



Highlights of [GAO-04-359](#), a report to congressional requesters

Why GAO Did This Study

Under Medicare's home health prospective payment system (PPS), home health agencies (HHA) are paid a fixed amount, adjusted for differences in individual patients' expected care needs, for providing an episode (up to 60 days) of care. For this payment, HHAs provide therapy, skilled nursing, medical social service, and aide visits to patients in their homes. GAO previously reported that PPS payments to HHAs were significantly above Medicare costs. GAO recommended that the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, modify the PPS to mitigate extreme financial gains and losses.

HHA representatives have raised concerns that Medicare's PPS financially disadvantages certain urban and rural HHAs. GAO was asked to examine (1) whether Medicare payments cover HHAs' costs and (2) what factors distinguished financially weak HHAs from financially strong performers under Medicare. To address these issues, GAO used Medicare cost reports and claims data for freestanding HHAs. GAO analyzed Medicare margins—the difference between Medicare payments and Medicare costs, divided by Medicare payments.

www.gao.gov/cgi-bin/getrpt?GAO-04-359.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Laura A. Dummit at (202) 512-7119.

MEDICARE HOME HEALTH

Payments to Most Freestanding Home Health Agencies More Than Covered Their Costs

What GAO Found

The total amount that Medicare paid freestanding HHAs as a group more than covered the overall costs of caring for their Medicare home health patients. In 2001, the aggregate Medicare margin for home health services provided by freestanding HHAs was 16.2 percent; in 2002, the aggregate margin rose to 17.8 percent. Medicare payments also more than covered costs for both HHAs that served exclusively rural patients and those that served exclusively urban patients. Moreover, more than four-fifths of individual HHAs had positive Medicare margins; two-thirds had margins of 10 percent or higher; and over one-fifth had high margins of more than 30 percent.

Per-visit costs distinguished the financially weak-performing HHAs (those with negative margins) from those that did well under Medicare. The cost of a home health visit for financially weak-performing HHAs was over 70 percent more than the cost for those with high margins. Two-thirds of the difference was attributable to overhead costs. Negative-margin HHAs spent more than twice as much on overhead and almost 40 percent more on direct patient care—the cost of nurses, therapists, medical social workers, and aides. However, compared to the patients of high-margin HHAs, those served by the negative-margin HHAs needed slightly less intensive care, as measured by Medicare's system of classifying patients according to their expected care needs. GAO also found that similarly sized HHAs in the same urban or rural areas had both negative and highly positive margins. This suggests that factors other than geographically linked special circumstances contributed to an HHA's weak financial performance.

In commenting on a draft of the report, CMS noted that research on case-mix payment adjustment issues was ongoing. However, CMS has not committed to a date for implementing a more accurate case-mix adjustment. GAO remains concerned that inadequacies in payment adjusters, identified in previous GAO reports, could lead to underpayments for some types of patients and overpayments for others. CMS also raised concerns about the implementation of risk sharing, which GAO had recommended in previous reports and discusses in this report. GAO continues to believe that the sharing of financial risk between Medicare and the HHAs could protect beneficiaries from impaired access, insulate agencies from extreme financial losses, and shield Medicare from burgeoning expenditures.