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MEDICARE

Home Health Utilization Expands While Program Controls Deteriorate

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Health, Education, and
Human Services Division

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March 27, 1996

The Honorable William S. Cohen
Chairman, Special Committee on Aging
United States Senate

Dear Mr. Chairman:

Use of the Medicare home health benefit has seen dramatic growth in recent years, with spending climbing from $2.7 billion in 1989 to $12.7 billion in 1994 and projected to exceed $21.0 billion by the year 2000. Changes in the benefit, the home health industry, and the characteristics of home health care users have strongly affected home health care utilization patterns and expenditure trends.

In several earlier reviews, we reported on lax controls over the use of the Medicare home health benefit. Two reports, issued in 1981 and 1986,[1] respectively, concluded that many claimed services were not medically necessary or did not meet the coverage criteria and, therefore, should not have been covered under the program. We also concluded that payment systems generally were not capable of detecting noncovered services. Thus, we recommended that steps be taken to increase the capability of Medicare's claims processing and utilization review systems to detect noncovered care.

The recent rapid growth in Medicare home health expenditures continues to raise questions about the extent to which abuse of the benefit may be contributing to this growth. Therefore, you asked us to determine the reasons for and the nature of the growth in the use of the Medicare home health benefit. Specifically, you asked us to examine

- changes in the composition of the home health industry,
- changes in the composition of Medicare home health users,
- differences in utilization patterns across geographic areas,
- incentives to overutilize services, and
- the effectiveness of payment controls in preventing payment for services not covered by Medicare.

To address these issues, we reviewed pertinent laws, regulations, court decisions, Health Care Financing Administration (HCFA) policies, and

[1]Medicare Home Health Services: A Difficult Program to Control (GAO/HRD-81-155, Sept. 25, 1981), and Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986).

relevant research. We interviewed staff from HCFA, two HCFA regional offices, and three regional home health intermediaries. We analyzed paid claims history data for 1989 through 1993 and provider of service data for 1989 through 1994. We did not, however, examine the internal and automatic data processing controls for automated systems from which we obtained data used in our analyses. With this exception, we conducted our study from July 1994 to December 1995 in accordance with generally accepted government auditing standards. (See app. I for details on our scope and methodology.)

Results in Brief

Recent growth in the use of Medicare's home health benefit has largely resulted from 1989 HCFA guideline changes that made Medicare home health coverage criteria less restrictive, resulting in an increase in both the number of beneficiaries receiving services and the number of services received by each beneficiary. To illustrate, in 1989, 1.7 million Medicare beneficiaries received home health services; by 1993, this number had increased to 2.8 million. During the same time, the number of visits provided to beneficiaries receiving home health care more than doubled, from an average of 26 visits per year in 1989 to an average of 57 visits per year in 1993. The number of home health beneficiaries receiving services for longer periods of time also increased; in 1993, more than 25 percent of home health beneficiaries were receiving 60 or more visits per year, up from approximately 11 percent of home health beneficiaries in 1989.

The number of Medicare-certified home health agencies (HHA) has also grown, from 5,692 agencies in 1989 to 7,864 at the end of 1994; 83 percent of this growth has consisted of proprietary (for-profit) agencies. Our analyses show that proprietary agencies consistently provide more home health visits in all areas of the country than nonprofit agencies. In 1993, proprietary agencies provided beneficiaries with an average of 78 visits per year, while voluntary and government agencies provided an average of 46 visits. An analysis of beneficiaries with one of four frequently occurring diagnoses shows that proprietary agencies provide significantly more visits than nonprofits for beneficiaries with the same primary diagnoses. For example, home health patients with a primary diagnosis of diabetes received an average of 53 visits from proprietary agencies compared with an average of 27 visits from voluntary agencies and 24 from government agencies.

Although we have been reporting on program weaknesses over the last 15 years, controls over the Medicare home health benefit remain essentially

nonexistent. Few home health claims are subject to medical review and most claims are paid without question. Further, because (1) few on-site coverage audits are done, (2) beneficiaries are rarely visited by intermediaries, and (3) physicians have limited involvement in home health care, verifying whether the beneficiaries receiving home care truly qualify for the benefit, need the care being delivered, or are even receiving the services billed to Medicare is nearly impossible.

Background

Medicare, administered by HCFA within the Department of Health and Human Services (HHS), is a health insurance program that covers almost all Americans 65 years old and older and certain individuals under 65 years old who are disabled or have chronic kidney disease. The program, authorized under title XVIII of the Social Security Act, provides protection under two parts. Part A, the hospital insurance program, covers inpatient hospital services, posthospital care in skilled nursing homes, and care in patients' homes. Part B, the supplementary medical insurance program, covers primarily physician services but also home health care for beneficiaries not covered under part A.

Coverage Criteria

To qualify for Medicare home health care, a person must be confined to his or her residence (homebound); under a physician's care; and need part-time or intermittent skilled nursing care and/or physical therapy or speech therapy. The services must be furnished under a plan of care prescribed and periodically reviewed by a physician.[2] Home health benefits covered by Medicare include

- part-time or intermittent nursing care provided by or under the supervision of a registered nurse;
- physical, occupational, and speech therapy;
- medical social services related to the patients' health problems; and
- part-time or intermittent home health aide services when provided as an adjunct to skilled nursing or therapy care.[3]

[2]The legislative authority for coverage of home health services is contained in § 1814, § 1835, and § 1861 of the Social Security Act; governing regulations are found in title 42 of the Code of Federal Regulations (CFR); and HCFA coverage guidelines are found in the Medicare Home Health Agency Manual and Medicare Intermediary Manual.

[3]Home health aides provide hands-on personal care of beneficiaries that must be necessary to the treatment of the beneficiary's illness or injury. Home health aide services include (1) personal care services, such as assistance with eating, bathing, and toileting; (2) simple surgical dressing changes; (3) assistance with some medications; (4) activities to support skilled therapy services; and (5) routine care of prosthetic and orthotic devices. A beneficiary whose sole need is for custodial or personal care, however, does not qualify for home health aide services.

Medicare beneficiaries may receive home health care as long as it is reasonable and necessary for the treatment of illness or injury; no limits exist on the number of visits or length of coverage. Medicare does not require copayments or deductibles for home health care.

Medicare home health services must be furnished by Medicare-certified HHAs or by others under arrangement with such an agency. Agencies participating in the program must meet specific requirements of the Social Security Act. HHAs are reimbursed for the reasonable costs incurred in providing covered visits to eligible beneficiaries up to specified cost limits established for each area of the country.[4]

Medicare-certified HHAs are classified into one of three ownership categories. Proprietary HHAs are private, for-profit agencies. Voluntary agencies are private (nongovernmental), nonprofit agencies that are exempt from federal income taxation; for example, Visiting Nurse Associations and Easter Seal Societies. Government agencies are operated by a state or local government.

Program Administration

HCFA currently administers the home health care program through nine[5] regional home health intermediaries (RHHI)—eight Blue Cross plans and the Aetna Life and Casualty Insurance Company.[6] These intermediaries

- serve as a communication channel between HHAs and HCFA,
- make payments to HHAs for covered services provided to Medicare beneficiaries, and
- establish and apply payment safeguards to prevent program abuse.

[4]Under authority originally provided through § 223 of the Social Security Amendments of 1972 (P.L. 92-603), HCFA has established upper limits on the amount Medicare will pay HHAs. Based on the cost experience of freestanding HHAs, these limits are set by type of home health visit (such as skilled nursing or home health aide). For each agency, they are applied in the aggregate; that is, costs above the limit for one type of visit can be offset by costs below the limit for another type. Separate limits are set for urban and rural HHAs (because costs tend to differ between them) and adjusted to reflect local wage rates.

[5]Since conducting our review, one Blue Cross plan has dropped out of the Medicare claims processing business; its responsibilities will be assumed by one of the remaining eight intermediaries.

[6]Before the consolidation of home health intermediary functions in fiscal year 1987, 47 intermediaries administered the home health program.

Changes in Eligibility Criteria Key to Home Health Growth

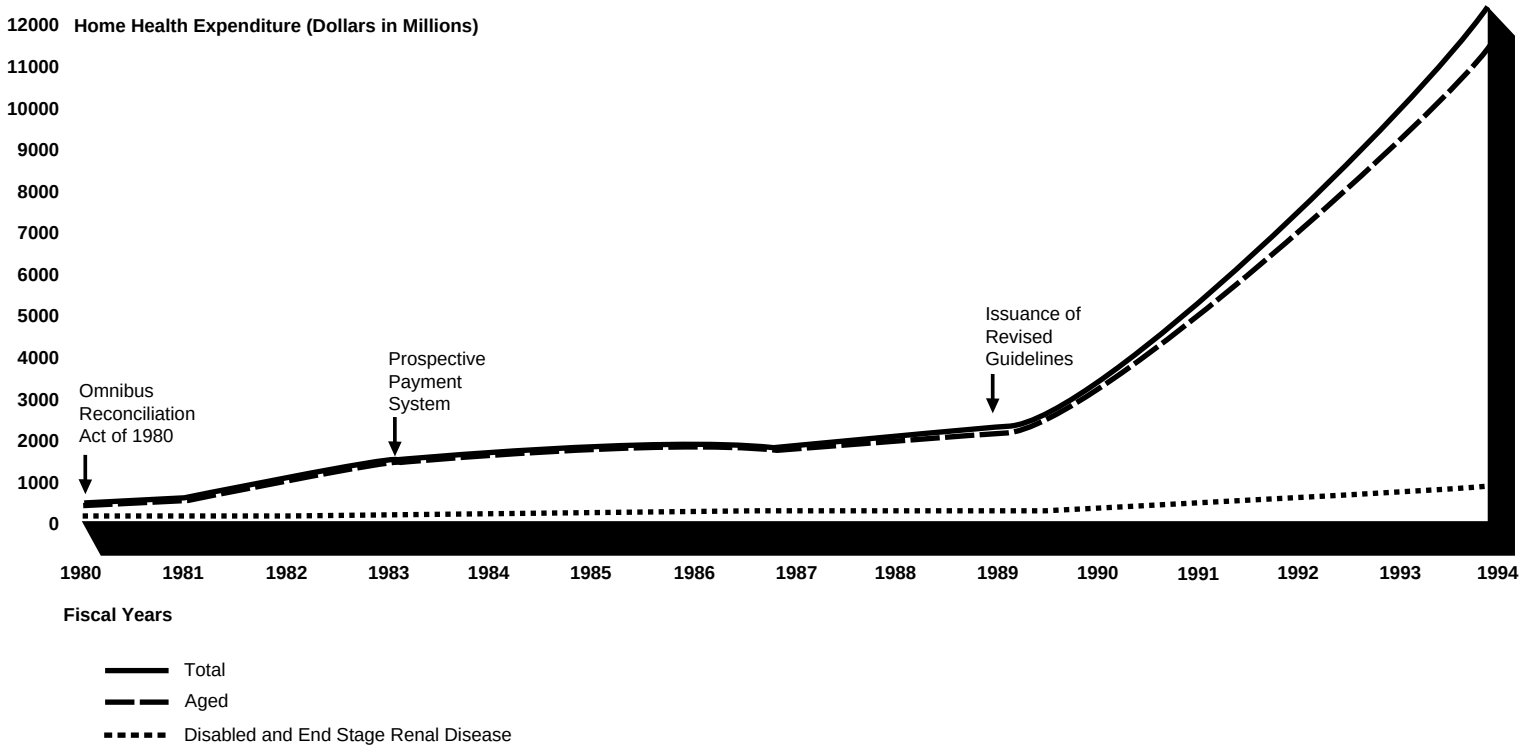
Changes in the legal and regulatory provisions governing the home health benefit together with changes in HCFA's policies have played a key role in the increase in the benefit's use. At Medicare's inception in 1966, the home health benefit under part A provided limited posthospital care of up to 100 visits per year that required a prior hospitalization of at least 3 days. In addition, the services could only be provided within 1 year after the patient's discharge and had to be for the same illness. These restrictions were eliminated by the Omnibus Budget Reconciliation Act of 1980.

With the implementation of the Medicare inpatient prospective payment system in 1983, the utilization of the home health benefit was expected to grow as patients were discharged from the hospital earlier in their recovery period. However, expenditures changed little over the next 5 years[7] (see fig. 1). The Deficit Reduction Act of 1984 reduced the number of intermediaries processing home health claims, and HCFA intensified education of the home health intermediaries to promote more consistency in claims review. Additionally, HCFA instructed the intermediaries to increase the number of claims receiving medical review before payment. This increased review in addition to a requirement for more detailed documentation contributed to an increased claim denial rate—from 3.4 percent in 1985 to 7.9 percent in 1987.[8]

[7]Helbing, C., J.A. Sangl, and H.A. Silverman, "Home Health Agency Benefits," Health Care Financing Review, 1992 Annual Supplement (1992), p. 125.

[8]Medicare: Increased Denials of Home Health Claims During 1986 and 1987 (GAO/HRD-90-14BR, Jan. 24, 1990).

Figure 1: Medicare Home Health Expenditures, 1980-94



Source: HCFA, Office of the Actuary.

A lawsuit was filed in 1988 (Duggan v. Bowen)[9] that struck down HCFA's interpretation of benefit coverage requirements. As a result of the suit, HCFA revised the Medicare Home Health Agency and Medicare Intermediary manuals in 1989 so that the criteria for coverage of home health visits would be consistent with "part-time or intermittent care," as required by statute, rather than "part-time and intermittent care," as HCFA had been interpreting it.[10] This change enabled HHAs to increase the frequency of visits because they no longer had to be intermittent. The requirements were also changed so that patients now qualify for skilled observation by a nurse or therapist if a reasonable potential for

[9]Duggan v. Bowen, 691 F. Supp. 1487 (D.D.C. 1988).

[10]The manual revisions also added definitions of part-time and intermittent (see p. 17).

complications or possible need to change treatment existed.[11] Further, the benefit now allows maintenance therapy where therapy services are required to simply maintain function rather than the previous criteria that patients show improvement from such services.

