
October 1997

MEDICARE HOME HEALTH

Differences in Service Use by HMO and Fee-for-Service Providers



**Health, Education, and
Human Services Division**

B-271479

October 21, 1997

The Honorable Charles E. Grassley
Chairman, Special Committee on Aging
United States Senate

Dear Mr. Chairman:

In an effort to contain health care spending while preserving access to services and quality of care found in Medicare fee-for-service, the Congress authorized the use of risk-contract health maintenance organizations (HMO)¹ in the Medicare program. Unlike fee-for-service, where Medicare usually makes a separate payment for each service provided, Medicare pays risk-contract HMOs a capitated—or fixed per patient—payment to cover all health services. Medicare HMO enrollment is growing by more than 100,000 beneficiaries per month. More than 12 percent, or almost 4.9 million, of the approximately 38 million Medicare beneficiaries are now enrolled in risk-contract HMOs. Proponents of managed care state that HMOs offer the potential to coordinate all the services needed to treat a patient and to ensure the appropriate use of services. Critics, however, argue that Medicare HMOs may withhold necessary services to save money.

Given the increasingly important role of managed care in Medicare and your interest in the ability of HMOs to meet the needs of vulnerable populations, you asked us to examine home health services provided by Medicare HMOs. In the fee-for-service program, home health services are used intensively by some of Medicare's sickest and most functionally impaired beneficiaries. In contrast, relatively little is known about the use of home health services by Medicare HMO enrollees. Therefore, you asked us (1) to examine how Medicare HMOs provide and manage home health services, as compared to fee-for-service providers, and (2) what is known about the appropriateness of home health services provided to HMO enrollees, especially to vulnerable populations.

To address these questions, we visited six Medicare HMOs, which together account for about 10 percent of all Medicare beneficiaries enrolled in risk-contract HMOs. At these HMOs, we interviewed utilization review and quality assurance staff and gathered documents relating to these areas. We

¹Our use of the term HMO in this report includes both HMOs and competitive medical plans holding Medicare risk contracts for prepaid care. Competitive medical plans are subject to regulatory requirements similar to those for HMOs, but they have more flexibility in how they set premiums and services for commercial members.

also interviewed staff from eight home health agencies that contract with these HMOs. Most of these agencies also provide services to Medicare fee-for-service patients and thus were able to describe their experiences with home health under both the HMO and fee-for-service programs. We also interviewed officials from the Health Care Financing Administration (HCFA), which manages the Medicare program; reviewed a sample of appeals from Medicare HMO enrollees who were denied home health services; and reviewed pertinent laws, regulations, HCFA policies, and research by others. Details on our scope and methodology are provided in the appendix.

Results in Brief

Since the late 1980s, when the Congress and the courts liberalized Medicare coverage of home health services, the contrasting financial incentives of HMO and fee-for-service providers have led to some divergence in the use of these services. Fee-for-service providers generally have responded to the increased latitude in the home health benefit by providing more patients with more services for longer periods, in some cases providing excessive services. In contrast, home health agencies and HMOs in our study reported that HMOs tend to emphasize shorter-term recuperation and rehabilitation goals—much as fee-for-service providers did prior to the changes in coverage guidelines. Differences between HMO and fee-for-service providers are most apparent in the use of home health aides. In the fee-for-service program, the use of home health aides to provide long-term care for patients with chronic conditions is growing, whereas the six HMOs we visited report that they do not provide aide services on a long-term basis.

Typically, Medicare HMOs manage home health care much more actively than the fee-for-service program. For example, the Medicare HMOs we visited use case managers, preservice authorization, and selective contracting with home health agencies to manage home health services and avoid providing unnecessary care. In contrast, the fee-for-service program has less effective controls for preventing unnecessary and noncovered services, such as care provided to patients who are not homebound.

Our interviews and recent studies also indicate that home health utilization differs between HMO and fee-for-service patients. The greater emphasis on short-term goals and the more active management of care by HMOs likely contribute to shorter episodes of care and the use of fewer home health visits, especially by home health aides. In addition, data from

one managed care market suggest utilization differences are more pronounced for longer-term home health patients. Given the approach to home health care by some Medicare HMOs, including a greater focus on post-acute needs, Medicare beneficiaries with long-term care needs and chronic illnesses enrolled in HMOs may not receive the same services as they would in fee-for-service Medicare.

Although there are these differences in utilization, HCFA does not have the information it needs to evaluate the home health care patients receive in either the HMO or fee-for-service program. HCFA does not collect data on the services provided to HMO enrollees, as it does for fee-for-service beneficiaries, and therefore cannot identify outlier HMOs or beneficiary groups for further review. In addition, HCFA does not specifically review home health care during biannual monitoring visits to HMOs. Patient assessment information and outcomes data could assist HCFA in determining whether differences in home health utilization under HMOs and under fee-for-service are appropriate. HCFA plans to collect some outcomes information, but it will not be available for some time.

Background

Medicare is a health insurance program available to almost all people 65 years of age and older and to certain disabled people. The program provides protection under two parts. Part A, the hospital insurance program, covers inpatient hospital, skilled nursing facility, home health, and hospice services. Part B, the supplementary medical insurance program, primarily covers physician services but also covers home health care for beneficiaries not covered under part A.² Although most of the 38 million Medicare beneficiaries receive their health care from fee-for-service providers, the nearly 5 million beneficiaries enrolled in HMOs participating in Medicare's risk-contract program receive home health care through their HMOs.

