Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

HOW HMOs MANAGE HOME HEALTH SERVICES

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EXECUTIVE SUMMARY

PURPOSE

To describe home health service management by Medicare health maintenance organizations as compared to fee-for-service.

BACKGROUND

Home health care is nursing, therapeutic, medical social, and aide service provided in a person's home. It allows people with limited mobility to live independently while still receiving professional health care services. Generally, a Medicare beneficiary must be homebound to be eligible for home health care. Also, their care must be prescribed by a physician.

Over the past 5 years, Medicare expenditures for home health services have increased over fourfold to $15.1 billion and expenditures have varied significantly among the nation's home health agencies.

The rapidly escalating costs and wide variation among providers raised concern about differences in how home health care is managed by various providers. Prior Office of Inspector General (OIG) reports have shown that costs can be controlled. Cost for home health by about two-thirds of fee-for-service providers is well below the national average.

In view of the reputation of Medicare risk health maintenance organizations (HMOs) for controlling costs, we examined how those HMOs manage home health services. Where possible, we compared HMO management of home health care to practices used by fee-for-service providers, including selected home health agencies which also contract with HMOs. We surveyed 132 risk HMOs which served at least 450 Medicare beneficiaries each. Our response rate was 77 percent. We also surveyed 93 HMO home health contractors. Our response rate was 46 percent.

FINDINGS

MOST HMOs CLOSELY MANAGE HOME HEALTH SERVICES

HMOs Generally Contract for Home Health Services

Eighty-nine percent of HMOs contract for all of the home health services they provide beneficiaries. Most HMOs pay home health contractors on a fee-for-service basis. HMOs and their contractors expressed opinions that contracting for home health care benefits HMOs, contractors, and Medicare beneficiaries.

They Use Case Managers to Help Control the Number and Quality of Home Health Visits

Virtually all of the HMOs use case managers to approve, coordinate, and monitor home health visits. The primary control methods used are pre-authorizing services, conducting case management conferences, reviewing patient progress reports, and evaluating services provided.

HMOs Tightly Control Costs and the Number of Visits

Data from 49 of the HMOs we surveyed showed that they authorized only 19 percent as many home health visits per beneficiary in 1994 as were authorized under the fee-for-service system. The average was 11 visits for HMOs and 58 visits for fee-for-service. In many instances, HMOs specify the number and type of visits each beneficiary will receive. Other factors such as cost per visit, health status, duration of care, and enforcement of homebound status influence costs. However, by controlling the number of visits, the overall cost of home health care in HMOs is less.

Almost Half the HMOs We Surveyed Provided Home Health Care for About One-Fourth the Cost Under the Fee-For-Service System

Of 102 HMOs, 49 reported that home health cost $882 per beneficiary in 1994. This was about 25 percent of the average cost per beneficiary under the fee-for-service system. The home health contractors we surveyed corroborated the cost per beneficiary. They stated that, on average, home health care costs for HMO beneficiaries is about 23 percent of that for fee-for-service beneficiaries.

HOME HEALTH CONTRACTOR OPINIONS ARE MIXED ON ADEQUACY OF THE NUMBER OF VISITS AUTHORIZED BY HMOs

About 56 percent of the home health contractors we surveyed expressed views that the number of visits authorized by HMOs was adequate. However, 51 percent of the contractors said HMO beneficiaries are disadvantaged in terms of overall home health care, when compared to fee-for-service beneficiaries.

AGENCY COMMENTS

The HCFA had no comments on this report.

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INTRODUCTION

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BACKGROUND

Home health care is nursing, therapeutic, medical social, and aide service provided in a person's home. It allows people with limited mobility to live independently while still receiving professional health care services. Generally, a Medicare beneficiary must be homebound to be eligible for home health care. All home health services must be specified in a plan of care certified by a physician.

The Social Security Act authorized Medicare Part A payments for home health care. Beneficiaries who do not have Part A entitlement may be covered under Part B. Home health services may be provided through fee-for-service providers and through Medicare managed care -- such as health maintenance organizations. The Health Care Financing Administration (HCFA), Department of Health and Human Services has Federal oversight of the Medicare program, including home health services.

This inspection examines the provision of home health services by HMOs. Risk HMOs receive a fixed payment per beneficiary. Therefore, they have an incentive to judiciously manage home health services and control cost. Where possible, we compare HMO practices for managing home health care to those used by fee-for-service providers, including selected home health agencies that contract with HMOs to provide care to Medicare beneficiaries.