The 1989 Medicare Home Health Agency Manual changes also required that intermediaries, in order to deny claims on the basis of medical necessity, determine that each denied visit was not medically necessary at the time services were ordered. Before this change, intermediaries were denying all visits beyond what the intermediary judged necessary; for example, denying 10 visits out of 50 visits claimed, if the intermediary could determine that the beneficiary could be adequately treated with 40 visits. The intermediary did not need to review each visit. This change has made it more costly for intermediaries to determine whether services are medically necessary and, therefore, fewer claims are denied.

The effect of changes in Medicare law, regulations, and policy has been that home health care is now available to more beneficiaries, for less acute conditions, and for longer periods of time. For example, in 1992, approximately one-third of home health beneficiaries entered the program without a hospital stay at one time during the year. Of those who had been hospitalized, only half had a hospital stay in the 30 days before starting home health care.[12]

Medicare Beneficiaries Receiving More Home Health Services

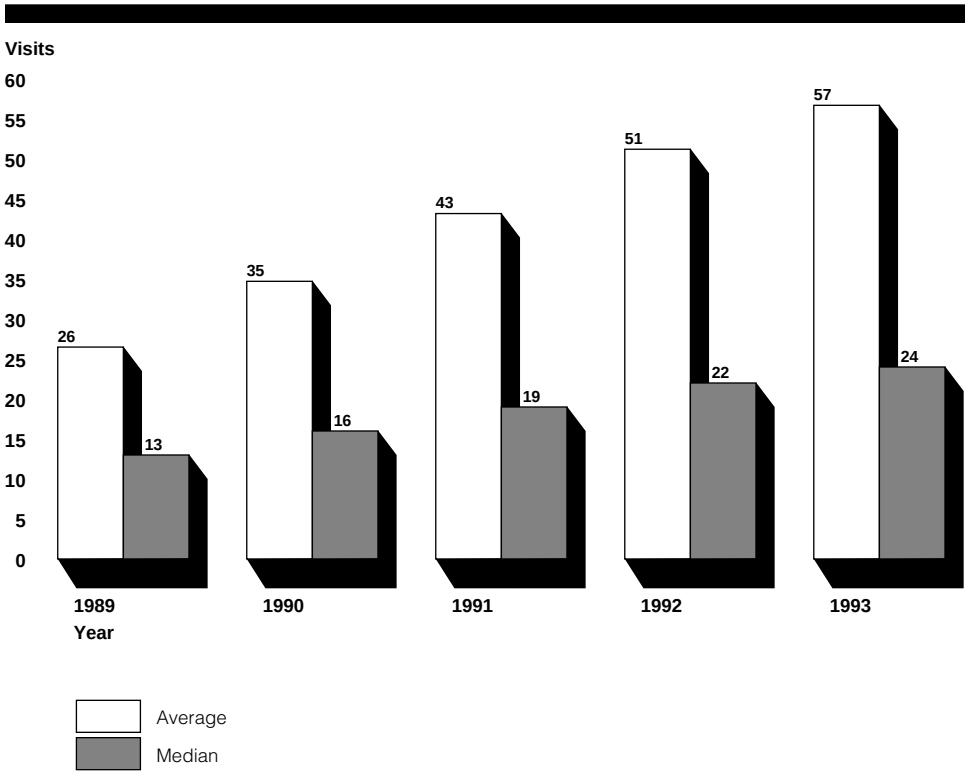
Since the Medicare Home Health Agency Manual and Medicare Intermediary Manual changes of 1989, the percentage of Medicare beneficiaries receiving home health services and the number of home health visits received per year per home health user have increased significantly. In 1989, 1.7 million beneficiaries (5.6 percent of the Medicare population) received home health care. In 1993, the number of beneficiaries receiving such care increased to 2.8 million (8.8 percent of the Medicare population). Beneficiaries receiving home health services are typically female and over 75 years old; however, the number of disabled beneficiaries under 65 years old receiving services has been growing. (See table II.1 in app. II.)

[11]This skilled observation, in turn, qualifies the beneficiary for home health aide visits.

[12]The increased ability of agencies to provide high-technology care in the home has also contributed to an increase in the number of users. Patients who might have formerly received care in an institution can now receive services such as infusion therapy and ventilator care in the home.

The average number of visits received per home health beneficiary has also increased dramatically since 1989. From 1989 through 1993, the average number of visits received per year more than doubled, from 26 to 57 visits. Over the same period, the median number of visits almost doubled, from 13 to 24 visits (see fig. 2). Most of the increase in visits has resulted from an increased use of skilled nursing (average visits increased from 15 per year in 1989 to 26 visits per year in 1993) and home health aide visits (average visits increased from 25 visits per year for beneficiaries who received any aide visits in 1989 to 56 visits per year in 1993).

Figure 2: Growth in Average Visits Per Year Per Beneficiary, 1989-93

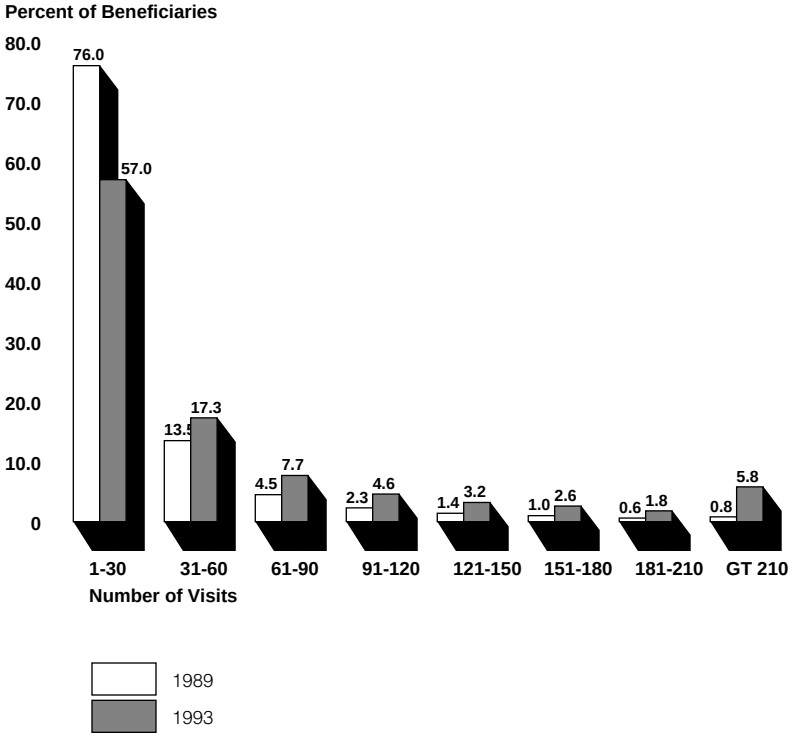


Source: GAO analysis of data from the Medicare Standard Analytical File: Home Health Claims History Database.

The distribution of visits across home health beneficiaries has become increasingly skewed toward heavy users (see fig. 3). From 1989 to 1993,

the percentage of users having more than 60 visits in a year increased from 10.6 percent to 25.7 percent. While beneficiaries who had 60 or fewer visits in 1993 averaged only 20 home health visits (with a median of 15 visits), those with more than 60 visits, averaged 163 visits (with a median of 125 visits).[13] The percentage of beneficiaries receiving more than 210 visits in 1 year has also increased, from fewer than 1.0 percent in 1989 to 5.8 percent in 1993.

Figure 3: Distribution of Medicare Beneficiary Visits, 1989 and 1993



Source: GAO analysis of data from the Medicare Standard Analytical File: Home Health Claims History Database.

Home Health Industry Expanding Rapidly

The home health industry has experienced rapid growth since 1989. The number of Medicare-certified HHAs increased from 5,692 in 1989 to 7,864 at

[13]Home health users with more than 60 visits during the year were more likely to have a primary diagnosis of the chronic diseases of diabetes and hypertension than those receiving fewer than 60 visits. On the other hand, home health users with fewer than 60 visits were more likely to be diagnosed with osteoarthritis or hip fracture than those receiving more than 60 visits.

the end of 1994. Growth has occurred mainly in HCFA's Dallas, San Francisco, and Chicago regions.[14] (See fig. II.1 in app. II for individual state growth data.)

Recent HHA growth has primarily taken place in proprietary agencies, while the percentage of more traditional nonprofit home health providers—visiting nurse associations and government agencies—has declined (table 1). In 1989, approximately 35 percent of all Medicare-certified HHAs were proprietary. In 1994, close to 50 percent of all HHAs were in this category. (See fig. II.1 in app. II for state breakdowns.) This increased percentage of proprietary agencies was responsible for 83 percent of the growth in the number of HHAs between 1989 and 1994.[15]

Table 1: Growth in HHAs Providing Medicare Services, 1989-94

	1989		1994	
HHA type	**Number**	**Percent[a]**	**Number**	**Percent[a]**
Government	1,443	25.35	1,353	17.20
Proprietary	2,007	35.26	3,815	48.51
Voluntary	2,242	39.39	2,696	34.28
Total	**5,692**	**100.00**	**7,864**	**100.00**

[a]Percentages may not add to 100 due to rounding.

Source: GAO analysis of HCFA's Provider of Service File.

Utilization Varies by Geographic Area and Type of HHA

A comparison of average visits per beneficiary receiving home health services in 1993 indicates that beneficiaries in certain HCFA regions—most notably in the Atlanta, Boston, and Dallas regions—receive considerably more services on average than beneficiaries in other areas (see table 2). (Refer to fig. II.3 in app. II for data on total home health visits per Medicare beneficiary by state.) A further breakdown of these figures by ownership category indicates that in all regions, proprietary HHAs provide

[14]The Dallas region includes Arkansas, Louisiana, New Mexico, Oklahoma, and Texas; the San Francisco region includes Arizona, California, Hawaii, and Nevada; and the Chicago region includes Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin.

[15]In 1989, 29.5 percent of home health beneficiaries received care from proprietary agencies. In 1993, this number had increased to 33.3 percent of home health beneficiaries. At the same time, total visits provided by proprietary agencies increased from 38.3 percent of total home health visits in 1989 to 45.8 percent of all visits in 1993.

many more services per case than voluntary or government-run agencies.[16] (See fig. II.2 in app. II for state breakdowns.)

Table 2: Average and Median Home Health Visits by HCFA Region[a] and Ownership Type, 1993

	All HHAs		Proprietary		Government		Voluntary	
HCFA region	**Average**	**Median**	**Average**	**Median**	**Average**	**Median**	**Average**	**Median**
Boston[a]	66.2	26	89.8	37	57.4	24	62.9	24
New York[b]	38.5	19	52.4	25	29.9	13	38.3	19
Philadelphia[c]	40.1	19	53.0	23	38.4	16	35.8	18
Atlanta[d]	79.3	37	91.6	44	60.8	28	68.4	32
Chicago[e]	44.2	20	60.5	28	38.9	17	38.8	18
Dallas[f]	77.1	33	92.8	43	55.5	25	56.8	24
Kansas City[g]	43.2	20	59.4	27	38.1	17	39.8	18
Denver[h]	55.6	22	85.0	33	42.3	18	47.7	21
San Francisco[i]	39.7	17	53.0	23	29.8	14	31.4	15
Seattle[j]	36.3	17	55.2	23	33.8	16	32.0	16
Total	**56.7**	**24**	**78.0**	**34**	**45.9**	**19**	**46.1**	**20**

[a]Includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

[b]Includes New Jersey, New York, Puerto Rico, and the Virgin Islands.

[c]Includes Delaware; Washington, D.C.; Maryland; Pennsylvania; Virginia; and West Virginia.

[d]Includes Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.

[e]Includes Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin.

[f]Includes Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.

[g]Includes Iowa, Kansas, Missouri, and Nebraska.

[h]Includes Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming.

[i]Includes Arizona, California, Hawaii, and Nevada.

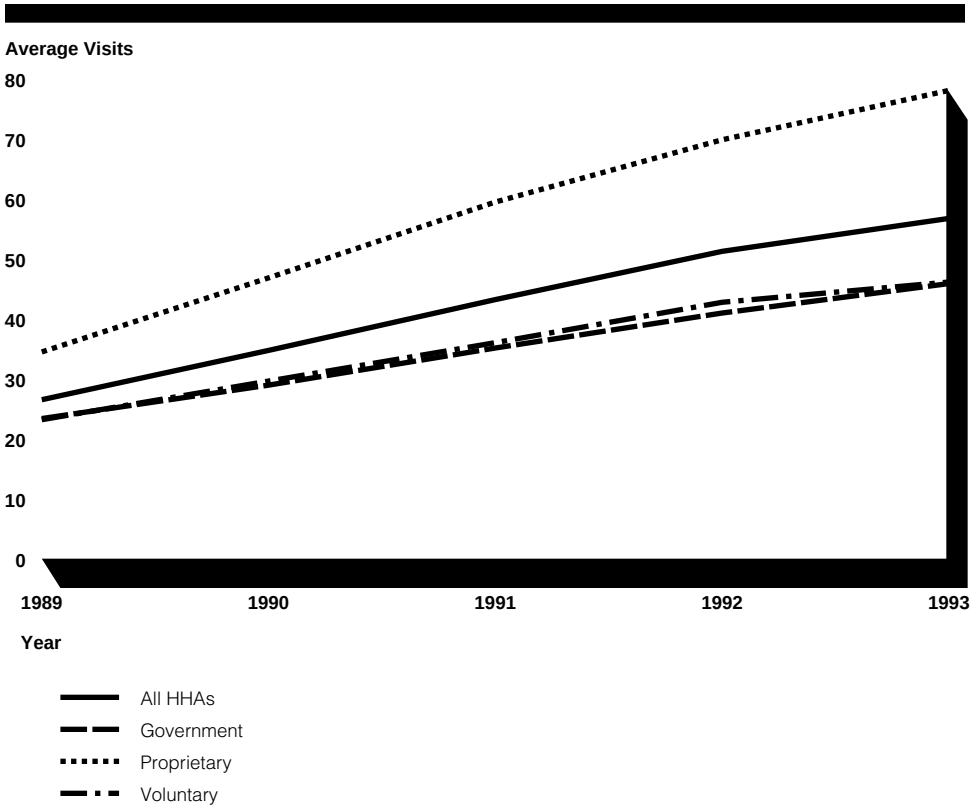
[j]Includes Alaska, Idaho, Oregon, and Washington.