Medicare Fee-for-Service Home Health Program

To qualify for home health care, a Medicare beneficiary must be homebound, that is confined to his or her residence; require intermittent skilled nursing, physical therapy, or speech therapy; and be under the care of a physician. In addition, the services must be furnished under a plan of

²The Balanced Budget Act of 1997 (P.L. 105-33) revised which of the two parts of the Medicare program pays for home health services but not the extent of benefits received. Beginning in January 1998, part B will pay for any visits in excess of 100 following a hospital stay and for all visits not related to hospitalization, unless the beneficiary is not enrolled in part B. In cases where a beneficiary is only enrolled in one part of Medicare, that part will pay for all covered home health visits.

care that is prescribed and reviewed at least every 62 days by a physician. If these conditions are met, Medicare will pay for skilled nursing; physical, occupational, and speech therapies; medical social services; home health aide visits; and durable medical equipment and medical supplies. As long as the care is reasonable and necessary and meets the above criteria, there are no limits on the number of home health visits or length of coverage.

The home health benefit is one of the fastest growing components of Medicare fee-for-service spending. From 1989 to 1996, part A fee-for-service expenditures for home health increased more than 600 percent—from \$2.4 billion to \$17.7 billion. The number of beneficiaries receiving home health care more than doubled, from 1.7 million in 1989 to about 3.9 million in 1996. While the Congress liberalized the Medicare home health benefit in 1980, the dramatic growth in these services is primarily the result of changes to HCFA's home health guidelines made in 1989. HCFA was ordered by a federal court to make these changes in response to a court decision that invalidated HCFA's interpretation of the coverage requirements.³ The 1980 statutory amendments removed the requirements that home health visits under part A be preceded by a hospital stay of at least 3 days and be for a condition related to the hospitalization. The amendments also abolished the 100-home-health-visit limitation under parts A and B. The new guidelines issued in 1989 allowed home health agencies to increase the frequency of visits by clarifying the definition of "part-time" or "intermittent" care, making it easier to qualify for skilled care, and increasing the standard of review before payment for services could be denied. These changes made the home health benefit available to more beneficiaries, for less acute conditions, and for longer periods of time.

Under Medicare fee-for-service, providers are paid for each home health visit and, except for durable medical equipment, beneficiaries do not share in the cost. Therefore, neither providers nor beneficiaries has financial incentives to control the number of services used.⁴ At the same time that home health expenditures have been growing rapidly, funding for program safeguards, such as reviewing claims, decreased sharply. The recent

³Duggan v. Bowen, 691 F. Supp. 1487 (D. D.C. 1988).

⁴The Balanced Budget Act of 1997 mandates a prospective payment system for all fee-for-service home health services beginning on or after October 1, 1999. Under this system, home health agencies will receive a set payment for each unit of service they provide (not yet defined), adjusted for patient case mix and area wages. This system will replace the reasonable-cost payment method, which pays home health agencies based on their costs, subject to certain limits. Until the prospective payment system is established, the Balanced Budget Act established an interim payment system to help control the cost and utilization of services. Prospective payments for home health services will alter the financial incentives fee-for-service providers face.

enactment of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) has increased future funding for program safeguards. After adjusting for inflation, however, per-claim expenditures for program safeguards will remain below the 1989 level. HCFA has recently taken several steps to address the growing problem of home health fraud, such as a temporary moratorium on the entry of new home health agencies into Medicare while the agency reviews its requirements for home health agencies to enter and remain in the program.

Medicare HMO Program

Medicare risk-contract HMOs are paid a fixed amount per month per beneficiary under a payment method known as capitation.⁵ This method places HMOs at risk for health costs that exceed this capitated amount, giving them a financial incentive to provide fewer services, emphasize preventive care, and avoid unnecessary care. As of August 1, 1997, almost 4.9 million Medicare beneficiaries, or more than 12 percent, were enrolled in risk-contract HMOs.

Medicare HMOs are required to provide the complete health benefit package available under the fee-for-service program, but they can choose to provide more services. For instance, while Medicare fee-for-service requires that patients be homebound to qualify for home health services, Medicare HMOs can waive this restriction. In addition, HCFA guidance states that the HMO is allowed to direct the delivery of care. In contrast, a patient in fee-for-service may, in consultation with a physician, seek home health services without obtaining authorization from a third-party—a requirement most HMOs impose.

Medicare patients may appeal an HMO refusal to provide health services they believe are covered or medically necessary. If a patient appeals such a denial, the HMO must reconsider its initial decision. If the HMO's reconsideration is not fully favorable to the patient, the HMO must forward the appeal for independent review by a HCFA contractor—the Center for Health Dispute Resolution, formerly the Network Design Group—which makes the final reconsideration decision. If dissatisfied with this decision

⁵Almost 90 percent of Medicare beneficiaries now in managed care are enrolled in risk-contract HMOs. The remaining beneficiaries are enrolled in cost HMOs, health care prepayment plans (HCPP), or demonstration plans. Cost HMOs do not restrict provider choice but require beneficiary payments for care received outside the HMO network. These HMOs are reimbursed by HCFA for the cost of providing covered Medicare services. HCPPs do not operate like risk-contract or cost HMOs. For example, HCPPs may cover only Medicare part B services and may have restrictive enrollment policies. Demonstration plans include other types of managed care plans, such as provider-sponsored networks and preferred provider organizations.

and the amount in dispute is \$100 or more, HMO patients can take their appeals to an administrative law judge, as can fee-for-service patients.

Role of Home Health Services Varies Between HMO and Fee-for-Service Providers

Contrasting financial incentives and different interpretations of the Medicare home health benefit have led to some divergence in the way home health services are used by HMO and fee-for-service providers. Staff at the six HMOs and the eight home health agencies we reviewed described different approaches for home health services used by HMO and fee-for-service providers. The reports from the two groups suggest that these HMOs emphasize shorter-term, rehabilitation goals, while fee-for-service providers may give more emphasis to social and environmental factors affecting service needs, especially in their use of home health aides. The coverage criteria for Medicare's home health benefit allow providers enough latitude to interpret the criteria in a manner that favors their financial interests. While HMOs control services more closely than fee-for-service providers, home health agencies that serve both HMO and fee-for-service patients told us they were generally able to obtain approval to provide services they considered sufficient to HMO enrollees. Some home health agency staff did express concerns about the HMOs' approaches to home health care; however, home health agency staff also acknowledged that fee-for-service patients sometimes receive unnecessary services.

