROM: Assistant Secretary for
Planning and Evaluatiion

SUBJECT: OIG Draft Report "Variation Among Home Health Agencies in Medicare Payments for Home Health Services," OEI-04-93-00260 - COMMENTS

We are pleased to have the opportunity to comment on such an important report. The study shows clear evidence of patterns in home health agency practice where visit and reimbursement rates vary significantly from agency to agency, and appear to have an upward trend in certain agency groupings (non-affiliated). This report is significant, and as such, the findings should stimulate additional close review which are essential to efforts to control fraud and abuse in "Operation Restore Trust."

This report clearly demonstrates patterns that should be investigated and more thoroughly understood. We understand that this report is a quick effort to try to identify reasons for variation. However because the data are limited, particularly the data on patient characteristics and severity of illness, we suggest that you proceed cautiously when offering recommendations for change. Strong unsubstantiated recommendations may prove harmful to patients if incorrectly interpreted.

Accordingly, we make several suggestions regarding revisions to this report:

- **First**, eliminate the recommendations that affect patients directly (i.e., agency visit limits and beneficiary limit pp. 17-18) and instead suggest a follow-up study to determine a cause and effect relationship with a regression analysis factoring in agency patterns and essential patient characteristics (e.g., age, gender, severity of illness).

- **Second,** the findings identify interesting agency patterns that could be used to streamline government oversight. Agencies that fall outside the patterns found in the study should be targeted for intensified review. The government representatives could use the following mechanisms to target specific agencies and cases:

1. Establish visit triggers for intensified review by intermediaries to assess appropriate volume and levels of care based on selective criteria, e.g., more than 50, 100, or 150 visits should have intensive review by qualified case-managers to look at functional status, medications, diagnosis, age, gender, and home environment.

2. Increase efforts by auditors, program integrity and fraud and abuse teams to capture agency mismanagement of the benefit. Target agencies that are outliers. For example, non-affiliated agencies with high visit averages and branch offices, or agencies with high reimbursement averages, complaints and deficiencies.

- **Third,** we suggest that all references to determining causality be eliminated. The purpose of the study is stated as "to determine the extent and causes of variation . . . " (P.1) but in fact it did not measure any cause and effect relationships. Other causal statements throughout the text should be eliminated to avoid misinterpretations of the findings.

David T. Ellwood

Prepared by: RuthI 260-0370