Source: GAO analysis of data from the Medicare Standard Analytical File: Home Health Claims History Database.

On the national level, proprietary agencies have provided a significantly higher number of average visits per home health beneficiary since 1989 (see fig. 4).

[16]For example in 1993, beneficiaries receiving home health aide visits from proprietary agencies received an average of 69 of such visits, while those receiving home health aide visits from voluntary and government agencies received an average of 43 and 48 visits, respectively.

Figure 4: Growth in Medicare Home Health Visits Per Beneficiary by Type of Agency, 1989-93



Source: GAO analysis of data from the Medicare Standard Analytical File: Home Health Claims History Database.

A recent study[17] noted that some of the regional variation in services may reflect differences in the availability of substitute services. Additionally, the study reported some regional differences in patient characteristics; however, these differences did not seem to have a clear pattern that might partially explain variations in utilization. Another study[18] indicated that regional variation could in part be explained by patient characteristics. For instance, the study found that compared with Medicare home health users

[17]Mauser, E., and N.A. Miller, "A Profile of Home Health Users in 1992," Health Care Financing Review, Fall (1994), p. 17.

[18]Schore, J., "Patient, Agency, and Area Characteristics Associated with Regional Variation in the Use of Medicare Home Health Services," Mathematica Policy Research, Inc. (1994), reference number 7899-400.

nationally, beneficiaries in the East South Central[19] region were more likely to be frail, chronically ill, and in poorer health. The study also noted that home health care in the East South Central region tended to be delivered outside large metropolitan counties and in counties that had unusually high percentages of elderly persons living in poverty (both characteristics associated with higher than average home health use).

While evidence might suggest that the availability of substitute services and beneficiary case-mix may explain some of the regional variation in utilization of home health services, why proprietary agencies consistently provide more visits in all regions is not clear. To learn more about the differences between care provided by proprietary and other types of HHAs, we conducted an episode-of-care analysis[20] for four diagnoses: diabetes, heart failure, hypertension, and hip fracture.[21] (See app. I for our methodology and app. III for detailed results.)

For these diagnoses, proprietary agencies, on average, provided care for the longest period of time and provided the most visits per episode during the period studied (see table 3). Although government-run agencies provided care for similar lengths of time as proprietary agencies, government-run HHAs provided 32 to 45 percent fewer visits to beneficiaries with these four diagnoses. Voluntary agencies, in general, provided care for the shortest period of time for all four diagnoses, but they provided slightly more visits per episode than government-run agencies. Variations in utilization between the different types of HHAs were most notable in cases of diabetes, which is regarded as a chronic problem, and less notable in cases of hip fracture, which is more of an acute problem.

[19]Consists of Alabama, Kentucky, Mississippi, and Tennessee.

[20]Because home health episodes are not clearly defined by admission and discharge dates, we defined episodes of care as a series of home health visits preceded and followed by a 60-day period with no visits.

[21]Approximately 22 percent of home health beneficiaries have one of these four primary diagnoses.

Table 3: Average Episode Length and Visits Per Episode—Four Diagnoses, 1992-93

	All HHAs		Government		Proprietary		Voluntary	
Diagnosis	Average length[a]	Average visits	Average length[a]	Average visits	Average length[a]	Average visits	Average length[a]	Average visits
Diabetes	59.0	38.2	61.3	28.7	63.7	52.6	55.3	30.5
Heart failure	54.9	32.1	56.1	25.8	59.7	43.4	52.1	27.5
Hypertension	57.4	34.9	58.5	26.4	62.0	44.0	52.8	27.8
Hip fracture	43.3	29.3	42.9	24.1	44.6	35.3	42.8	27.3

[a]In days.

Source: GAO analysis of data from the Medicare Standard Analytical File: Home Health Claims History Database.

Several HCFA and intermediary officials expressed concern that the growing number of proprietary agencies may be generating increased utilization of home health services. They believe that because the beneficiary incurs no cost and little data exist on the effectiveness of different plans of care, HHAs primarily compete by offering greater numbers of services to beneficiaries. Some HHS Office of Inspector General and intermediary officials further believe that the nonprofit HHAs are being forced to offer increasingly more services in order to stay in business.

Benefit Controls Weakened as Utilization Expands

In two reports issued in 1981 and 1986, respectively,[22] we criticized HCFA's administration of the Medicare home health benefit. We reported that about 27 percent of the visits reviewed at 37 agencies and paid for under the benefit were questionable or improper. We attributed those problems to the vagueness of the coverage criteria (particularly uncertainty over the exact meaning of terms such as homebound and intermittent care), insufficient information being submitted with the claims upon which to base a coverage decision, and poor performance of the intermediaries in reviewing claims. We also noted that other control problems were adversely affecting proper utilization of the home health benefit, including insufficient physician involvement and inadequate monitoring of beneficiary status. In revisiting these issues, we found that while controls had improved during the mid- and late 1980s, they have largely deteriorated since then.

[22]Medicare Home Health Services: A Difficult Program to Control (GAO/HRD-81-155, Sept. 25, 1981), and Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986).

Considerable Room for Interpretation of Coverage Criteria Remains

Homebound Status

The Social Security Act requires that a beneficiary be "confined to the home" (homebound) to be eligible for Medicare home health care. In our 1981 report, we found that determining whether beneficiaries are homebound is difficult due to the inadequacy of the definition provided by HCFA. The report recommended that HCFA's criteria for determining homebound status be clarified and made more specific. The Omnibus Reconciliation Act of 1987 added a definition of homebound to the Social Security Act[23] using the same wording as the HCFA Home Health Agency Manual definition. Therefore, the definition of homebound remains essentially unchanged and considerable discretion remains in interpreting and applying the homebound definition.

As stated in the Medicare Home Health Agency Manual, homebound means that

> "the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort.
>
> "[Further,] if the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive medical treatment." (See app. IV for a full definition.)

Several HCFA and intermediary officials said that few denials are made on the basis that the beneficiary was not homebound.[24] One intermediary official said that the RHHI made fewer than 10 denials a year based on the homebound criteria. An HCFA official further noted that although the RHHIs tend to interpret the homebound criteria fairly consistently, the criteria are so broad that very few claims are denied on the basis that the coverage criteria have not been met. Finally, even if intermediaries do make a denial based on the homebound criteria, so much room for interpretation still

[23]Social Security Act § 1814(a), 42 U.S.C. 1395f(a).

[24]Denials were made only in obvious cases; for example, when the aide frequently noted in the patient's record that she was unable to supply care because the patient was not home at the time.

exists in the infrequent or short duration requirements that such denials may end up being reversed at the reconsideration or appeals level.[25]

A recent study conducted by one of the RHHIs[26] identified some of the types of abuses that are difficult for the intermediary to prevent because of the range of interpretations possible for the homebound criterion. For example, the study identified an instance where a physician called the RHHI to complain that some of his patients were being told by an HHA that they were homebound because they did not own a car. The survey also revealed an example of a home health beneficiary who would put her home health care on hold so that she could go fishing for a week or two. She would then come back and resume her care.

Intermittent Care

The Medicare Home Health Manual sets the parameters of the term intermittent in two ways. The first pertains to beneficiary eligibility requirements; to meet the requirement for intermittent skilled nursing care, an individual must have a "medically predictable recurring need for skilled nursing services."[27] In most instances, the definition will be met if a patient requires a skilled nursing service at least once every 60 days.[28] In contrast, a person expected to need more or less full-time skilled nursing care over an extended period of time would usually not qualify for home health benefits because he or she needs a higher level of care.

The second parameter of intermittent pertains to the frequency of visits allowed by Medicare in a given time frame and is usually used together

[25]In 1991, HCFA attempted to develop numerical parameters to better define the terms: infrequent, short duration, and confined to the home. However, HCFA's proposal received so many negative responses during the comment period, from intermediaries as well as home health agencies, that this proposal was never implemented. Many HHAs expressed concerns that such absolute limits would rob them of flexibility in interpretation of the benefit.

[26]In 1993, Aetna of Florida did a pilot study that involved sending a sample of physicians and beneficiaries detailed lists of claims filed on behalf of their patients or themselves, respectively.

[27]Social Security Act, § 1814(a)(2)(C); Medicare Home Health Agency Manual, § 204.4 and § 205.1C.

[28]The manual further states that since the need for intermittent skilled nursing care makes the individual eligible for other covered home health services, the intermediary should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days. Thus, it is possible that a beneficiary may receive skilled care less than once every 60 days.

with the term part-time.[29] According to the Medicare Home Health Agency Manual,[30] intermittent care is defined as

- up to and including 28 hours per week of skilled nursing and home health aide services combined provided on a less than daily basis;
- up to 35 hours per week of skilled nursing and home health aide service combined that are provided on a less than daily basis, subject to review by fiscal intermediaries on a case-by-case basis, and determined on the basis of documentation justifying the need for and reasonableness of such additional care; or
- up to and including full-time (that is, 8 hours per day) skilled nursing and home health aide services combined that are provided and needed 7 days per week for temporary but not indefinite periods of time of up to 21 days with allowances for extensions in exceptional circumstances where the need for care in excess of 21 days is finite and predictable.[31]

Because a range of interpretations is possible for intermittent, the requirement is difficult to enforce. For example, individuals can be provided intermittent services (for example, blood tests or periodic skilled observation) every 60 days simply to qualify for aide services on a long-term basis.[32] Under the part-time or intermittent coverage rules, determining whether someone who needs daily care for an extended period meets the intermittent requirement or might require institutional care is difficult. Moreover, without further review, to determine whether daily care itself is really necessary is not possible. During our recent investigation of a large home health organization, for example,[33] employees alleged instances where managers instructed nurses to visit new patients daily for the first 14 or 21 days of care regardless of condition—intermediaries usually do not question daily visits during the first 21 days of care.

[29]Part-time means any number of days per week up to and including 28 hours per week of skilled nursing and home health aide services combined for fewer than 8 hours per day, or up to 35 hours per week of skilled nursing and home health aide services combined for fewer than 8 hours per day subject to review by fiscal intermediaries on a case-by-case basis, based upon documentation justifying the need for and reasonableness of such additional care.

[30]Revised in 1989 to implement the decision of the District Court of the District of Columbia in the Duggan v. Bowen case.

[31]§ 206.7(B).

[32]For example, Aetna's 1993 survey identified cases where patients received unneeded skilled services in order to qualify for aide services.

[33]See Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

Less Information Is Available to Intermediaries for Making Coverage Decisions

In August 1985, HCFA implemented standardized medical information forms[34] for HHAs to use in requesting payment from intermediaries. These plan-of-care and update forms, which were to be submitted with the initial claim and the claim closest to the recertification date 60 days later, gave medical reviewers more detailed information on each beneficiary's general physiological condition, homebound status, functional limitations, nutritional requirements, services prescribed, and services received. The additional information was intended to increase the accuracy and consistency of coverage decisions.

In our 1990 report,[35] we noted that the regional intermediaries generally agreed that denials associated with the implementation of the new forms were a contributor to increases in denials in fiscal year 1986.[36] HCFA has, however, dropped the requirement for routine submittal. In a September 1994 revision, the Medicare Intermediary Manual was changed to state:

"These forms [485/486] are no longer submitted routinely with the initial claim or other subsequent claim. The completed HCFA-485, signed by the physician, is retained in the HHA files and a copy of the signed form is submitted [to the intermediary] when requested for medical review. The HCFA-486 is completed only when required for medical review."

An HCFA official explained that the primary reason for dropping this requirement was that over time HHAs learned how to fill out the forms in a manner that would most likely result in the services being approved for payment; the completed forms all started to look alike and were less useful. Currently, the only information the intermediary routinely receives is the bill from the HHA. A notation in the annotated intermediary version of the Medicare Home Health Agency Manual states that RHHIs will

"assume that the type and frequency of services ordered are reasonable and necessary unless objective clinical evidence clearly indicates otherwise, or there is a lack of clinical evidence to support coverage."

[34]HCFA forms 485, Home Health Certification and Plan of Care, and 486, Medical Update and Patient Information. Other forms implemented at the same time include an addendum to the plan of treatment and patient information form (the 487 form) and an intermediary medical information request form (the 488 form).

[35]Medicare: Increased Denials of Home Health Claims During 1986 and 1987 (GAO/HRD-90-14BR, Jan. 24, 1990).

[36]We concluded that this initiative contributed to more claims denials because (1) medical reviewers had more information on which to make coverage decisions and (2) some intermediaries denied claims because certain information was missing, instead of requesting the required data.

Because the current billing form alone does not supply adequate information to make this type of determination, most bills are paid without question.

Little Medical Review Is Done

The regional home health intermediaries are responsible for procedures to assure that they only make payments for home health services that are covered by Medicare and avoid paying for services that are (1) provided to beneficiaries who do not meet Medicare home health criteria, (2) not reasonable or medically necessary, or (3) in excess of the services called for by the approved plan of treatment. Currently, the RHHI's primary procedure for detecting noncovered services is medical review of claims.[37]

Prepayment Reviews

The Consolidated Omnibus Budget Reconciliation Act of 1985 more than doubled the funds available for medical review and audit of home health and other Medicare claims. This allowed intermediaries to increase the number of medical reviews performed; they conducted medical reviews on 62 percent of home health claims processed in fiscal years 1986 and 1987. The increased number of claims subjected to medical review resulted in more denials and higher denial rates even though the percentage of claims being denied during medical review did not increase significantly. For example, in both 1985 and 1987, intermediaries denied about 10 percent of the claims subjected to medical review. However, because over twice as many claims were subjected to medical review in 1987, there were over twice as many denials. As a result, the HCFA-reported denial rate was 7.9 percent in 1987 compared with 3.4 percent in 1985.

Due to budget cuts since 1989,[38] however, intermediaries are now required to conduct medical reviews (pre- and postpayment) on a target of 3.2 percent of all claims, including home health claims.[39] At the same time, home health claims volume increased from 5.5 million claims in 1989 to 16.6 million claims in 1994. Of the 3.7 percent of home health claims

[37]Medical review involves reviewing additional information requested from and submitted by the HHA, such as the 485, Plan of Care Form, and the beneficiary's medical records.