HMOs Emphasize Different Goals for Home Health Services

Home health agency staff described HMOs as having a somewhat different approach to home health than fee-for-service providers. They told us that HMOs tend to focus more on shorter-term goals that allow the HMO to discontinue services as soon as possible. Staff at several HMOs we visited reported that their goal for home health services is to help patients function independently and not rely on home health care. To do so, they establish specific rehabilitation goals focused on a patient's needs. For instance, if a patient needs to climb six stairs to reach the bathroom at home, then the home health therapist will focus on this goal. Once the patient attains the specific goal, HMOs may terminate home health services if the patient does not require any other skilled nursing or skilled therapy care.

Home health agencies also seek to achieve independence for their fee-for-service patients. However, in contrast to HMOs, some home health agencies reported taking a broader approach to patient functioning, providing additional services—especially supportive or aide services—that

take into consideration the patient's overall condition and environment. With fee-for-service patients, home health agency staff said they tend to provide services over a longer period to ensure patients are fully healed and knowledgeable about the medical condition involved. In contrast, they said an HMO may authorize the home health agency only a certain number of visits to teach a patient about his or her other medical condition, even if environmental factors, such as family stress, suggest that the patient may have difficulty absorbing the information within the HMO's time frame.

A nurse manager in one home health agency explained that under managed care, home health agencies are learning to focus on the problem at hand rather than trying to give patients services for unrelated or other chronic conditions. She explained that in fee-for-service, the home health agency's goal has been to resolve every condition that a patient had. For instance, if home health services were initiated because a diabetic patient had a wound that required skilled nursing care, a home health agency might review educational materials about diabetes with the patient, even if the patient had had diabetes for a number of years. In contrast, HMOs tend to focus on the specific condition that initiated the home health episode.

Financial Incentives and Interpretation of Coverage Criteria Influence Use of Home Health Services

Because HMOs are at risk for service costs that exceed the capitated payment, they generally seek to provide enough services to maintain or restore patient health and prevent the need for more expensive care, while not providing more care than necessary. While there are financial incentives to limit services, discontinuing services too soon could become more costly if patient conditions worsen. Balancing these financial and health interests can influence the use of home health services. For example, an HMO may not believe it necessary for a home health nurse to continue to visit a wound patient until the wound is completely healed, while a fee-for-service provider may.

Applying the definitions of skilled services is not always straightforward and is based on clinical judgment in many cases. For example, the management of a care plan is considered a skilled service if it requires the skills of a nurse or therapist to ensure the patient's medical safety and recovery—even if all other services in the care plan are unskilled. Since such criteria are based on judgment and are open to interpretation, providers faced with borderline cases may make decisions that favor their financial interests. The executive director of one home health agency noted that the definitions for certain types of skilled nursing and therapy services are vague and inconsistently interpreted in fee-for-service. The

director for admissions at another home health agency said that there are always gray areas in the coverage guidelines and that fee-for-service providers tend to provide more services, while HMOs tend to provide fewer.

HMOs report that they use their flexibility to provide additional benefits or waive Medicare requirements for their Medicare enrollees to provide more cost-effective care. In general, the Medicare HMOs we visited reported that they occasionally covered more benefits than patients are entitled to in the Medicare fee-for-service program. For example, one HMO did not require that patients be homebound to receive home health services. Four other HMOs reported that while they formally required patients to be homebound, they would make exceptions if it would be cost-effective for the HMO and beneficial for the patient. In addition, two HMOs reported that if a patient had no skilled need, but could not be at home without assistance, they would, in rare cases, provide aide services for a short period until other arrangements could be made.

Use of Home Health Aides Differs

HMO and fee-for-service providers also differ in their use of home health aides. While custodial care—personal care that does not require the continued attention of trained professional staff—is generally excluded from Medicare coverage, Medicare can cover a home health aide to provide ongoing personal care services if the home care patient also requires intermittent skilled nursing or therapy services. Prior to the 1980 statutory changes and the 1989 court-ordered coverage guideline changes, the part A home health benefit had been used primarily for acute conditions following a hospitalization and not for chronic care. Many Medicare fee-for-service patients still receive home health services following hospitalization, but a growing number are receiving home care and aide services for long-term, chronic conditions not related to an acute episode. In a recent briefing, we reported that in the fee-for-service program, aide visits accounted for almost half the total of home health visits in 1994 and that the percentage of patients receiving more than 90 visits tripled between 1989 to 1993, from 6 to 18 percent.

In contrast, HMO staff told us they believe that Medicare home health services should not be expected to be used as long-term care for patients. Staff at many of the HMOs we visited expressed the belief that patients can become dependent on the assistance provided by aides and expect such services indefinitely. In their view, the fee-for-service system sometimes blurs the line between skilled and custodial care, creating unrealistic patient expectations about eligibility for Medicare home health services. In

addition, some HMO and HCFA staff expressed the belief that home health aides are sometimes provided in the fee-for-service program as much for social reasons as for health reasons. A study of Medicare home health claims from 1993 also suggested that many fee-for-service aide visits may be for social and custodial care and only tangentially related to medical care.⁶

While the HMOs we visited generally do not provide home health aides for custodial purposes, most had a social service department or designated staff that would try to arrange for community services. Several HMOs also had special programs that provided supportive social services not directly related to health. For example, one HMO provided a respite benefit to full-time caregivers in the home to prevent caregiver burnout. Another HMO received a grant from a health care foundation to create a service credit bank, where enrollees who provide assistance, such as meal preparation and transportation, to frail enrollees are given credits that can be used to purchase similar assistance when needed. The same HMO also helps enrollees access a friendly visitor program and a telephone reassurance program to provide social interaction and support. While these alternative services do offer some assistance to patients, they are unlikely to completely replace all of the personal care services that a home health aide can provide, such as assistance with bathing and dressing.