Health Maintenance Organizations

The HCFA contracts with health maintenance organizations (HMOs) to provide health care for Medicare beneficiaries. Medicare HMOs must offer all home health services that are available under fee-for-service systems. In some instances, HMOs may elect to provide services that are not covered under fee-for-service systems. For example, HMOs may elect to give home health care to a patient who is not homebound -- particularly if it appears home health care might prevent more expensive inpatient care.

The HCFA contracts with two types of HMOs. They are "risk" HMOs and "cost" HMOs. A risk HMO receives a fixed monthly Medicare payment per beneficiary. Such HMOs are at risk for any health care cost that exceeds the fixed payment. Medicare pays cost HMOs based on the costs they incur for health care services they provide. The majority of Medicare HMOs are risk HMOs.

Growth of Home Health Care

Medicare expenditures for home health care increased dramatically in recent years. To illustrate, between 1990 and 1995 Medicare expenditures for home health care grew from $3.7 billion to $15.1 billion -- an increase of over fourfold in just 5 years. By the year 2002, HCFA projects that Medicare home health care costs will be about $33 billion.

Variation In Cost For Home Health Care

Medicare expenditures for home health care per beneficiary have varied significantly among providers in recent years. To illustrate, we reported in 1995 that home health care provided by about two-thirds of the nation's home health agencies cost Medicare about $2065 per beneficiary. However, home health care provided by the remaining one-third of the home health agencies cost Medicare about $4431. We further reported that most of the variation can be attributed to the number of visits a provider chooses to make per beneficiary. On average, the high cost providers make five times more visits per beneficiary than do the low cost providers[1].

Concern About Escalating Cost of Home Health Care

The rapidly escalating cost and wide variation in cost among providers raised serious concern about differences in how home health care is managed by different providers.

Our prior reports on home health care have shown that controlling cost of home health care is possible. For example, over two-thirds of the home health agencies have demonstrated that home health care needs of Medicare beneficiaries can be met at or below the national average cost per beneficiary.

Concern About Quality of Home Health Under HMOs

Various health care researchers have raised concerns about the quality of home health care, including that provided by HMOs. According to a study funded by HCFA, HMO members receive fewer home health visits than beneficiaries under fee-for-service[2]. The researchers found that most HMO beneficiaries in that study had outcomes inferior to fee-for-service beneficiaries at the time home health services were terminated. However, the researchers did not substantiate that HMO beneficiaries needed more services than they were getting.

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[1] *Variation Among Home Health Agencies In Medicare Payments for Home Health Services*: OEI-04-96-00260

[2] Center for Health Policy Research, *A Study of Home Health Care Quality and Costs Under Capitated and Fee-For-Service Payment Systems*, February 1994

Efforts to assess quality include an ongoing initiative by HCFA to develop and test an instrument called the Standardized Outcome and Assessment Information Set (OASIS). In the future, HCFA expects the instrument to be a means by which the quality of home health services can be monitored.

METHODOLOGY

Selection of HMOs and Home Health Contractors

At the time of our inspection, HCFA contracted with 152 risk HMOs nationwide. Within that population, we identified 132 HMOs that served at least 450 Medicare beneficiaries. We included 100 percent of the 132 HMOs in our survey. We excluded the remaining 20 HMOs because their enrollment was less than 450. HMOs with low enrollment levels would likely have few beneficiaries who receive home health care. Therefore, such HMOs would have limited experience in managing home health services. Collectively, the 20 HMOs we did not select had an average enrollment of 171 Medicare beneficiaries.

Likewise, we surveyed 93 home health agencies (HHAs) that contract with our selected HMOs to provide home health care. Our selected HHAs represent 100 percent of the HHAs that our selected HMOs identified as their main contractor.

Data Collection and Analyses

We conducted our inspection between July 1995 and July 1996. We used standardized questionnaires to collect data from both selected HMOs and their contractors on costs and management of home health care by HMOs. We mailed our questionnaires to 120 of the 132 selected HMOs, and personally visited the remaining 12. Similarly, we mailed our questionnaires to 87 of the selected 93 HHA contractors, and personally visited the remaining 6. During each site visit, we interviewed appropriate staff on program management, controls, and results. We also reviewed contracts and other records on home health care operations.