[38]In 1989, total part A contractor funding for medical review/utilization was $61 million. Due to subsequent budget cuts, by 1992 this funding dropped to $31 million—an almost 50-percent cut. Fiscal year 1995 funding is $33.1 million. Payment safeguard funding for the home health benefit is based on the number of home health claims processed by the intermediary in relation to other types of claims processed.

[39]The contractor Budget and Performance Requirements, 1995 stipulate that "(t)he target review level is 3.2 percent, however, intermediaries may reduce the review level based on resources available. The minimum acceptable review level is 1 percent although it is expected that intermediaries review as many claims as possible."

denied in fiscal year 1994, only 0.6 percent were denied because the services were determined, through medical review, to not be medically necessary or because the beneficiary did not meet the qualifying coverage criteria.[40]

As a result of decreased review, HHAs are less likely to be caught if they abuse the home health benefit. An HCFA official noted that HHAs are aware that the intermediary only reviews a small number of claims and, therefore, can take chances billing for noncovered services. As long as they do not trigger the criteria that would cause the claim to be flagged,[41] HHAs can submit abusive claims that will never be reviewed.

Besides covering so few claims, prepayment medical review is limited in its ability to detect noncovered care in that it is simply a paper review done at the offices of the RHHI. According to HCFA and intermediary officials, it is often not possible to obtain enough information from a paper review alone no matter how complete the medical records submitted, to determine whether a provider is abusing the benefit or committing fraud. If the codes are valid, the forms filled out properly, and no unusual patterns are identified during the FMR process, the claim goes through. For example, our investigation of a large home health organization turned up allegations that staff were directed to alter or falsify medical records to ensure continued or prolonged visits, including recording visits that were never made or noting that patients were homebound even after they were no longer confined to the home.[42] To further illustrate, an intermediary official noted that sometimes the wrong diagnosis is put on the claim form to make beneficiaries appear sicker than they really are and, thus, in need of more care.

Postpayment Review

Postpayment utilization review differs from prepayment review in that its principal focus is on identifying HHAs that are providing significant amounts of noncovered care rather than on identifying services provided

[40]The remaining denials stemmed primarily from Common Working File edit checks; for example, the patient was not eligible to receive Medicare benefits, Medicare was the secondary payer, the bill was for noncovered services (such as some supplies), or the bill was a duplicate.

[41]To identify noncovered services, intermediaries currently evaluate claims through a focused medical review process (FMR). According to FMR procedures, the intermediaries are to target the review of claims where there is the greatest risk of inappropriate payment. Intermediaries analyze utilization data and develop measures to identify predictors of aberrant utilization among their providers. The intermediaries then put edits in their claim processing systems that flag the claims that exceed the chosen criteria; for example, high levels of utilization. A small percentage of the flagged claims are then reviewed. Even if a claim exceeds the screening criteria, it may still not be selected for the small percentage that are actually reviewed.

[42]See Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

to specific beneficiaries. In 1982, HCFA implemented a selective postpayment utilization review program that has cost effectively identified extensive noncovered services paid for by Medicare. The essential component of postpayment review, comprehensive medical review (CMR), is a thorough postpayment evaluation of claims and medical documentation that may involve an audit at the provider's site.[43] On-site audits give the reviewer access to the information in the provider's records, including plans of care and documentation of visits.

According to records obtained from HCFA, only 51 on-site audits were conducted by the nine RHHIs combined in fiscal year 1994.[44] Thus, fewer than 1 percent of all Medicare-certified HHAs were audited. Intermediaries are required to perform 10 on-site CMRs each year for all provider types, including, for example, outpatient, skilled nursing, and rehabilitation facilities. An HCFA representative noted that CMRs are so resource intensive that they may be done only in instances where a high level of return is expected. Because HHA claims may comprise a relatively small portion of an intermediary's total claims volume, the intermediary may not do any home health CMRs.

One of the best ways to verify information provided by the HHA is to visit beneficiaries at home. Beginning in 1984, intermediaries were required to make visits to a sample of five beneficiaries at targeted agencies to assess coverage status; however, this requirement was subsequently dropped due to cuts in contractor funding. In March 1995, HCFA revised the Medicare Intermediary Manual to say that intermediaries may perform visits to selected beneficiary homes but they are not required to do so. According to officials at the intermediaries visited, only one of the three was doing any beneficiary visits as part of its CMRs.[45]

A proposed sampling procedure for CMRs involves selecting a valid statistical sample of claims from agencies suspected of abusive practices and extrapolating the denial rate (and therefore payment recovery rate) in the sample to similar claim types during the same period. In our 1986 report, we suggested that by using statistically valid sampling techniques, such as those being used to estimate physician overpayments under

[43]Providers are selected for a CMR based on performance patterns identified in prepayment review; for example, the provider submits noticeably altered documentation, has a pattern of not complying with physician orders, or is suspected of fraud. In this type of CMR, overpayments are only collected on claims that are reviewed.

[44]The number of on-site audits ranged from none to 15 for each RHHI.

[45]This intermediary noted, however, that HHAs sometimes coach the beneficiaries on what to say and do to ensure that they would continue to get home health coverage.

Medicare part B, overpayments to HHAs for noncovered services could be projected to all claims submitted by the agency during the sampling period and could result in millions of dollars in additional recoveries. In addition, we recommended that HCFA require intermediaries to use such procedures. However, RHHIs are currently not required to use a projectable sample of home health visits to extend recoveries—recoveries are, therefore, limited to the cost of actual services reviewed and denied. HCFA is circulating a new draft sampling plan that delineates the methodology for selecting a representative sample. However, previous attempts to implement statistically valid postpayment sampling have not been successful, primarily due to opposition from the home health industry and other health care providers.

Physicians Not Actively Involved in Monitoring Patient Care

With the enactment of the Medicare program, it was expected that the physician would play an important role in determining utilization of services. Medicare law and regulations, therefore, require that home health items and services must be furnished under a plan of treatment established and periodically reviewed by a physician. HCFA requires that the plan is to be reviewed and recertified in writing by the attending physician at least every 62 days. The physician is expected but not required to see the patient.

Few data exist about the current nature of physician involvement in home health care. Concerns have been raised, based on audits of certain HHAs and anecdotal reports, that physicians are not appropriately involved in planning and coordinating home health services. For example, both HCFA and intermediary officials expressed concern that HHAs were preparing the plans of treatment and the physicians were signing them with little or no review.

A recent report issued by HHS' Office of the Inspector General (OIG)[46] that was based on a survey of physicians and HHAs around the country found that physicians generally have a relationship with patients for whom they sign plans of care. Physicians usually reported initiating referrals for home care and reviewing the plans of care that they sign; however, most do not prepare the plans of care themselves. The report also found that physicians were most involved when caring for patients with complex medical problems and were less involved when caring for patients with chronic or less complex conditions. Thus, physicians frequently are not

[46]See "The Physician's Role in Home Health Care," HHS, OIG, OEI-02-94-00170 (Washington, D.C.: 1995).

aware of the ongoing HHA services being provided to patients and billed to the Medicare program. HHS' Inspector General pointed out[47] the importance of recognizing that physicians usually do not make home visits themselves to monitor the HHA services provided and do not directly manage the care that a patient receives from an HHA. An intermediary official noted that some physicians feel that because they are ordering nonmedical services, which will generally not harm the patient, not much review is required.

The 1993 Aetna of Florida pilot study revealed examples of different levels of physician involvement. In one instance, a physician wrote that he took every Friday off to spend the whole day reviewing home health plans of care. Another physician, who received 100 plans of care a week, wrote a letter to his intermediary reprimanding it for asking him to read the plans of care. Our investigation of a large home health organization found that physicians typically rely on nurses' verbal recommendations, written recommendations, or both. We also noted allegations that physicians' signatures were forged and plans of care were altered after certification without the physicians' knowledge.

To compensate physicians for the time spent on preparing and reviewing home health plans-of-care forms, HCFA issued a new regulation in 1994 providing separate payment for physician care plan oversight services. As of January 1995, HCFA began allowing participating physicians to be paid for oversight requiring at least 30 minutes. Currently, the payment rate is approximately $81 per patient.

Physicians and Beneficiaries Not Aware of Services Billed

Neither the beneficiaries receiving nor the physicians ordering home health services are sent information about which services Medicare has paid. Beneficiaries do not receive an explanation of benefits because they are not billed for in-home services. Therefore, neither the physician nor the beneficiary has any way of knowing whether Medicare is paying the HHA for services not rendered or whether the home health services are provided according to the plan of care.

Denied Claims Likely to Be Paid Under Waiver of Liability

Under the waiver-of-liability provision of the Social Security Act (§ 1879) Medicare will pay for denied services if the beneficiaries and providers did not know and had no reason to know that the services were

[47]Testimony of June Gibbs Brown, Inspector General, HHS, before the Senate Special Committee on Aging (Mar. 21, 1995).

not medically reasonable and necessary or were based on the need for custodial rather than skilled care. In implementing this provision, HCFA generally presumed that HHAs did not know services were not covered as long as their number of denials did not exceed 2.5 percent of total visits billed. When a provider exceeded the 2.5-percent rate in a calendar quarter, Medicare would not reimburse the provider for denied services, usually for the next 3-month period.[48]

According to statistics obtained from HCFA, in fiscal year 1994 approximately half of all claims denied for lack of medical necessity or for not meeting the coverage criteria were eligible for waiver. Of those eligible for waiver, 73 percent were ultimately paid. In fiscal year 1994, the total amount reimbursed under waiver was approximately $45.5 million.

Because so few claims are reviewed and so few technical and medical necessity denials are made, most providers, especially those who submit large numbers of claims, would never exceed the 2.5-percent rate threshold.[49] In an earlier report,[50] we noted that savings could be realized by changing the waiver-of-liability rules and recommended that HCFA establish more stringent eligibility requirements for the application of waiver of liability for health care providers under part A of Medicare.[51]

HCFA Striving to Address Problems

In response to the changing climate surrounding home health care, the Administrator of HCFA convened an internal task force in the spring of 1994 (the Medicare Home Health Initiative) to examine the home health benefit from both a policy and an operations perspective. As of September 1995, the task force has held four open workgroup meetings at which HCFA officials solicited ideas and suggestions for benefit improvement from

[48]The Omnibus Budget Reconciliation Act of 1986 created a second waiver-of-liability category under which the beneficiary is not liable when services are denied for technical reasons; that is, because the beneficiary was not homebound or did not require intermittent skilled nursing care. HCFA pays providers for services denied for technical reasons using the same 2.5-percent rate criterion that applies to medical necessity denials.

[49]Providers who do exceed the threshold are usually targeted by intermediaries for high levels of review.

[50]Savings Possible by Modifying Medicare's Waiver of Liability Rules (GAO/HRD-83-38, Mar. 4, 1983).

[51]We suggested several ways to achieve savings: (1) eliminating the presumption that providers did not know or could not reasonably be expected to know that certain services were not covered and applying the waiver provision on a case-by-case basis; (2) tightening the denial rate criteria used to determine presumed eligibility (that is, reducing the threshold); and (3) changing the waiver-of-liability procedure so that after providers have participated in Medicare for some period of time, there would no longer be a presumption of eligibility. The legal provision requiring HCFA to use the presumptive level expired in January 1996. HCFA instructed the intermediaries to discontinue using presumption of eligibility for waiver of liability and make waiver decisions for each denied claim.

physician organizations, representatives of beneficiary groups, the home health industry, state governments and their Medicaid agencies, and others. The task force has also issued a draft revision of the conditions of participation, developed a pamphlet to better inform beneficiaries of what services are covered, and developed draft sampling instructions for postpayment utilization review. Further, the task force has implemented a four-state pilot program to investigate providing home health beneficiaries with claims information, begun pilots of team on-site medical review of HHAs,[52] revised the Medicare Intermediary Manual to allow unannounced on-site audits,[53] and implemented a two-state pilot program involving training state surveyors to assess patient eligibility as a part of HHA annual surveys.

These efforts by HCFA are commendable and should help somewhat in gaining control of the use of the home health benefit. However, as discussed earlier in this report, HCFA cannot address many of the major problems, such as the changes in the manuals made in response to a court decision, that make it harder to control use of services and the shortage of funds to perform program safeguard activities.

Conclusions

The Medicare home health program is judged by HCFA as being very difficult to control. While quantifying how much of the recent growth in home health care is due to abuse of the benefit is not possible, lax benefit controls leave the door open for abuses such as overutilization to occur. While HCFA has made some notable attempts to remedy several specific problems, a number of fundamental issues remain. For example:

- In response to a court decision, HCFA revised its requirements for determining Medicare home health eligibility. The revisions made it possible for more beneficiaries to qualify for Medicare home health services and more HHAs to receive payment for higher numbers of visits and for longer periods of care. Historically, part A of Medicare's home health benefit was directed at acute conditions after hospitalization. While many beneficiaries still use the benefit in this way, an increasing number

[52]The March 1995 Medicare Intermediary Manual revisions added the following statement under Review Options: "Team Reviews have been found to be very effective and are to be conducted whenever appropriate. The team may consist of medical review, and/or audit and fraud and abuse staff, state surveyors, carrier and/or Medicaid staff depending upon the issues identified. At minimum, prior to conducting CMRs you are to consult and share information with other internal and external (as appropriate) staff to determine if there are issues that you should be aware of or if a team review is needed."

[53]Until a March 1995 revision to the Medicare Intermediary Manual, RHHIs were required to give HHAs 10 days' notice before doing an on-site audit (none if fraud was suspected). The manual now leaves the decision of whether to give notice and how much to the RHHI.

of beneficiaries are receiving visits that are more directed at long-term care for chronic conditions.