HMO Practices Influence Delivery of Care, Causing Concern to Some Home Health Agencies

Staff from several home health agencies noted that they have changed the way they treat fee-for-service patients by adopting an approach more compatible with that used by HMOs. They explained that they do not want to treat patients differently based solely on health insurance status and acknowledged that under fee-for-service, some patients may receive unnecessary care. One home health agency noted that it now puts more emphasis on patient education, while another reported that it no longer seeks to attain maximum functional levels for patients before they are discharged from home health care. The latter also noted that it now provides services for shorter periods and it looks for community resources to provide assistance if a patient needs long-term assistance with some tasks, such as preparing insulin shots.

Home health agency staff also told us that although they were usually able to negotiate acceptable levels of service with HMOs, HMOs occasionally “push the envelope” in terms of providing the fewest possible services.

⁶H. G. Welch, D. E. Wennberg, and W. P. Welch, “The Use of Medicare Home Health Care Services,” *New England Journal of Medicine*, Vol. 335, No. 5 (1996), pp. 324-29.

Some were concerned that HMOs occasionally have unrealistic expectations about how quickly certain patients can function independently and may lead the patient to do more than he or she is able to do. For example, one home health agency reported that a local Medicare HMO, which was not part of our sample, may expect too much from the elderly population. The HMO has recommended clinical guidelines for coronary artery bypass surgery that call for patients to be discharged 4 days after surgery and only authorizes one home health agency visit following discharge. Because these patients generally are overwhelmed by the surgery and recovery, few can absorb all the necessary self-care information provided in this one visit. As a result, home health agency staff said that they have begun doing follow-up calls to these patients on their own initiative. Other home health agencies noted that some HMOs may require certain wound care patients to provide their own wound care before they are able to.

At the same time, some home health agencies noted beneficial changes in patient management that they believe arose from the influence of managed care. The director of one home health agency said that working with HMOs has taught her staff to develop reasonable, measurable goals and to focus their care on those goals. She believes that as a result, the quality of care provided has improved. The patient care coordinator at another home health agency noted that the agency is now more focused on functional outcomes and patient education.

HMOs Control Home Health Use Through More Active Management

The six Medicare HMOs we visited frequently review each home health patient's condition and progress; four also require preauthorization for home health services. This close management is intended to monitor both the cost and quality of care provided. In contrast, only a small percentage of claims in the fee-for-service program are actually reviewed by Medicare to assess whether they are reasonable and necessary. Moreover, these reviews are primarily paper reviews, which yield insufficient information to determine if the services provided are appropriate and meet Medicare criteria. Many fee-for-service home health agencies seek to manage patient care appropriately and cost effectively, but others may provide unnecessary services. As we reported in March 1996, inadequate controls make it nearly impossible to know whether a patient receiving home health care qualifies for the benefit, needs the care being delivered, or even receives the services being billed to Medicare.⁷

⁷See Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

To more actively manage home health services, the HMOs we visited use case management and preauthorization strategies, utilization reviews, and selective contracting.

Case Management and Preauthorization Help HMOs Curb Inappropriate Utilization

Each of the six HMOs that we visited use nurse case managers to follow each patient's progress and to determine when services can be discontinued. At two of the HMOs, the case managers operate out of a central office separate from the physician offices. The managers receive patient information, collaborate with physicians as needed by phone, and approve or disapprove requested services. At two other HMOs, the case managers work within the physician offices and make decisions about services to be provided in collaboration with the primary care physician. The case managers at the two remaining HMOs coordinate services but are not responsible for approving service levels because these HMOs do not have a preauthorization requirement.

Staff from the home health agencies report that the HMO case managers review patient care plans much more frequently than the home health agencies review plans for their fee-for-service patients. At each HMO we visited, case managers generally review patient cases every few days to 2 weeks, depending on the patient's condition, to determine how much more care is needed. In the Medicare fee-for-service program, home health care plans must be reviewed by a physician at least every 62 days. While some home health agencies may develop shorter care plans, others routinely develop 62-day care plans for their fee-for-service patients. Moreover, when the initial 62-day period ends and a new care plan is written, the Medicare contractors who process fee-for-service home health claims do not routinely review the updated plans.

HMO staff reported that their closer scrutiny of each patient is intended to both prevent the unnecessary utilization of services and improve the quality of care. However, contracted home health agencies also noted that the scrutiny can sometimes be excessive and believe that it would save providers time and effort if they did not have to seek approval for care after two or three visits when it is obvious that certain patients, such as stroke patients, need additional visits. At one home health agency, a staff member noted that there is a difference between managing utilization and actually managing care. She noted that some HMOs focus more on managing utilization and have no direct contact with patients, which precludes them from assessing the individual needs of patients.

Medicare HMOs vary in terms of their organization, payment mechanisms for physicians and home health agencies, and authorization processes. These factors also influence the utilization levels and management of home health services. For example, some HMOs employ their own physicians and nurses and have no preauthorization requirements for home health services; however, many HMOs contract with large numbers of independent physicians and have more restrictive preapproval processes to control the use of services. Similarly, an HMO that pays for home health services on a capitated basis may have fewer controls on the use of services than an HMO that pays for each home health visit provided.