We collected quantitative data on such practices as the numbers of Medicare beneficiaries served, visits made, and cost. We also collected qualitative data showing policies, procedures, and practices used to authorize, manage, and control use of home health care. We based our analyses on 1994 data. We used unaudited data provided by the selected HMOs and HHAs that responded to our survey.

Of the 132 selected HMOs, 102 responded to our survey -- a response rate of 77 percent. An analysis of HMO respondents and non-respondents showed that the possibility of bias based on HMO size is limited. Our non-response analysis is in Appendix A.

Of the 93 selected home health contractors, 43 responded to our survey, for a response rate of 46 percent. We did not conduct an analysis of contractor respondents and non-respondents for lack of available provider numbers for many contractors in both groups. However, the responding contractors are located in 19 States, serve Medicare beneficiaries under HMOs as well as fee-for-service, and represent proprietary and non-proprietary ownership about equally.

Where appropriate, we conducted t-tests on our findings to determine if differences noted were significant.

Operation Restore Trust

This inspection was part of the President's Operation Restore Trust initiative. The purpose of Operation Restore Trust (ORT) is to identify and prevent fraud, waste, and abuse in the Medicare and Medicaid programs. ORT is a joint initiative involving the Health Care Financing Administration, Administration On Aging, Office of Inspector General, and various State agencies. In 1995, ORT began targeting home health agencies, nursing homes, hospices, and durable medical equipment suppliers in five States for evaluations, audits, and investigations. The five States are Florida, New York, Texas, Illinois, and California. These States account for about 40 percent of the nation's Medicare and Medicaid beneficiaries and program expenditures.

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

FINDINGS

HMOs CLOSELY MANAGE HOME HEALTH SERVICES

Most HMOs Contract For Home Health Services

About 89 percent (91 of 102) of the Medicare HMOs that responded to our survey contract for all home health services they provide to beneficiaries. On average, the remaining 11 percent contract for about 25 percent of home health services and provide about 75 percent directly.

The HMOs we surveyed each use an average of 12 home health agencies (HHAs) as contractors. The number of contractors used by individual HMOs ranged from 1 to 90 home health agencies.

Contracting for home health services appears to benefit HMOs, contractors, and Medicare beneficiaries

According to the 102 HMOs and 43 HHAs that responded to our survey, contracting for home health care is advantageous to HMOs, HHAs, and Medicare beneficiaries.

HMO benefits: The HMOs responding to our survey said that by contracting with HHAs, they expand the geographic coverage and availability of home health care and clinical expertise. To illustrate, in some communities, an HMO may have difficulty staffing a particular type of home health service, such as infusion therapy. Further, the need for home care in some communities is occasional, and it may not be practical for an HMO to provide those services directly. In such communities, an HMO may contract with HHAs to expand the scope of its services.

Also, the HMOs said that contracting for home health care is cost effective. They said that, because HHAs are interested in getting and keeping HMO business, HHAs generally offer quality home health care at competitive prices.

Home health agency benefits: The 43 HHAs that responded to our survey said that their contracts with HMOs for home health care offer two major advantages for them.

First, the HMO contracts offer HHAs a reliable source of revenue. They said payment for services are guaranteed and timely. Further, they said HMOs are gaining prominence in the health industry, offering opportunities for business growth to HHAs that serve HMOs successfully.

Second, the HMO contracts offer HHAs an opportunity to provide continuity of care for many patients. The HHAs said that in many instances they establish an ongoing

professional relationship with HMO physicians and case managers, thereby facilitating continued care and generally better health results.

Medicare beneficiary benefits: By contracting with HHAs, HMOs improve access to home health care expertise for many beneficiaries. For example, HMOs gain access to expertise in the home care field that they do not have in-house. Collectively, HHAs offer a wide range of specialized services and trained clinicians which can effectively focus on problems such as insulin-dependent diabetes and surgical wounds. According to the HMOs that responded to our survey, it is not always practical to keep such expertise in-house.

Accreditation is the primary criterion for selecting home health contractors

Of 63 HMOs that cited a primary criterion for selecting contractors, 60 percent (38) said accreditation is the most important (see Table 1). They tended to rely largely on accreditation by the Joint Commission on Accreditation of Health Organizations. About 88 percent (90 of 102) of the HMOs that responded to our survey said they use all of the five criteria in Table 1 for selecting contractors to provide home health care.