- Physicians tend to depend on HHAs to design plans of care, especially for less complex cases, and agencies as a rule have incentives to furnish as many visits as possible. This combination can lead to the overprovision of services.
- Medicare has reduced on-site audits and reviews so that HHAs have less incentive to follow Medicare rules. The percentage of claims that are reviewed has decreased from over 60 percent in 1987 to approximately 3 percent in 1994. We have testified on a number of occasions that program safeguard activities are cost effective, returning close to $14 in savings for each $1 invested in 1994, and cuts in payment safeguard areas translate into increased program losses from fraud, waste, and abuse. When claims volume increases and medical review of claims declines, intermediaries' ability to detect and prevent erroneous payments is substantially lessened. Further, even when claims are denied, they were often paid because the HHA qualified for a waiver of liability.
- It is nearly impossible for intermediaries to assess from paper review alone whether a beneficiary meets the eligibility criteria, whether the services received are appropriate given the beneficiary's current condition, and whether the beneficiary is actually receiving the services billed to Medicare. Coverage criteria, such as confined to the home or intermittent, are not meaningful when the HHAs are in effect the only ones monitoring beneficiaries.

Matters for Consideration by the Congress

The emphasis of Medicare's home health benefit program has recently shifted from primarily posthospital acute care to more long-term care. At the same time, HCFA's ability to manage the program has been severely weakened by coverage changes mandated by court decisions and a decrease in the funds available to review HHAs and the care they provide. The Congress may wish to consider whether the Medicare home health benefit should continue to become more of a long-term care benefit or if it should be limited primarily to a posthospital acute care benefit. The Congress should also consider providing additional resources so that controls against abuse of the home health benefit can be better enforced.

Agency Comments

We provided HHS an opportunity to comment on our draft report, but it did not provide comments in time for them to be included in the final report.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 7 days after its issue date. At that time, we will send copies to the Secretary of HHS, the Administrator of HCFA, interested congressional committees, officials who assisted our investigation, and other interested parties. Copies also will be made available to others on request.

Please contact me on (202) 512-6808 if you have any questions about this report. Other GAO contacts and staff acknowledgments are listed in appendix V.

Sincerely yours,

Sarah F. Jaggar
Director, Health Financing and
Policy Issues

Contents

Abbreviations

CFR	Code of Federal Regulations
CMR	comprehensive medical review
ESRD	end-stage renal disease
FMR	focused medical review
HCFA	Health Care Financing Administration
HHA	home health agency
HHS	Department of Health and Human Services
OIG	Office of Inspector General
RHHI	regional home health intermediary

Scope and Methodology

Our work was done primarily at HCFA headquarters. We also visited three regional home health intermediaries (in Chicago, Illinois; Milwaukee, Wisconsin; and Clearwater, Florida) and two HCFA regional offices (Chicago and Atlanta) to obtain workload and performance data, information concerning RHHI claims review operations, and an update on HCFA's implemented and planned program changes. We also interviewed officials at HHS' Office of the Inspector General in Baltimore and Atlanta.

We reviewed pertinent laws, regulations, court decisions, and HCFA policies to identify changes in eligibility determination and medical review practices. And we reviewed studies related to home health benefit utilization and control issues.

To identify home health growth patterns and variations in utilization, we analyzed data from Medicare's Provider of Service and Home Health National Claims History files. These data include information on all paid claims for the period 1989 through 1993.[54] We used data from the Provider of Service file to determine agency growth through time and across geographic regions and to identify provider ownership type. And we used the Medicare claims data to calculate mean and median home health visits, by total and by each type of service, broken out by geographic area[55] and HHA ownership types.

While the average visits per year provides a general indication of variations in utilization of home health services, it does not indicate the length of each individual's episode of care nor does it provide a picture of the intensity of services provided during this time. To obtain a more in-depth look at variations in practice patterns, both across regions and among various types of HHAs, we conducted an episode-of-care analysis for four diagnoses: diabetes, heart failure, hypertension, and hip fracture.[56] The first three diagnoses were selected because they are among the most common primary diagnoses associated with home health care.[57] Hip fracture was selected because it is generally regarded as having a more predictable pattern of treatment with a more finite end point. We selected beneficiaries with one of the above primary diagnoses who began

[54]Most recent data available.

[55]Geographic breakdowns were based on the state of beneficiary residence.

[56]Because home health episodes are not clearly defined by admission and discharge dates, we defined episodes of care as a series of home health visits preceded and followed by a 60-day period with no visits.

[57]Approximately 22 percent of Medicare home health patients have one of these four primary diagnoses.

receiving home health services in 1992. We then tracked beneficiaries' visits up to 210 days after their episode start date.[58]

The principal sources of our automated data were Medicare paid claims data systems, which are subject to periodic HCFA reviews and examinations. HCFA relies on the data obtained from these systems as evidence of Medicare-covered services and expenditures and to support its management and budgetary decisions. For this reason, we did not independently examine the internal and automatic data processing controls for automated systems from which we obtained data used in our analyses. With this exception, we conducted our work in accordance with generally accepted government auditing standards between July 1994 and December 1995.

[58]Because some episodes of care continued indefinitely, that is, without a 60-day gap in claims for visits, we selected a cutoff point that allowed us to analyze utilization of most of the patients. A cutoff point of 210 days allowed us to look at full episodes for 99.22 percent of hip fracture beneficiaries, 94.60 percent of heart failure beneficiaries, 94.59 percent of hypertension beneficiaries, and 91.54 percent of diabetes beneficiaries.

Detailed Data Tables

Table II.1: Characteristics of Medicare Home Health Beneficiaries

	1989		1990	
	Number of beneficiaries	Percent	Number of beneficiaries	Percent
	1,682,139	100	1,955,170	100
Sex				
Female	1,073,674	63.83	1,253,685	64.12
Male	608,169	36.15	701,451	35.88
Race				
White	1,422,569	84.57	1,650,857	84.44
Black	185,959	11.05	213,174	10.90
Other	25,448	1.51	32,676	1.67
Age				
Less than 65	96,103	5.71	114,578	5.86
65-70	263,740	15.68	304,211	15.56
71-80	692,258	41.15	793,679	40.59
81 or older	630,038	37.45	742,702	37.99
Medicare eligible				
Aged without ESRD[a]	1,573,317	93.53	1,824,379	93.31
Aged with ESRD	7,022	0.42	9,540	0.49
Disability without ESRD	94,728	5.63	112,010	5.73
Disability with ESRD	3,616	0.21	4,659	0.24
ESRD only	3,456	0.21	4,582	0.23

1991		1992		1993	
Number of beneficiaries	Percent	Number of beneficiaries	Percent	Number of beneficiaries	Percent
2,228,701	100	2,526,978	100	2,836,912	100
1,433,111	64.30	1,628,771	64.46	1,834,899	64.68
795,89	35.70	898,207	35.54	1,002,008	35.32
1,876,723	84.21	2,118,644	83.84	2,369,476	83.52
243,891	10.94	278,888	11.04	314,829	11.10
42,558	1.91	54,208	2.15	67,328	2.37
132,153	5.93	156,143	6.18	186,840	6.59
338,514	15.19	373,912	14.80	407,177	14.35
897,289	40.26	1,009,229	39.94	1,111,308	39.17
860,745	38.62	987,694	39.09	1,131,587	39.89
2,076,599	93.18	2,345,992	92.84	2,621,323	92.40
12,388	0.56	16,321	0.65	19.382	0.68
128,320	5.76	150,133	5.94	178,340	6.29
5,647	0.25	7,550	0.30	9.632	0.34
5,747	0.26	6,982	0.28	8,235	0.29

[a]End-stage renal disease.

Source: GAO analysis of data from the Medicare Standard Analytical File: Home Health Claims History Database.

Figure II.1: Growth in Medicare Home Health Agencies, 1989-94

		1989				1994			
			Percent				Percent		
Region	State	Total HHAs	Government	Proprietary	Voluntary	Total HHAs	Government	Proprietary	Voluntary
Boston	Connecticut	103	13.59	27.18	59.22	114	9.65	36.84	53.51
	Maine	22	0.00	27.27	72.73	30	0.00	40.00	60.00
	Massachusetts	141	9.22	19.86	70.92	171	4.09	38.01	57.89
	New Hampshire	38	7.89	13.16	78.95	40	5.00	22.50	72.50
	Rhode Island	14	0.00	7.14	92.86	18	0.00	33.33	66.67
	Vermont	16	0.00	0.00	100.00	13	0.00	0.00	100.00
New York	New Jersey	57	17.54	10.53	71.93	53	15.09	5.66	79.25
	New York	194	34.54	10.82	54.64	213	28.17	16.43	55.40
	Puerto Rico	45	4.44	0.00	95.56	44	4.55	2.27	93.18
	Virgin Islands	1	100.00	0.00	0.00	2	50.00	50.00	0.00
Philadelphia	Delaware	20	20.00	25.00	55.00	19	0.00	36.84	63.16
	D.C.	13	7.69	46.15	46.15	19	5.26	68.42	26.32
	Maryland	82	18.29	40.24	41.46	75	17.33	37.33	45.33
	Pennsylvania	256	0.39	41.02	58.59	313	0.00	48.88	51.12
	Virginia	168	22.02	45.83	32.14	200	12.50	54.00	33.50
	West Virginia	56	39.29	17.86	42.86	67	32.84	31.34	35.82
Atlanta	Alabama	118	57.63	25.42	16.95	168	52.98	26.19	20.83
	Florida	232	5.60	61.64	32.76	306	4.58	63.40	32.03
	Georgia	71	8.45	52.11	39.44	82	3.66	58.54	37.80
	Kentucky	102	24.51	36.27	39.22	107	24.30	36.45	39.25
	Mississippi	78	50.00	23.08	26.92	76	47.37	28.95	23.68
	North Carolina	127	48.82	19.69	31.50	149	38.26	29.53	32.21
	South Carolina	46	39.13	28.26	32.61	66	25.76	45.45	28.79
	Tennessee	269	27.51	55.76	16.73	237	12.66	67.51	19.83
Chicago	Illinois	245	18.78	31.84	49.39	303	14.52	42.90	42.57
	Indiana	131	26.72	38.93	34.35	203	15.27	56.16	28.57
	MIchigan	162	24.69	35.19	40.12	175	14.29	37.71	48.00
	Minnesota	194	46.91	22.68	30.41	230	38.70	28.26	33.04
	Ohio	246	21.14	34.55	44.31	341	12.90	49.56	37.54
	Wisconsin	157	34.39	29.30	36.31	171	26.32	31.58	42.11
Dallas	Arkansas	161	58.39	14.29	27.33	203	50.25	15.76	33.99
	Louisiana	174	13.79	63.22	22.99	431	5.10	77.03	17.87
	New Mexico	46	8.70	47.83	43.48	81	12.35	59.26	28.40
	Oklahoma	82	24.39	39.02	36.59	218	16.06	59.63	24.31
	Texas	451	15.30	58.31	26.39	937	7.79	75.45	16.76
Kansas City	Iowa	154	66.23	7.79	25.97	173	54.34	12.14	33.53
	Kansas	126	47.62	19.05	33.33	163	36.20	33.13	30.67
	Missouri	182	29.67	29.67	40.66	230	20.43	44.78	34.78
	Nebraska	46	32.61	15.22	52.17	64	29.69	28.13	42.19
Denver	Colorado	108	26.85	30.56	42.59	154	17.53	46.75	35.71
	Montana	43	32.56	6.98	60.47	47	23.40	10.64	65.96
	North Dakota	33	12.12	24.24	63.64	32	9.38	18.75	71.88
	South Dakota	19	15.79	15.79	68.42	33	15.15	18.18	66.67
	Utah	37	27.03	35.14	37.84	64	10.94	57.81	31.25
	Wyoming	30	73.33	20.00	6.67	52	61.54	23.08	15.38
San Francisco	Arizona	56	19.64	35.71	44.64	94	6.38	55.32	38.30
	California	344	13.66	49.42	36.92	604	8.61	63.41	27.98
	Hawaii	19	31.58	21.05	47.37	25	16.00	32.00	52.00
	Nevada	24	20.83	62.50	16.67	41	7.32	78.05	14.63
Seattle	Alaska	7	28.57	14.29	57.14	18	27.78	16.67	55.56
	Idaho	28	25.00	39.29	35.71	56	28.57	42.86	28.57
	Oregon	59	27.12	23.73	49.15	80	12.50	38.75	48.75
	Washington	58	18.97	24.14	56.90	59	15.25	27.12	57.63
National Totals		**5,692**	**25.35**	**35.26**	**39.39**	**7,864**	**17.20**	**48.51**	**34.28**

(Figure notes on next page)

Source: GAO analysis of the Medicare Provider of Service File.