Utilization Reviews Help HMOs Monitor Quality and Use

In addition to using case managers to review and approve care, HMOs sometimes review aggregate data—such as utilization statistics, patient satisfaction survey data, or rehospitalization data—to monitor quality and identify possible aberrant utilization patterns. For example, one HMO monitors its contracted physician groups for underutilization and overutilization of services, using established benchmarks or HMO averages. The HMO identified one medical group with low utilization of home health services compared to the HMO average and asked the group to explain the disparity and provide any available information on patient satisfaction or patient outcomes. Another HMO has established screens, such as dehydration or readmission to a hospital, to identify instances of poor patient outcomes. If a provider has five or more instances during a 3-month period (for instance, five patients suffering from dehydration), the HMO will review the provider to determine if there are quality of care problems. However, if immediate action appears warranted, a physician may review cases sooner.

Selective Contracting Helps HMOs Coordinate Oversight of Patient Care

HMOs also manage home health care more closely by restricting the number of home health agencies they use or by having common corporate ownership of agencies used. Two of the HMOs we visited share common corporate ownership with one or more home health agencies that provide services almost exclusively to the HMOs' enrollees. This arrangement allows HMO and home health agency staff to work closely with each other to provide active oversight of the care provided. Two other HMOs are in the process of shrinking their home health agency networks to allow their staff to spend more time on site at these facilities, provide closer oversight of the care provided, and work with the contractors to manage enrollee care. One HMO reduced the number of home health agencies it contracted

with from over 80 to only 2. Most of the HMOs also are establishing formal processes for credentialing home health contractors.

Different Goals and Management Approaches Contribute to Different Utilization Patterns

Three recently published studies on home health use and our review of selected home health agencies provide evidence that Medicare HMO patients receive fewer home health visits than Medicare fee-for-service patients. These differences in utilization likely stem from HMOs' more active management of home health services and greater emphasis on rehabilitation and acute care, along with a lack of controls in the fee-for-service program and reported problems with overutilization. Underlying differences in the health status of the two populations may also contribute to these differences. Several studies suggest that, on average, Medicare beneficiaries who enroll in HMOs may be healthier than patients who remain in the Medicare fee-for-service program and, consequently, use fewer services.⁸

One study, which compared the use of home health services by frail elderly Medicare patients in HMOs and fee-for-service, found that—after adjusting for differences in demographic, physical, mental, and functional status—HMO patients were just as likely to have home health episodes as fee-for-service patients but received 71 percent fewer visits.⁹ A second study, conducted by the Department of Health and Human Services' (HHS) Office of the Inspector General, found substantially fewer home health visits provided to Medicare HMO enrollees in 1994; however, the study did not adjust for differences in patient health and demographic status.¹⁰ A third study, funded by HCFA, found that Medicare HMO and fee-for-service patients received home health services for similar lengths of time; however, HMO patients averaged 13 visits per episode of care, while fee-for-service patients averaged 20 visits.¹¹ Further analysis indicated that HMO patients received fewer home health services than similar

⁸A 1996 study published in HCFA's Health Care Financing Review (Vol. 17, No. 4) estimated that HMO enrollees' costs were 12 percent lower than average, and a 1996 Physician Payment Review Commission study estimated that enrollees' costs were 37 percent lower than those for comparable fee-for-service patients. See also Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO-HEHS-97-16, Apr. 25, 1997), which reported that HMO enrollees in California are healthier than fee-for-service beneficiaries.

⁹B. Experton and others, "The Impact of Payor/Provider Type on Health Care Use and Expenditures Among the Frail Elderly," *American Journal of Public Health*, Vol. 87, No. 2 (1997), pp. 210-16.

¹⁰HHS, Office of the Inspector General, *How HMOs Manage Home Health Services*, OEI-04-95-00080 (Washington, D.C.: HHS, Sept. 1997).

¹¹R. E. Schlenker, P. W. Shaughnessy, and D. F. Hittle, "Patient-Level Cost of Home Health Care Under Capitated and Fee-for-Service Payment," *Inquiry*, Vol. 32 (1995), pp. 252-70.

fee-for-service patients, even after adjusting for differences in functional status, medical condition, and demographic factors.

Home health agency staff generally agreed with these findings. Virtually all said that their HMO patients overall receive fewer services than fee-for-service patients. In particular, they described sizable differences in the use of home health aides. Some home health agency staff also said HMO patients may receive less skilled care services, such as therapy services. In some cases, they attributed lower utilization of aides to earlier termination of home health services by HMOs.

One large urban home health agency compared its 1996 Medicare fee-for-service and Medicare HMO patients and found statistically significant differences in use.¹² When fee-for-service patients were matched with HMO patients for age and gender, the HMO group had fewer total visits and fewer visits for most service types—including physical therapy and skilled nursing—as well as shorter episodes of care, fewer comorbidities, and somewhat different diagnostic groupings. (See table 1.) Because the number of visits per week by service type were generally similar for the two groups, these overall utilization differences likely stem from the fact that HMO patients generally received services over a shorter period relative to fee-for-service patients.

Table 1: Average Home Health Utilization for Medicare HMO and Fee-for-Service Patients in One Large Urban Home Health Agency, 1996

	HMO patients	Matched fee-for-service patients
Episode of care		
Less than 31 days	1,830 (53.7%)	5,108 (33.9%)
31-120 days	1,457 (42.8%)	8,480 (56.4%)
More than 120 days	121 (3.6%)	1,458 (9.7%)
Total	3,408 (100%)	15,046 (100%)
Average service utilization		
Nursing visits	9.8	17.4
Physical therapy visits	8.8	13.1
Home health aide visits	23.6	38.8
Home health aide hours	98.5	151.6

Note: All diagnoses; fee-for-service patients matched to HMO gender and age distribution.