TABLE 1

CRITERIA HMOs USE FOR SELECTING HOME HEALTH CONTRACTORS

CRITERIA	HMOs USING CRITERIA		PRIMARY CRITERIA *
	NUMBER	PERCENT	
Reputation	91	89	10
Competitive pricing	95	93	2
Geographic coverage	99	97	6
Adequate staffing	90	88	3
Accreditation	91	89	38
Other	33	32	4

* This shows the number of HMOs that considered each criterion as most important to their selection of a contractor. Only 63 of the 102 HMOs that responded to our survey identified a primary criterion.

The "other" category of criteria in Table 1 includes quality of care, which was cited by about 11 percent of the HMOs (11 of 102). That category also includes miscellaneous criteria, such as having a philosophy compatible with HMOs, effective customer service, and a low Medicare fee-for-service denial rate.

Most Health Maintenance Organizations pay contractors on a fee-for-service basis

About 73 percent of the 102 HMOs that responded to our survey said they compensate contractors on a fee-for-service basis. Only 9 percent of HMOs pay their contractors on a capitated basis. The remaining 18 percent used several methods of payment. Most of the 18 percent used a combination of the capitation and fee-for-service methods. Some of those HMOs also paid on a per episode, per diem, per visit, or per hour basis.

HMOs Use Case Managers To Help Control The Number And Quality Of Home Health Visits

Most HMO staffs expressed views that the number and quality of home health visits are appropriate for the needs of their patients. They described procedures and quality assurance activities designed to assure adequacy of their home health care -- regardless of whether the care was provided directly by an HMO or under contract with a home health agency. For example, they described specific case management activities, management reviews, evaluations, and quality assurance techniques used to help assure that the number and quality of visits for each beneficiary are appropriate.

Case manager responsibilities for reviewing and approving patient care

HMOs describe the primary purpose of their home health visits as meeting patient medical needs after inpatient care, improving patient ability to function independently after inpatient care, and keeping patients from needing inpatient care. Toward that end, virtually all of the HMOs we surveyed use case managers to approve, coordinate, and monitor home health visits. Those HMOs reported that case managers are responsible for

- Working with physicians to plan care and write orders,
- Reviewing and approving initial and continuing visits,
- Reviewing medical necessity and assuring that treatment plans are effective,
- Making recommendations to medical groups and physicians on patient options,
- Tracking and reporting outcomes and cost savings on a monthly basis, and
- Participating in quality assurance activities such as clinical record reviews, team meetings, and case conferences.

Case manager control techniques

Generally, HMOs stated that their case managers are not authorized to unilaterally approve or deny home health services requested by physicians. However, the scope of their responsibilities clearly indicates that case managers significantly influence the extent and type of home health visits Medicare beneficiaries receive. About 88 percent of the HMOs said their case managers control both home health cases and cases involving other services. The remaining 12 percent said their case managers control only home health cases.

Case managers control the type and extent of home health care in various ways. The primary methods cited by respondents to our survey are summarized below.

Assigning control numbers: One way that case managers control home health services is by assigning a pre-authorization number. Without such a number, and the accompanying pre-approval, HMO home health contractors are not paid for visits they report having made to beneficiaries.

Case management conferences: About 88 percent of HMOs use case management conferences to help assure the quality and adequacy of home health visits. Typically, case managers use the telephone to confer with physicians and contractor staff on the extent and type of home health care needed by Medicare beneficiaries. The conferences are held weekly or as-needed. Generally, HMOs said the conferences are intended to result in beneficiaries getting the appropriate number of visits, based on their medical needs.

Reviewing patient progress: About 82 percent of HMO case managers review contractor progress reports for beneficiaries to assess quality and appropriateness of home health visits provided. Through such reviews, case managers determine beneficiary ability to perform activities of daily living, and the degree to which home health visits are improving medical conditions.

Also, about 75 percent of HMO case managers discuss patient progress with physicians, and about 30 percent audit patient records. Such reviews enable case managers to assess progress in individual cases and patterns of care, such as the number of visits needed for various diagnoses and hospital readmissions after home visits.

Evaluating care provided: Many HMOs said case managers are responsible for evaluating the need for, and provision of, home health services to assure appropriate use. Similarly, 24 of 102 HMOs and 17 of 43 contractors that responded to our survey said they have performed outcome evaluations. However, in many cases, comments by those HMOs and contractors revealed that they referred to satisfaction rates as outcomes.