Figure II.2: Average and Median Number of Visits per Beneficiary per Year, 1989 and 1993

		1989								1993							
		All HHAs		Government		Proprietary		Voluntary		All HHAs		Government		Proprietary		Voluntary	
Region	State	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Boston	Connecticut	26.28	13	23.62	12	29.50	17	26.26	13	63.08	26	45.12	20	87.23	40	56.71	24
	Maine	22.70	11	17.45	8	19.00	10	22.98	11	55.46	22	34.21	19	64.86	25	54.22	22
	Massachusetts	23.80	11	23.30	11	23.75	12	23.80	11	74.42	28	68.92	28	99.84	39	71.32	27
	New Hampshire	22.58	10	25.48	11	37.48	18	21.62	10	50.15	19	69.68	28	72.56	32	48.49	19
	Rhode Island	23.22	11	17.57	13	28.57	15	23.14	11	55.48	23	41.90	11	71.91	32	54.70	22
	Vermont	25.96	11	22.00	7	19.28	13	26.13	11	54.46	22	36.19	22	49.31	22	54.55	22
New York	New Jersey	19.21	10	18.77	10	20.22	11	19.17	10	37.10	18	31.69	16	48.67	24	36.75	18
	New York	17.61	10	16.02	8	22.39	13	17.84	11	40.68	20	29.92	12	55.35	27	40.81	21
	Puerto Rico	19.16	12	19.05	12	28.30	12	19.13	12	31.03	17	23.64	14	26.94	16	31.58	17
	Virgin Islands	14.28	10	13.93	8	16.71	8	13.86	11	29.86	13	16.37	10	43.38	21	48.02	10
Philadelphia	Delaware	28.04	15	22.24	11	33.74	17	27.60	15	43.75	19	33.52	10	53.21	21	42.42	19
	D.C.	21.85	13	48.11	16	21.04	13	21.92	14	37.80	20	34.88	28	37.31	20	39.24	21
	Maryland	21.81	12	19.66	10	24.68	14	20.85	12	35.44	18	32.66	15	39.69	19	33.11	17
	Pennsylvania	22.99	13	20.55	10	26.13	14	22.34	13	39.29	19	34.77	15	56.92	25	35.52	18
	Virginia	26.15	13	26.54	13	30.24	15	23.63	13	44.14	19	40.39	18	56.61	24	36.41	17
	West Virginia	24.92	11	21.31	10	30.75	13	24.28	11	45.11	17	41.29	16	63.26	25	38.64	16
Atlanta	Alabama	44.76	21	36.04	16	58.79	28	37.35	18	102.25	52	89.12	51	116.88	58	91.55	46
	Florida	31.82	18	22.99	13	34.28	20	28.40	17	68.35	34	49.19	21	72.78	36	63.23	33
	Georgia	41.85	22	35.30	17	45.43	25	37.93	19	95.09	49	74.03	39	107.37	58	72.39	35
	Kentucky	32.48	14	29.83	13	37.26	16	30.02	12	60.10	24	50.40	21	75.31	32	52.48	21
	Mississippi	55.49	31	47.72	25	58.95	33	56.92	32	100.98	54	84.41	43	102.86	54	105.73	59
	North Carolina	28.93	15	24.71	13	36.52	18	28.11	15	52.71	23	38.87	18	66.82	30	52.00	22
	South Carolina	27.41	15	24.78	14	36.02	19	29.79	16	57.16	28	52.52	28	71.52	35	44.34	23
	Tennessee	52.37	26	40.29	21	60.65	32	37.81	19	105.58	51	68.74	34	122.48	65	78.74	34
Chicago	Illinois	22.16	12	22.41	12	25.40	15	20.98	12	44.33	22	39.00	19	59.01	30	39.79	20
	Indiana	23.56	12	23.68	12	30.49	15	21.30	11	63.09	26	53.67	23	86.25	39	54.07	22
	MIchigan	24.42	14	21.98	12	27.75	17	23.37	13	38.00	20	42.33	19	48.46	26	33.15	18
	Minnesota	18.08	10	19.53	10	19.69	10	16.94	10	34.82	15	30.03	13	50.33	20	31.37	14
	Ohio	20.25	10	17.16	9	21.83	11	20.48	11	44.65	20	34.31	15	63.13	27	38.82	18
	Wisconsin	20.85	11	18.72	10	22.46	12	21.15	11	38.90	16	32.77	14	53.67	21	36.71	16
Dallas	Arkansas	33.68	16	33.00	17	39.30	18	32.03	15	64.59	29	57.68	27	87.22	40	59.07	27
	Louisiana	36.87	17	30.92	15	43.66	21	27.15	13	96.05	47	63.93	29	111.32	61	64.71	27
	New Mexico	21.57	11	18.52	11	27.84	14	19.09	10	41.60	18	33.34	16	56.09	25	31.58	15
	Oklahoma	29.98	13	22.68	11	41.52	19	22.16	11	81.67	33	52.10	23	107.16	48	60.57	25
	Texas	29.14	15	22.42	12	33.09	17	25.05	13	73.48	32	53.09	24	84.38	38	55.42	23
Kansas City	Iowa	20.79	10	18.24	9	28.30	14	21.53	11	40.67	18	39.02	17	60.21	24	38.99	18
	Kansas	24.88	11	20.69	9	27.76	13	25.07	11	47.51	21	35.49	16	64.38	28	44.15	20
	Missouri	24.72	13	23.32	12	28.20	14	23.88	13	44.61	21	39.63	19	57.43	28	39.59	19
	Nebraska	21.01	10	18.10	10	30.64	16	20.70	10	39.26	16	30.11	15	76.76	26	37.40	15
Denver	Colorado	25.15	13	19.20	10	29.91	17	23.96	13	49.63	22	35.62	18	79.27	35	41.67	20
	Montana	23.86	12	22.69	12	39.78	22	22.92	11	45.51	20	39.74	19	116.53	43	40.59	19
	North Dakota	19.67	11	16.31	11	20.38	11	19.61	11	40.95	18	27.96	14	53.30	19	36.72	18
	South Dakota	17.50	9	13.71	7	17.93	10	19.25	9	31.06	14	22.00	10	50.01	24	33.27	15
	Utah	34.79	16	36.27	18	48.31	22	28.54	13	85.44	34	69.81	29	104.20	41	75.64	31
	Wyoming	23.97	13	21.79	11	26.66	13	24.04	14	65.80	26	57.53	25	64.70	26	76.09	25
San Francisco	Arizona	22.74	11	17.30	8	28.64	15	18.60	9	49.47	21	33.24	15	65.45	27	36.70	17
	California	18.77	10	16.27	9	21.40	12	17.83	10	37.64	17	29.53	14	49.75	21	30.63	15
	Hawaii	16.42	8	12.86	6	18.20	12	18.78	10	35.53	14	29.10	10	48.35	17	29.75	13
	Nevada	26.08	13	17.39	10	29.26	15	22.65	11	62.70	27	30.72	15	73.90	32	42.85	21
Seattle	Alaska	17.89	9	27.03	11	16.70	10	18.05	9	35.20	16	52.14	13	44.65	19	32.60	16
	Idaho	20.52	10	18.08	10	25.28	12	17.44	9	45.68	20	41.40	19	56.90	23	37.34	18
	Oregon	18.57	10	17.75	10	22.88	11	18.01	10	35.26	16	28.46	14	57.48	24	31.30	15
	Washington	19.88	11	19.48	11	20.30	11	19.90	12	34.64	17	32.00	15	52.82	24	31.72	16
National Averages		**26.49**	**13**	**23.35**	**11**	**34.45**	**17**	**23.16**	**12**	**56.71**	**24**	**45.85**	**19**	**78.04**	**34**	**46.11**	**20**

Source: GAO analysis of data from the Medicare Standard Analytical File: Home Health Claims History Database.

Figure II.3: Home Health Visits per Medicare Beneficiary, 1993, in Descending Order

State	Medicare eligible	Total visits	Visits/ eligible	State	Medicare eligible	Total visits	Visits/ eligible
Tennessee	737,000	9,866,429	13.39	Idaho	142,000	454,006	3.20
Mississippi	383,000	4,813,997	12.57	West Virginia	322,000	1,020,495	3.17
Louisiana	554,000	6,651,997	12.01	Virginia	768,000	2,383,971	3.10
Alabama	612,000	6,814,524	11.13	Ohio	1,610,000	4,956,780	3.08
Georgia	788,000	7,587,534	9.63	MIchigan	1,298,000	3,929,160	3.03
Massachusetts	908,000	7,284,572	8.02	Montana	125,000	359,260	2.87
Oklahoma	473,000	3,372,091	7.13	New York	2,512,000	6,740,424	2.68
Utah	176,000	1,237,638	7.03	New Mexico	195,000	516,688	2.65
Vermont	79,000	538,294	6.81	District of Columbia	75,000	198,111	2.64
Florida	2,510,000	16,727,455	6.66	Kansas	375,000	981,367	2.62
Texas	1,967,000	12,622,321	6.42	New Jersey	1,130,000	2,926,460	2.59
Connecticut	487,000	2,844,258	5.84	California	3,369,000	8,640,750	2.56
Arkansas	410,000	2,322,859	5.67	Maryland	573,000	1,466,533	2.56
Rhode Island	164,000	822,751	5.02	North Dakota	101,000	251,500	2.49
Maine	193,000	955,931	4.95	Puerto Rico	455,000	1,077,297	2.37
Kentucky	557,000	2,746,786	4.93	Arizona	556,000	1,308,968	2.35
New Hampshire	148,000	683,849	4.62	Iowa	469,000	1,100,447	2.35
Wyoming	57,000	248,383	4.36	Nebraska	244,000	537,357	2.20
South Carolina	475,000	2,048,481	4.31	Washington	655,000	1,376,519	2.10
Missouri	809,000	3,382,821	4.18	Wisconsin	743,000	1,544,315	2.08
North Carolina	970,000	3,957,762	4.08	Oregon	451,000	909,287	2.02
Indiana	802,000	3,121,017	3.89	Alaska	29,000	48,261	1.66
Pennsylvania	2,036,000	7,374,983	3.62	Minnesota	614,000	898,178	1.46
Colorado	391,000	1,407,697	3.60	South Dakota	114,000	164,935	1.45
Nevada	178,000	623,129	3.50	Hawaii	138,000	132,001	0.96
Illinois	1,574,000	5,486,165	3.49	Virgin Islands	8,000	5,046	0.63
Delaware	96,000	311,048	3.24				

Source: GAO analysis of data from the Medicare Standard Analytical File: Home Health Claims History Database and the Social Security Bulletin, Annual Statistical Supplement, 1994.

Episode-of-Care Analysis

The following figures present tables (figs. III.1 to III.4) that show the average length of episode and the average number of visits per episode for patients with a primary diagnosis of diabetes, heart failure, hypertension, and hip fracture for the different types of HHAs. Length of episode refers to the average period of time during which a beneficiary receives care,[59] and visits per episode refers to the average number of home health services a beneficiary receives during that time. We examined episodes of care beginning during 1992. For these episodes we tracked care throughout 1992 and 1993.

Much variation in both lengths of episode and average number of visits per episode can be seen among the different types of agencies for these four diagnoses. For example, on a national level, proprietary agencies provided an average of 53 visits to beneficiaries with diabetes over an average period of 64 days. Government agencies, on the other hand, provided an average of 29 visits to diabetic beneficiaries over a similar period of time. The variation in utilization between the different types of agencies is less pronounced in cases of hip fracture, which may be regarded as an acute condition, than in cases of diabetes, heart failure, and hypertension, which may be regarded as more chronic conditions.

Variations in utilization are also seen across geographic regions. For example, beneficiaries diagnosed with hypertension receiving care in the Atlanta or Dallas regions received more care for longer periods of time than beneficiaries in other regions with the same diagnosis. (See fig. III.3.) HHAs in these two regions, on average, consistently provided more care for cases of diabetes, heart failure, and hypertension, while HHAs in the Boston region provided the most care to beneficiaries with hip fracture. Some of the variation between regions may be explained by case-mix differences and availability of alternative sources of care. And some of the differences are probably due to geographic variations in practice patterns.

Table III.5 shows the average number of two types of visits provided to beneficiaries—skilled nursing visits and home health aide visits. Again, proprietary agencies provided more of these types of services for all diagnoses. For example, in cases of hypertension, proprietary agencies provided almost twice as many skilled nursing visits as voluntary agencies during a beneficiary's episode of care.

[59]Capped at 210 days. Refer to app. I for methodology.