¹²Patients dually eligible for Medicare and Medicaid were excluded from the analysis.

When the analysis was restricted to patients with a primary diagnosis involving the circulatory system,¹³ the home health agency found that differences in the total number of visits increased with the length of the care episode. (See tables 2 and 3 for a summary of this comparison.) HMO patients were almost twice as likely to have a shorter episode of care. For the shortest episodes of care (under 31 days), there were relatively small, and not statistically significant, differences in the number of home health services between the fee-for-service and HMO patients. Greater differences, especially in the use of aides, were found for patients with longer episodes of home health care.

Table 2: Length of Home Health Care Episodes for Medicare Fee-for-Service and HMO Patients With Circulatory System Diagnoses in One Large Urban Home Health Agency, 1996

Episode of care	HMO patients	Matched fee-for-service patients
Less than 31 days	610 (55.2%)	1,230 (31.1%)
31-120 days	468 (42.3%)	2,340 (59.3)
More than 120 days	28 (2.5%)	379 (9.6%)
Total	1,106 (100%)	3,949 (100%)

Note: Fee-for-service patients matched to HMO gender and comorbidity distribution.

¹³Diseases of the circulatory system include hypertension, acute myocardial infarction, heart failure, angina, phlebitis, and varicose veins.

Table 3: Average Home Health Utilization for Medicare HMO and Fee-for-Service Patients With Circulatory System Diagnoses in One Large Urban Home Health Agency, 1996

	Age 65-74		Age 75-84		Age 85+	
	Fee-for-service patients	HMO patients	Fee-for-service patients	HMO patients	Fee-for-service patients	HMO patients
Episodes of care less than 31 days						
Nursing visits	5.2 ^a	4.5 ^a	5.0	4.0	4.6 ^a	4.1 ^a
Physical therapy visits	3.8 ^a	3.7 ^a	3.5 ^a	3.8 ^a	3.2 ^a	4.1 ^a
Home health aide visits	9.1 ^a	7.3 ^a	8.6 ^a	7.5 ^a	9.4 ^a	8.7 ^a
Home health aide hours	37.3 ^a	28.1 ^a	33.5 ^a	28.6 ^a	34.9 ^a	33.4 ^a
Episodes of care 31-120 days						
Nursing visits	15.1	11.3	15.2	12.6	15.3	8.3
Physical therapy visits	12.9	10.3	12.4	10.1	11.5 ^a	9.9 ^a
Home health aide visits	33.1	27.4	33.7	24.1	35.3	22.2
Home health aide hours	128.7	105.8	129.7	93.6	134.5	95.0
Episodes of care more than 120 days						
All services ^b	NA	NA	NA	NA	NA	NA

Note: Fee-for-service patients matched to gender and comorbidity distribution of HMO patients.

^aThe differences for these variables were not statistically significant at the .05 level.

^bThere were not enough cases of patients with episodes of care more than 120 days to allow for this analysis. See table 2 for the number of cases involved.

A recent analysis by the Kaiser Family Foundation indicated that many Medicare fee-for-service home health patients are sick and functionally impaired and increasingly rely on home health services to fulfill long-term care or complex medical needs. The analysis found only about one-third of fee-for-service home health users were receiving home health services after hospital discharge to meet a short-term, post-acute need.¹⁴ The remaining two-thirds received more visits over a longer period. Half of this group were seriously ill, had complex medical problems, and used more hospital care than other fee-for-service home health users. The other half were medically stable but functionally impaired and used home health care, especially aide services, to meet long-term care needs. Information is not available on either the prevalence of chronically ill beneficiaries who enroll in HMOs or their receipt of services. Therefore, the effect of HMOs' emphasizing short-term rehabilitation and functional improvement on service utilization by chronically ill beneficiaries is unknown.

¹⁴J. Leon, P. Neuman, and S. Parente, *Understanding the Growth in Medicare's Home Health Expenditures* (Washington D.C.: The Henry J. Kaiser Foundation, 1997).

HCFA Has Limited Data to Evaluate HMO Home Health Services

Currently, HCFA has little data on home health services provided by HMOs to Medicare enrollees. Without information on the care provided, HCFA cannot target plans or patient groups for further review. Home health agency and HCFA staff told us that it is difficult to evaluate the significance of home health care utilization differences between managed care and fee-for-service settings without comparative data on patient outcomes—information that links the care provided to the patient’s health status. HCFA has initiatives under way to collect some information on patient outcomes from home health services, but that data will not be available for some time. In their absence, we reviewed a sample of appeals cases to see if these data reveal any systemwide issues regarding access to care. However, because of the low numbers of appeals and their focus on administrative rather than clinical issues, these data offered little insight regarding HMOs’ provision of home health care.

HCFA Collects Limited Data on HMO Services

HCFA has little information about how much or what types of home health care HMO enrollees are receiving. Therefore, HCFA cannot use indicators, such as low utilization levels, to target patient groups or plans for more detailed review. Because HMOs are paid on a capitated basis to provide all Medicare-covered services to enrollees, HCFA does not receive claims for the services provided. In addition, HMOs are not required to provide data on utilization levels for home health services. While HCFA reviews Medicare HMO performance at least every 2 years, these reviews do not specifically target home health care. As we noted in 1995, HCFA’s routine reviews focus on whether the HMO has capable staff and appropriate procedures for quality assurance and utilization management, rather than whether the quality assurance and utilization management systems actually operate effectively and ensure that HMOs make appropriate care decisions.¹⁵ At the same time, there are currently few, if any, generally accepted standards for home health care, which could be useful in evaluating any utilization data or other information about care provided to Medicare enrollees.