Figure III.1: Average Episode Length and Visits per Episode—Diabetes, 1992-93

		Diabetes							
		All HHAs		Government		Proprietary		Voluntary	
Region	State	Average Length	Average Visits	Average Length	Average Visits	Average Length	Average Visits	Average Length	Average Visits
Boston		**54.83**	**37.24**	**47.24**	**27.88**	**54.64**	**54.48**	**55.07**	**35.52**
	Connecticut	45.95	36.79	40.33	24.62	47.64	48.95	45.86	34.46
	Maine	62.85	35.76	29.00	7.00	53.20	40.95	63.94	35.22
	Massachusetts	57.00	41.79	50.21	27.78	62.30	67.11	56.69	39.75
	New Hampshire	59.31	29.83	57.82	40.89	58.18	36.82	59.42	29.08
	Rhode Island	46.49	26.76	0.00	0.00	56.24	33.88	45.91	26.30
	Vermont	65.48	27.38	27.00	14.00	19.50	11.38	66.00	27.56
New York		**54.11**	**25.18**	**43.37**	**16.72**	**48.14**	**38.22**	**52.40**	**25.19**
	New Jersey	37.93	22.20	24.54	15.29	41.08	26.96	39.02	22.49
	New York	42.75	31.42	39.47	18.15	47.36	47.52	42.90	32.31
	Puerto Rico	74.57	17.18	89.90	11.00	60.97	19.54	74.39	17.39
	Virgin Islands	63.89	11.11	72.03	10.74	14.00	9.00	13.25	14.50
Philadelphia		**52.06**	**26.45**	**61.40**	**23.31**	**55.24**	**36.19**	**50.40**	**23.39**
	Delaware	42.90	26.90	64.56	49.78	27.77	30.65	43.63	26.32
	D.C.	44.17	23.42	22.50	4.00	43.78	22.88	46.65	26.58
	Maryland	43.40	24.73	53.99	21.37	44.48	27.31	40.23	23.72
	Pennsylvania	51.00	25.13	46.15	11.92	56.41	38.27	49.96	22.56
	Virginia	56.44	31.13	61.81	23.16	60.14	41.04	53.37	25.46
	West Virginia	66.79	29.33	65.85	24.44	66.69	39.87	67.38	26.68
Atlanta		**68.32**	**49.59**	**71.86**	**34.89**	**68.66**	**56.59**	**66.20**	**44.10**
	Alabama	76.73	60.53	77.21	51.82	77.27	69.93	75.44	52.37
	Florida	51.69	49.12	54.80	40.56	51.54	52.77	51.83	43.51
	Georgia	77.61	58.71	72.36	39.40	77.83	64.36	77.60	45.87
	Kentucky	69.49	37.11	75.58	28.35	69.55	50.34	66.15	30.93
	Mississippi	80.57	51.27	77.22	42.96	80.48	50.57	82.09	55.72
	North Carolina	66.98	36.89	66.61	24.70	67.77	47.48	66.61	38.48
	South Carolina	68.40	34.66	69.98	28.30	70.93	46.43	59.57	31.01
	Tennessee	73.68	53.80	72.27	39.08	75.12	58.12	69.99	45.92
Chicago		**55.68**	**30.21**	**59.20**	**24.87**	**57.04**	**42.29**	**54.56**	**26.62**
	Illinois	62.38	30.07	69.82	22.76	63.68	40.47	61.05	27.45
	Indiana	64.25	38.92	64.65	32.91	66.13	56.87	63.29	31.46
	MIchigan	45.43	25.19	58.58	27.70	46.77	29.91	42.93	22.62
	Minnesota	44.87	29.22	43.56	22.38	48.93	40.59	44.33	28.91
	Ohio	57.30	29.81	57.68	19.58	58.01	44.18	57.00	26.42
	Wisconsin	47.73	32.17	52.67	25.10	48.88	60.02	45.45	26.61
Dallas		**67.28**	**52.06**	**67.82**	**34.46**	**69.54**	**61.38**	**62.56**	**40.13**
	Arkansas	70.49	38.86	70.73	32.61	71.57	50.91	69.69	38.45
	Louisiana	75.31	54.82	76.51	34.48	76.92	62.25	70.15	39.34
	New Mexico	53.69	23.93	62.89	17.70	54.59	28.13	50.51	20.65
	Oklahoma	64.22	61.73	62.01	39.84	66.87	81.98	61.16	40.25
	Texas	64.05	52.88	62.45	35.55	66.56	59.27	58.76	42.57
Kansas City		**58.30**	**29.24**	**59.27**	**24.98**	**63.13**	**39.37**	**56.13**	**26.81**
	Iowa	51.73	26.03	51.17	25.67	52.68	41.82	52.05	24.63
	Kansas	56.59	30.82	57.26	21.30	61.50	45.19	54.18	28.71
	Missouri	61.00	30.15	68.47	26.68	63.78	37.37	57.81	27.08
	Nebraska	57.50	27.59	58.63	21.77	72.55	59.92	56.32	26.48
Denver		**53.98**	**39.41**	**55.09**	**27.37**	**56.65**	**61.46**	**52.52**	**33.52**
	Colorado	50.95	32.80	51.24	24.34	55.70	47.20	48.79	28.70
	Montana	56.83	31.70	56.86	28.63	48.97	52.76	57.42	31.75
	North Dakota	46.21	28.63	37.40	12.93	44.90	40.17	46.88	25.81
	South Dakota	54.04	22.33	53.73	18.54	73.17	28.50	53.45	23.79
	Utah	60.51	67.12	62.63	38.23	60.56	87.20	60.08	55.22
	Wyoming	55.73	32.05	58.99	36.98	57.17	31.57	49.54	26.29
San Francisco		**44.26**	**32.47**	**40.80**	**24.50**	**47.36**	**44.23**	**42.33**	**23.64**
	Arizona	44.70	39.53	45.33	19.45	46.76	57.84	42.78	25.82
	California	43.99	31.39	40.30	24.98	47.36	42.41	42.06	23.26
	Hawaii	46.54	25.50	48.66	16.88	46.40	39.18	45.75	22.05
	Nevada	47.59	40.56	40.38	27.84	48.30	45.79	46.95	28.98
Seattle		**50.93**	**27.88**	**50.59**	**22.98**	**56.57**	**42.56**	**49.55**	**24.95**
	Alaska	47.83	25.00	50.22	30.56	29.43	22.00	49.13	24.65
	Idaho	60.87	37.47	64.21	27.63	63.26	48.35	56.19	31.66
	Oregon	48.62	25.00	44.60	20.33	51.91	33.04	48.36	23.72
	Washington	49.55	26.98	44.88	21.14	54.70	46.07	49.36	24.78
National Averages		**58.99**	**38.24**	**61.28**	**28.74**	**63.73**	**52.58**	**55.29**	**30.54**

(Figure notes on next page)

Source: GAO analysis of data from Medicare Standard Analytical File: Home Health Claims History Database.

Figure III.2: Average Episode Length and Visits per Episode—Heart Failure, 1992-93

		Heart Failure							
		All HHAs		Government		Proprietary		Voluntary	
Region	State	Average Length	Average Visits	Average Length	Average Visits	Average Length	Average Visits	Average Length	Average Visits
Boston		**56.95**	**37.67**	**49.92**	**32.35**	**55.42**	**52.31**	**57.32**	**36.29**
	Connecticut	49.34	38.30	43.22	27.60	51.08	51.30	49.41	36.34
	Maine	63.00	35.68	1.50	32.50	57.98	52.23	63.74	33.55
	Massachusetts	60.06	40.14	57.29	37.90	59.16	55.37	60.21	38.88
	New Hampshire	54.77	30.60	64.14	21.86	67.35	32.50	54.34	30.61
	Rhode Island	53.65	31.67	90.50	30.50	58.12	36.15	53.49	31.56
	Vermont	64.97	30.08	43.00	63.00	27.10	37.60	65.66	29.85
New York		**41.01**	**21.96**	**37.00**	**15.44**	**43.61**	**29.81**	**41.44**	**22.38**
	New Jersey	38.23	20.94	26.12	14.71	38.89	22.60	39.24	21.36
	New York	41.01	23.41	38.90	15.92	45.44	33.26	41.05	24.10
	Puerto Rico	51.95	14.67	50.97	8.46	47.11	16.05	52.11	15.00
	Virgin Islands	50.94	11.72	52.09	8.27	32.00	11.00	52.00	18.17
Philadelphia		**50.55**	**24.92**	**56.57**	**21.50**	**53.97**	**33.01**	**49.37**	**23.03**
	Delaware	44.04	25.77	26.00	15.00	29.07	21.27	45.30	26.16
	D.C.	41.06	21.30	23.33	13.33	40.10	19.48	43.60	25.65
	Maryland	43.73	22.43	49.78	22.53	46.05	24.13	41.29	21.48
	Pennsylvania	50.03	24.89	36.70	16.04	53.47	35.89	49.48	23.10
	Virginia	55.81	28.03	67.39	25.85	60.74	36.84	52.50	23.77
	West Virginia	62.39	24.21	58.65	19.72	71.49	37.83	60.74	21.01
Atlanta		**63.81**	**44.96**	**68.95**	**35.20**	**63.75**	**50.18**	**62.03**	**40.74**
	Alabama	71.46	53.51	71.36	49.00	72.22	58.45	70.29	48.97
	Florida	50.73	41.73	55.97	35.67	50.97	44.25	50.17	38.57
	Georgia	71.16	53.13	64.97	40.55	70.33	57.83	73.54	43.86
	Kentucky	64.60	32.48	70.81	27.78	60.99	37.21	64.85	30.52
	Mississippi	74.77	51.31	71.28	44.06	74.07	50.52	77.38	55.85
	North Carolina	64.74	32.94	65.73	24.80	64.48	41.22	64.26	32.79
	South Carolina	69.86	36.28	72.58	31.33	71.30	49.00	58.13	28.70
	Tennessee	69.39	51.44	66.29	35.46	71.10	56.54	65.95	43.21
Chicago		**54.98**	**26.92**	**57.17**	**23.56**	**56.29**	**35.23**	**54.20**	**24.56**
	Illinois	61.30	27.95	68.56	25.10	62.43	35.72	60.21	25.69
	Indiana	64.28	35.93	64.60	31.35	64.57	48.92	64.14	31.80
	MIchigan	47.55	24.87	55.82	25.65	48.91	31.06	45.97	22.03
	Minnesota	45.46	21.99	43.10	18.97	52.70	31.73	44.90	21.17
	Ohio	56.47	25.98	57.04	18.92	58.08	34.89	55.91	23.86
	Wisconsin	47.63	23.85	50.09	20.66	44.47	28.99	47.60	23.67
Dallas		**63.99**	**41.85**	**63.79**	**30.87**	**66.21**	**49.77**	**60.69**	**33.72**
	Arkansas	68.21	37.88	66.57	31.71	70.59	47.87	68.21	37.43
	Louisiana	70.00	46.75	70.64	36.62	71.85	54.55	66.16	34.51
	New Mexico	50.79	24.70	58.75	17.55	52.57	31.02	48.13	20.83
	Oklahoma	60.73	40.71	59.23	28.41	63.84	53.55	57.71	30.67
	Texas	62.47	42.29	61.20	29.81	64.74	48.04	58.44	34.64
Kansas City		**55.16**	**26.23**	**54.00**	**22.93**	**57.96**	**33.26**	**54.64**	**25.02**
	Iowa	50.71	24.89	50.89	24.39	50.79	31.85	50.57	24.52
	Kansas	54.95	28.42	51.59	19.11	54.76	33.88	56.28	29.69
	Missouri	57.32	26.51	58.51	23.38	59.53	33.11	56.14	24.29
	Nebraska	52.63	24.30	56.66	18.84	49.51	37.15	52.33	24.19
Denver		**54.06**	**33.23**	**53.06**	**24.95**	**58.46**	**49.33**	**52.74**	**29.57**
	Colorado	49.57	29.11	43.98	21.64	54.71	38.31	49.08	27.67
	Montana	58.51	29.88	63.41	27.85	60.86	117.00	56.78	26.44
	North Dakota	55.13	26.95	67.00	33.17	46.43	24.08	57.21	27.57
	South Dakota	46.66	18.98	41.18	17.39	55.80	38.00	48.56	19.36
	Utah	61.31	52.01	63.39	33.08	64.94	65.72	57.92	44.68
	Wyoming	62.22	38.64	67.84	30.62	63.06	47.13	50.66	38.76
San Francisco		**43.49**	**22.68**	**40.62**	**16.90**	**45.53**	**28.77**	**42.80**	**19.92**
	Arizona	46.71	29.27	46.24	23.04	47.82	36.91	46.01	24.74
	California	42.98	21.53	40.59	16.52	45.09	27.15	42.22	19.18
	Hawaii	44.65	18.71	27.27	8.80	48.49	23.12	47.19	18.83
	Nevada	45.95	32.27	36.31	27.87	46.50	35.94	46.42	25.16
Seattle		**51.43**	**24.88**	**53.05**	**24.43**	**55.76**	**35.70**	**50.21**	**22.54**
	Alaska	50.63	23.38	64.00	57.14	52.71	17.00	49.67	21.67
	Idaho	61.10	31.91	69.65	33.17	62.88	36.67	54.63	26.82
	Oregon	49.70	25.26	39.74	17.77	56.74	39.75	49.42	22.99
	Washington	50.18	22.99	51.60	23.03	49.18	31.52	50.13	21.78
National Averages		**54.86**	**32.14**	**56.12**	**25.84**	**59.70**	**43.43**	**52.14**	**27.49**

(Figure notes on next page)

Source: GAO analysis of data from the Medicare Standard Analytical File: Home Health Claims History Database.

Figure III.3: Average Episode Length and Visits per Episode—Hypertension, 1992-93

		Hypertension							
		All HHAs		Government		Proprietary		Voluntary	
Region	State	Average Length	Average Visits	Average Length	Average Visits	Average Length	Average Visits	Average Length	Average Visits
Boston		**56.42**	**31.85**	**47.02**	**26.98**	**59.90**	**48.93**	**56.29**	**29.67**
	Connecticut	49.00	32.16	39.03	22.69	55.02	43.69	47.89	29.61
	Maine	57.45	29.33	36.00	7.00	59.99	28.19	57.10	29.55
	Massachusetts	59.81	34.19	49.83	29.97	64.90	58.51	59.45	31.41
	New Hampshire	53.27	22.36	67.17	27.33	57.76	35.21	52.52	21.27
	Rhode Island	51.76	28.82	0.00	0.00	47.71	32.81	51.91	28.67
	Vermont	63.77	20.95	0.00	0.00	24.50	20.50	64.74	20.96
New York		**40.60**	**19.80**	**35.38**	**13.48**	**40.02**	**27.18**	**41.40**	**20.17**
	New Jersey	34.78	18.83	21.56	12.49	36.13	20.90	36.43	19.50
	New York	39.60	22.74	36.88	15.09	41.17	29.51	39.92	23.38
	Puerto Rico	47.67	15.19	46.41	9.71	45.33	21.75	47.79	15.67
	Virgin Islands	58.06	18.67	55.38	8.85	69.25	46.50	48.00	35.00
Philadelphia		**46.11**	**21.86**	**50.08**	**17.22**	**50.94**	**30.47**	**43.91**	**18.55**
	Delaware	35.39	19.58	0.00	0.00	27.67	35.08	35.73	18.91
	D.C.	39.77	21.45	47.00	15.00	39.17	19.79	42.00	28.08
	Maryland	36.85	18.58	38.16	14.97	38.08	19.56	35.53	18.41
	Pennsylvania	44.89	21.28	32.00	14.67	50.40	33.19	43.34	17.90
	Virginia	54.53	27.44	67.23	22.50	59.53	34.46	49.09	22.19
	West Virginia	58.77	22.00	49.43	16.30	65.60	29.68	59.66	20.08
Atlanta		**63.93**	**45.33**	**68.54**	**35.63**	**64.68**	**48.82**	**61.29**	**41.25**
	Alabama	72.79	57.47	69.66	47.99	75.08	64.86	70.65	50.02
	Florida	49.10	40.40	49.35	35.59	47.84	39.74	50.73	41.35
	Georgia	74.41	52.31	72.02	38.98	75.06	56.80	72.39	38.31
	Kentucky	62.23	29.24	71.88	23.48	58.63	35.07	60.57	27.00
	Mississippi	71.89	46.21	69.62	41.38	71.97	44.86	72.54	49.55
	North Carolina	63.75	34.39	63.84	22.27	64.07	40.72	63.39	36.54
	South Carolina	69.66	38.35	71.72	30.78	71.09	50.09	61.48	28.78
	Tennessee	68.58	48.26	67.45	33.54	69.57	51.15	65.44	42.48
Chicago		**55.21**	**25.57**	**58.65**	**20.16**	**56.56**	**32.84**	**54.00**	**22.66**
	Illinois	61.32	26.81	69.06	20.87	60.89	33.41	60.39	23.98
	Indiana	65.61	34.34	64.61	25.74	65.87	44.81	65.76	29.71
	MIchigan	44.14	22.31	52.25	21.97	46.63	27.03	41.80	19.33
	Minnesota	41.52	18.43	36.60	15.09	51.70	29.13	40.29	16.55
	Ohio	56.12	24.80	56.94	16.88	58.36	32.87	55.19	22.56
	Wisconsin	44.56	18.58	45.80	16.14	41.59	24.37	44.77	18.17
Dallas		**64.68**	**41.97**	**63.94**	**29.62**	**66.71**	**47.30**	**59.39**	**32.19**
	Arkansas	65.80	35.07	64.72	27.57	67.86	44.29	64.95	33.77
	Louisiana	73.54	52.27	74.05	34.28	75.04	57.11	66.90	37.84
	New Mexico	47.96	23.53	52.50	17.20	48.95	27.84	45.19	17.28
	Oklahoma	59.21	39.35	59.34	30.17	60.69	46.04	55.86	28.34
	Texas	60.92	38.22	59.33	28.95	62.77	41.71	56.24	31.12
Kansas City		**52.78**	**23.51**	**51.89**	**19.27**	**55.50**	**29.63**	**51.64**	**21.64**
	Iowa	47.63	18.58	47.22	16.82	46.71	32.27	47.98	18.68
	Kansas	53.42	26.22	49.49	18.38	54.49	32.68	53.69	23.63
	Missouri	54.63	24.96	56.97	22.90	56.27	28.83	52.96	22.72
	Nebraska	48.58	17.85	52.63	11.91	45.15	27.74	48.17	18.08
Denver		**52.38**	**30.13**	**52.70**	**21.58**	**59.23**	**47.50**	**47.99**	**22.50**
	Colorado	45.23	25.02	44.20	19.57	48.80	32.68	43.55	22.17
	Montana	55.41	20.86	56.83	20.27	70.77	33.69	52.40	19.78
	North Dakota	44.59	22.04	32.13	13.88	49.71	32.02	43.56	19.23
	South Dakota	44.95	17.04	31.13	8.49	70.67	57.50	49.01	16.94
	Utah	63.22	48.06	56.99	31.16	68.59	62.48	56.84	30.96
	Wyoming	64.72	35.56	74.28	28.18	58.73	46.53	55.80	21.50
San Francisco		**44.24**	**24.42**	**39.22**	**15.22**	**47.83**	**31.30**	**40.92**	**18.19**
	Arizona	47.81	30.33	39.33	16.86	51.08	38.37	45.08	22.84
	California	43.76	23.44	39.79	15.31	47.50	30.19	40.15	17.41
	Hawaii	47.91	21.76	27.19	9.44	61.09	28.36	48.55	22.55
	Nevada	46.46	33.63	19.48	11.43	47.16	36.53	49.60	27.57
Seattle		**51.85**	**23.03**	**52.42**	**22.48**	**55.84**	**30.53**	**50.45**	**20.67**
	Alaska	45.25	18.00	81.00	27.00	80.50	35.25	38.17	15.10
	Idaho	58.55	24.70	61.10	23.88	58.82	26.03	56.21	23.32
	Oregon	49.84	24.19	48.24	20.59	53.69	37.24	48.69	20.09
	Washington	50.96	21.86	46.91	22.16	53.93	28.24	51.01	20.79
National Averages		**57.44**	**34.93**	**58.52**	**26.38**	**62.00**	**43.96**	**52.75**	**27.78**

(Figure notes on next page)

Source: GAO analysis of data from the Medicare Standard Analytical File: Home Health Claims History Database.

Figure III.4: Average Episode Length and Visits per Episode—Hip Fracture, 1992-93

		Hip Fracture							
		All HHAs		Government		Proprietary		Voluntary	
Region	State	Average Length	Average Visits	Average Length	Average Visits	Average Length	Average Visits	Average Length	Average Visits
Boston		**51.75**	**40.00**	**45.36**	**30.53**	**52.04**	**47.72**	**51.89**	**38.67**
	Connecticut	45.70	42.21	43.12	29.98	47.01	52.16	45.38	39.19
	Maine	49.07	29.09	51.00	21.00	39.99	27.26	50.79	29.45
	Massachusetts	56.14	44.06	48.62	32.08	57.41	47.22	56.09	43.74
	New Hampshire	49.91	30.52	29.00	6.00	67.33	51.29	49.30	29.80
	Rhode Island	45.57	33.64	0.00	0.00	56.78	50.78	45.15	32.99
	Vermont	57.66	26.60	28.75	13.50	22.50	13.00	58.23	26.85
New York		**43.55**	**30.53**	**38.61**	**21.97**	**44.66**	**35.61**	**44.19**	**31.31**
	New Jersey	39.76	26.07	35.24	23.09	46.84	29.39	39.76	26.20
	New York	45.08	33.09	39.78	21.50	43.98	38.47	46.13	34.41
	Puerto Rico	46.38	25.80	49.61	22.25	37.62	19.24	46.57	26.17
	Virgin Islands	77.33	29.00	55.50	7.00	121.00	73.00	0.00	0.00
Philadelphia		**40.39**	**23.58**	**42.03**	**20.93**	**40.90**	**26.43**	**40.15**	**22.79**
	Delaware	35.63	25.65	31.00	26.00	41.92	31.33	34.70	24.79
	D.C.	42.05	27.35	57.00	38.00	43.32	28.15	40.35	26.26
	Maryland	37.58	22.19	39.16	18.67	38.31	23.28	36.78	22.13
	Pennsylvania	41.63	24.45	26.50	16.40	41.15	28.52	41.75	23.72
	Virginia	38.99	22.33	51.03	26.42	40.26	25.29	37.55	20.45
	West Virginia	43.12	21.84	40.48	20.24	49.97	29.79	40.58	18.22
Atlanta		**46.01**	**34.66**	**49.17**	**27.75**	**46.13**	**39.26**	**44.68**	**31.52**
	Alabama	45.45	34.92	50.28	37.04	44.23	35.06	44.00	33.22
	Florida	42.49	37.59	41.60	27.55	43.37	41.10	41.50	33.98
	Georgia	49.24	38.06	45.97	27.29	48.11	42.63	50.98	32.89
	Kentucky	46.52	25.28	52.38	26.09	46.05	28.39	44.59	22.21
	Mississippi	49.35	38.63	51.85	35.61	49.84	39.97	47.41	37.73
	North Carolina	45.27	26.60	45.23	21.20	44.21	31.41	46.17	27.29
	South Carolina	52.09	29.95	57.20	30.22	49.64	34.77	42.63	21.81
	Tennessee	49.63	38.62	43.72	29.99	51.91	43.89	47.76	32.54
Chicago		**43.93**	**25.90**	**42.12**	**21.79**	**45.16**	**32.47**	**43.47**	**23.91**
	Illinois	49.54	27.77	56.39	29.59	53.17	35.31	47.93	25.31
	Indiana	48.38	31.77	41.05	22.09	51.46	45.22	48.20	26.44
	MIchigan	41.01	25.99	38.99	24.56	43.87	32.39	40.24	23.86
	Minnesota	35.66	22.42	37.45	22.05	38.17	26.32	34.25	21.22
	Ohio	42.33	23.58	38.68	16.49	41.97	28.36	43.01	21.98
	Wisconsin	39.06	22.78	40.83	18.37	37.50	25.13	38.95	23.47
Dallas		**42.93**	**32.23**	**45.11**	**29.44**	**45.44**	**38.65**	**39.23**	**25.33**
	Arkansas	45.87	29.39	47.92	30.78	49.11	33.46	43.35	26.86
	Louisiana	46.01	35.54	41.38	28.28	47.88	41.60	44.62	27.97
	New Mexico	38.69	22.36	46.15	19.35	41.00	31.75	37.20	18.74
	Oklahoma	45.96	35.08	47.72	28.07	50.16	45.01	40.48	26.20
	Texas	41.24	32.70	42.93	30.13	43.92	37.68	36.72	25.32
Kansas City		**45.19**	**27.50**	**46.47**	**24.62**	**47.02**	**36.27**	**44.38**	**25.82**
	Iowa	45.21	27.29	49.03	28.37	42.07	35.05	43.45	24.64
	Kansas	45.31	29.89	39.26	14.74	51.76	44.85	44.39	28.09
	Missouri	45.78	27.68	46.70	25.78	46.88	33.17	45.31	26.45
	Nebraska	41.55	23.24	45.77	14.69	43.65	42.95	40.87	21.66
Denver		**43.80**	**31.32**	**42.34**	**26.00**	**49.22**	**42.88**	**42.36**	**28.72**
	Colorado	41.15	29.04	37.58	24.03	48.89	39.97	39.87	27.23
	Montana	44.36	26.29	45.04	22.08	58.00	57.52	42.88	24.86
	North Dakota	40.78	28.58	19.00	12.60	46.29	45.98	39.39	22.33
	South Dakota	41.15	24.49	35.84	17.88	50.00	45.67	41.80	24.65
	Utah	50.79	40.41	52.60	41.38	50.46	42.83	50.76	38.77
	Wyoming	45.08	36.41	49.11	29.36	45.13	47.08	38.44	32.28
San Francisco		**35.75**	**21.64**	**32.72**	**17.50**	**38.76**	**26.65**	**34.38**	**19.18**
	Arizona	35.70	25.30	29.64	16.77	39.70	32.24	33.24	20.70
	California	35.55	20.88	33.04	17.62	38.48	25.34	34.27	18.80
	Hawaii	36.94	18.95	32.80	10.04	37.69	20.57	37.42	19.97
	Nevada	40.76	30.47	29.74	19.94	40.90	34.02	42.76	26.56
Seattle		**39.46**	**20.86**	**37.38**	**19.31**	**41.86**	**27.07**	**39.16**	**19.50**
	Alaska	42.17	25.35	26.00	11.00	35.68	25.50	45.23	25.56
	Idaho	45.54	28.86	39.32	20.45	46.24	34.77	47.66	28.83
	Oregon	37.03	18.98	35.05	17.16	35.37	22.98	37.66	18.39
	Washington	40.18	20.82	38.55	20.59	45.16	27.76	39.16	19.13
National Averages		**43.32**	**29.32**	**42.85**	**24.09**	**44.62**	**35.30**	**42.77**	**27.26**

(Figure notes on next page)

Source: GAO analysis of data from the Medicare Standard Analytical File: Home Health Claims History Database.

Table III.1: Average Home Health Services per Episode by Type of Service, 1992-93

	Government	Proprietary	Voluntary
Skilled nursing visits			
Diabetes	16.70	30.79	19.14
Heart failure	12.74	19.53	14.54
Hypertension	12.14	18.41	13.54
Hip fracture	8.24	11.79	9.37
Home health aide visits			
Diabetes	36.11	48.71	32.86
Heart failure	27.51	38.81	26.13
Hypertension	32.48	43.28	29.48
Hip fracture	18.78	24.81	19.78

Source: GAO analysis of the Medicare Standard Analytical File, National Claims History Data.

HCFA Definition of Confined to the Home

§ 204.1: Medicare Home Health Intermediary Manual (HCFA Publication 11)

A. Patient Confined to His Home--In order for a beneficiary to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the beneficiary is confined to his home. (See § 240.1.) An individual does not have to be bedridden to be considered as confined to his home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive medical treatment. Absences attributable to the need to receive medical treatment include attendance at adult day centers to receive medical care, ongoing receipt of outpatient kidney dialysis, and the receipt of outpatient chemotherapy or radiation therapy. It is expected that in most instances absences from the home which occur will be for the purpose of receiving medical treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, would not necessitate a finding that the individual is not homebound so long as the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

Generally speaking, a beneficiary will be considered to be homebound if he has a condition due to an illness or injury which restricts his ability to leave his place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if he has a condition which is such that leaving his home is medically contraindicated. Some examples of homebound patients which are illustrative of the factors to be taken into account in determining whether a homebound condition exists would be: (1) a beneficiary paralyzed from a stroke who is confined to a wheelchair or who requires the aid of crutches in order to walk; (2) a beneficiary who is blind or senile and requires the assistance of another person in leaving his place of residence; (3) a beneficiary who has lost the use of his upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and, therefore, requires the assistance of another individual in leaving his place of residence; (4) a patient who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, his actions may be restricted by his physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.; and (5) a patient with arteriosclerotic heart disease of such severity that he must avoid all stress and physical activity; and (6) a patient with a psychiatric problem if his illness is manifested in

part by a refusal to leave his home environment or is of such a nature that it would not be considered safe for him to leave his home unattended, even if he has no physical limitations.

The aged person who does not often travel from his home because of feebleness and insecurity brought on by advanced age would not be considered confined to his home for purposes of receiving home health services unless he meets one of the above conditions. A patient who requires speech therapy but does not require physical therapy or nursing services must also meet one of the above conditions in order to be considered as confined to his home.

Although a patient must be confined to his home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required which cannot be made available there. If the services required by an individual involve the use of such equipment, the home health agency may make arrangements with a hospital, [skilled nursing facility], or a rehabilitation center to provide these services on an outpatient basis. (See § 200.2 and § 206.5.) However, even in these situations, for the services to be covered as home health services the patient must be considered as confined to his home; and to receive such outpatient services it may be expected that a homebound patient will generally require the use of supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility.

If for any reason a question is raised as to whether an individual is confined to his home, the agency will be requested to furnish the intermediary with the information necessary to establish that the beneficiary is homebound as defined above.

B. Patient's Place of Residence--A patient's residence is wherever he makes his home. This may be his own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if it:

1. Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

2. Meets at least the basic requirement in the definition of a [skilled nursing facility], i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. All nursing homes that participate in Medicare and/or Medicaid as skilled nursing facilities, and most facilities that participate in Medicaid as intermediate

care facilities meet this basic requirement. In addition, many nursing homes which do not choose to participate in Medicare or Medicaid meet this test. Check with your fiscal intermediary or Medicare regional office before serving nursing home patients.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in (A) or (B) above, he is not entitled to have payment made for home health services under either Part A or Part B since such an institution may not be considered his residence.

When a patient remains in a participating [skilled nursing facility] following his discharge from active care, the facility may not be considered his residence for purposes of home health coverage.

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Related GAO Products

Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

Medicare: Increased Denials of Home Health Claims During 1986 and 1987 (GAO/HRD-90-14BR, Jan. 24, 1990).

Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986).

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Home Health Care Services—Tighter Fiscal Controls Needed (GAO/HRD-79-17, May 15, 1979).

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