Information Sources to Evaluate Home Health Services

Although HCFA and home health agency staff told us that it would be impossible to evaluate the significance of utilization differences without data on patient outcomes, comparative information on utilization levels could be a useful monitoring tool. Utilization data can be used to identify home health agencies, HMOs, or patient groups whose atypical utilization may indicate quality of care problems and thus enable HCFA to target

¹⁵Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995).

potential problem providers for further review and analysis. For example, at least two state Medicaid programs use encounter data as an indicator of potential under- or overutilization of services. In the Medicare fee-for-service program, this technique has been used successfully to identify providers with fraudulent or abusive billing practices. HCFA is currently collecting encounter data in one state as a pilot project but has no definitive plan to collect these data on a nationwide basis.¹⁶

To date, research comparing the health outcomes of HMO and fee-for-service patients has been limited, partly because of the difficulty in defining and measuring an array of health outcomes that consider both skilled and unskilled services. The 1995 HCFA-funded study comparing home health utilization of Medicare HMO and fee-for-service patients was the only study we identified that attempted to measure patient outcomes. The results suggest that HMO patients may experience slightly worse outcomes than fee-for-service patients. However, because the study includes only patients who were beginning a home health episode and only followed them for 12 weeks, it may not include many patients receiving home health services for chronic conditions.

HCFA recently announced that within the next few years it plans to collect some outcomes data from all home health agencies that provide care to Medicare HMO or fee-for-service patients through a standardized patient assessment data set, known as OASIS (Outcomes and Assessment Information Set). The OASIS data set will collect information on a number of health status measures, such as ability to walk after hip replacement surgery; mental status; and ability to perform activities of daily living, like bathing or eating. HCFA may use OASIS data to monitor HMOs and the effectiveness of home care they provide. Patients with chronic illnesses and conditions, however, may not experience the types of substantial improvements or restoration of functions that can be measured easily through such outcomes data. The needs of the chronically ill for ongoing assistance to maintain health status and functional ability may also conflict with medical necessity standards used by some managed care plans that focus on rehabilitation. Some state Medicaid programs have recognized similar concerns in contracting with managed care plans for disabled recipients. They have included an explicit definition of medical

¹⁶HHS has had broad authority to require HMOs to develop and provide pertinent data needed to administer and oversee HMOs for a long time. However, the Balanced Budget Act of 1997 provides HCFA the specific authority to require entities participating under the new Medicare Choices program, including HMOs, to provide information on services in order to facilitate HCFA's development of risk-adjustment factors for payment rates.

necessity in HMO contracts that includes services necessary to maintain a patient's existing level of functioning.

Appeals Provide Little Information

Data on the number and results of appeals filed by Medicare patients who are dissatisfied with HMO care decisions are one of the few currently available indicators that might be useful in evaluating HMO home health care. We reviewed 48 home health appeals filed by Medicare HMO patients during a 2-1/2-year period and found that HCFA's appeals contractor upheld most of the HMOs' denials. However, the usefulness of such data as an indicator of patient satisfaction may be limited by several factors. First, the small number of home health appeals limit their reliability as an indicator. In 1996, HCFA's appeals contractor received only 165 appeals involving home health services from the approximately 4 million Medicare beneficiaries enrolled in risk-contract HMOs.¹⁷ Second, in 60 percent of the cases we reviewed, the HMO appeals contractor decided the case based on whether the HMO and the patient followed correct administrative procedures, rather than the appropriateness of the HMO's clinical decision or the sufficiency of the services provided. Finally, because of weaknesses in the appeals system—including incomplete HMO compliance with the appeals process, limited enrollee awareness of appeal rights, and beneficiaries' ability to disenroll rather than appeal a denial—not all enrollee concerns about access to home health care reach the appeals contractor.

Conclusions

HMOs' more active management of home health services and their focus on shorter-term rehabilitation likely contribute to their Medicare enrollees receiving fewer services than their fee-for-service counterparts. Currently, however, HCFA has little data available to evaluate if differences in home health care utilization are appropriate. Given the growth in Medicare HMO enrollment, ensuring that HMOs meet the home health needs of all enrollees, particularly those with chronic conditions, will become increasingly important. HCFA plans to collect outcomes data for home health services; however, this information will not be available for several years and may provide only a partial picture of the care provided by HMOs. Still, without such data, it is difficult to determine to what extent

¹⁷As of August 28, 1997, HCFA required Medicare HMOs to review requests for reconsideration within 72 hours, if the standard 60-day time frame for issuing determinations could jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function. These new requirements for an expedited appeals process also clarified that decisions to discontinue services, such as physical therapy, are appealable determinations. This new process may increase the number of appeals received by the Center for Health Dispute Resolution for review.

utilization differences are appropriate or represent unnecessary services provided in fee-for-service or insufficient services provided by HMOs. In the meantime, HCFA cannot determine whether the needs of particularly vulnerable beneficiaries—such as those with medically complex needs and chronic conditions—are being met in HMOs.

While there are no generally accepted standards regarding the appropriate level of services for home health patients, identifying and reviewing HMOs and patient groups with aberrant utilization patterns could help focus oversight on potential problems—a technique that has been used successfully in the Medicare fee-for-service program. In addition, recognizing the unique needs of chronically ill enrollees and defining expectations for their care may assist beneficiaries with chronic conditions in deciding whether to enroll in an HMO, as well as facilitate HCFA's oversight of the care provided these enrollees.

Agency Comments and Our Evaluation

We provided a draft of this report to HCFA officials, who suggested that we clarify that HCFA's 1989 changes to its home health coverage regulations were made in response to statutory changes and court order. We have clarified those sections of the report and made other technical changes recommended by HCFA officials.

In addition, we provided a draft of this report to each of the HMOs we visited, the Center for Health Dispute Resolution, the National Association for Home Care, the American Association of Health Plans, and two of the home health agencies we interviewed. Most provided technical or clarifying comments, which we incorporated as appropriate.

The National Association for Home Care expressed concern that some HMOs use restrictive policies that conflict with what Medicare beneficiaries are entitled to receive under the Medicare home health benefit. The limited scope of our study precluded us from addressing this issue. While we did note some differences in the provision of home health services by HMO and fee-for-service providers, we did not collect information that would allow us to comment on the appropriateness of care offered to the two groups of patients.

As agreed with your office, unless you release its contents earlier, we plan no further distribution of this letter for 30 days. At that time, we will send copies to other interested parties and make copies available to others on request.

This report was prepared by Sara Galantowicz and Michelle St. Pierre, under the direction of William Reis, Assistant Director. Please call me at (202) 512-7114 or Mr. Reis at (617) 565-7488 if you or your staff have any questions about the information in this report.

Sincerely yours,

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

William J. Scanlon
Director, Health Financing
and Systems

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Abbreviations

CHDR	Center for Health Dispute Resolution
HCFA	Health Care Financing Administration
HCPP	health care prepayment plan
HMO	health maintenance organization
HHS	Department of Health and Human Services
IPA	independent practice association
OASIS	Outcomes and Assessment Information Set

Scope and Methodology

To collect information on how Medicare HMOs manage home health services, we visited six Medicare HMOs, conducted phone interviews with home health agencies that contracted with these HMOs to provide home health services, and reviewed appeals from Medicare HMO enrollees who were denied home health services. We interviewed staff from HCFA's central office and several of its regional offices. We also reviewed pertinent laws, regulations, HCFA policies, and research comparing utilization and outcomes between Medicare HMO and fee-for-service patients. We conducted our study from March 1996 to July 1997 in accordance with generally accepted government auditing standards; however, we did not independently verify the utilization data obtained from one home health agency.

The 6 HMOs we visited accounted for about 10 percent of all Medicare enrollees in the 292 risk-contract Medicare HMOs as of August 1, 1997. We chose the specific HMOs to include a variety of HMO models and a variety of contracting relationships with home health agencies, but they should not be considered representative of all Medicare risk-contract HMOs. Three of the six HMOs were nonprofit and three were for-profit. Two were group/staff model HMOs, two were independent practice association (IPA) models, and two represented mixed IPA/group models. Two HMOs shared common corporate ownership with the home health agencies that provided essentially all home health services for the HMOs' Medicare enrollees. The remaining HMOs contracted with a variety of independent home health agencies. In selecting HMOs, we also sought some geographic diversity—three of the HMOs are on the East Coast and three are on the West Coast. Given the number and diversity of HMOs and home health agencies that participate in the Medicare program, we cannot generalize from the small number that we visited.

At each HMO we interviewed case managers, utilization review staff, quality assurance staff, and other knowledgeable staff about how the HMO manages home health services. At one HMO, which capitates payments to its physician groups and delegates the utilization management function to the physicians, we also interviewed case managers at two of the contracted physician groups. We also interviewed staff at 10 home health agencies that provide services to the HMOs we visited to discuss the management of Medicare HMO home health patients compared to Medicare fee-for-service patients; 8 of the 10 provided services to both.¹⁸ In most cases, we interviewed at least two home health agencies that contracted

¹⁸The other two home health agencies provided care almost exclusively for patients from two of the HMOs we visited and, therefore, could not compare the management of fee-for-service and HMO patients.

with the HMOs we visited—some of which contracted with more than one of the HMOs.

Finally, we reviewed a sample of appeals filed by Medicare HMO patients and decided by HCFA's HMO appeals contractor, the Center for Health Dispute Resolution (CHDR). The Medicare HMO appeals process is a two-step process, in which the HMO itself first reconsiders its original denial. If the HMO's reconsideration is not fully favorable to the beneficiary, the HMO is required to forward the appeal to CHDR to make the final reconsideration decision. We did not review HMO-level appeals because HCFA does not maintain data on appeals at that level, making it impossible to identify the universe of appeals and to draw a sample. However, the six plans we visited reported that nearly all appeals in the past year involving home health services were forwarded to CHDR.

From a universe of 254 home health appeals decided by CHDR between January 1, 1994, and August 23, 1996, we selected a random sample of 48 cases, or 18.9 percent of the 254 cases involving home health. The appeals came from all Medicare HMOs, not just the six we visited. While this sample is representative of all CHDR-level appeals cases decided during the sample time frame, it should be noted that the appeals that reach CHDR represent only a fraction of all disputes because not all initial HMO denials are appealed or even recognized, and others may be overturned at the plan level. As noted in the body of this report, HMO patients may choose not to appeal an HMO denial, either because they are not aware of their appeal rights or because they choose to disenroll from the HMO. Also, Medicare HMOs do not always forward appropriate appeals to HCFA's contractor, as reported in a recent HHS, Office of the Inspector General study.¹⁹

¹⁹HHS, Office of the Inspector General, *Medicare HMO Appeal and Grievance Processes*, OEI-07-94-00280 (Washington, D.C.: HHS, Dec. 1996).

Related GAO Products

Medicare Home Health Agencies: Certification Process Is Ineffective in Excluding Problem Agencies ([GAO/T-HEHS-97-180](#), July 28, 1997).

Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings ([GAO/HEHS-97-108](#), June 13, 1997).

Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments ([GAO/HEHS-97-16](#), Apr. 25, 1997).

Medicare: Home Health Cost Growth and Administration's Proposal for Prospective Payment ([GAO/T-HEHS-97-92](#), Mar. 5, 1997).

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

Medicare: Increased HMO Oversight Could Improve Quality and Access to Care ([GAO/HEHS-95-155](#), Aug. 3, 1995).

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