Only four home health contractors, and no HMOs, said they had performed evaluations showing quantitative results. One contractor that had performed a quantitative evaluation reported positive results. They conducted a study to determine if newly diagnosed insulin-dependent diabetes patients could be taught to independently prepare and administer insulin by the 15th home health visit. The study showed that 17 of a sample of 20 such patients were successful by the 15th home health visit.

Also, 38 percent of the HMOs used beneficiary satisfaction surveys to assess adequacy of the number of home health visits.

Resolving disagreements: HMOs and their home health contractors said they occasionally disagree on home care issues, such as when to terminate visits for a beneficiary, and whether a beneficiary needs skilled care or custodial care. HMOs typically terminate home health visits earlier than a fee-for-service provider would, and deny, or limit, custodial visits. When an HMO and contractor disagree on the number and type of home health visits a beneficiary should receive, the case manager typically consults with HMO physicians and contractor staff to resolve the disagreement. Then, if necessary, the HMO medical director and the beneficiary's physician make the decision on home health visits needed. Beyond that, five contractors said they can appeal even that decision. Four of them cited a decisionmaker within the HMO and one cited a third-party--the State health agency.

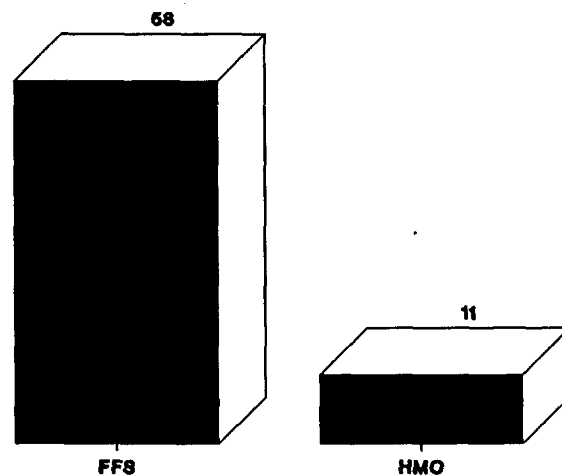
HMOs Control Costs By Controlling The Number Of Visits Per Beneficiary

HMOs authorize fewer visits per beneficiary than do fee-for-service providers

HMOs control costs by controlling the number of home health visits each beneficiary receives. HMOs authorize far fewer visits per beneficiary than do fee-for-service providers. Forty-nine of the 102 HMOs that responded to our survey provided data on the volume and cost of home health visits. Data from those 49 HMOs (48 percent) showed that, on average, they authorized 81 percent fewer visits per beneficiary in 1994 than did fee-for-service (FFS) providers (see Figure 1).

FIGURE 1

AVERAGE NUMBER OF VISITS PER BENEFICIARY



The number of visits per beneficiary was generally corroborated by 30 percent (13 of 34) of the HMO contractors who responded to our survey. The data provided by those 13 contractors showed that Medicare beneficiaries received about 74 percent

fewer visits when home health care was provided through an HMO. On average, the 13 contractors said that HMO patients received about 11 visits compared to about 42 for fee-for-service patients. The remaining 30 contractors did not respond to this survey question.

Comparison of home health visits by HMOs and fee-for-service: One home health agency, which is both an HMO contractor and a fee-for-service provider, gave a case example to illustrate the difference in visits authorized by HMOs and those typically provided under fee-for-service. The home health contractor cited a beneficiary with a history of heart disease and in need of post-operative home care for a fractured lower extremity. Based on experience, the contractor estimated that such a beneficiary could receive as many as 169 more visits under fee-for-service than under an HMO. Likewise, such a beneficiary would likely receive 80 more aide visits under fee-for-service than under an HMO. Based on the example, Table 2 shows the differences between visits under fee-for-service and those under HMOs for a beneficiary with the same health conditions.

TABLE 2

A CONTRACTOR'S COMPARISON OF VISITS TYPICALLY AUTHORIZED BY HMOs VS. VISITS UNDER FEE-FOR-SERVICE

	Period of services	TYPES AND NUMBER OF VISITS			
		Nurses	Physical therapists	Home health aides	Social workers
Fee-for-service (FFS)	2 - 4 months	2 or 3 times per week (16 - 48 visits)	3 times per week (24 - 48 visits)	3 - 5 times per week (24 - 80 visits)	1 or 2 visits total (1 or 2 visits)
HMOs	1 - 2 months	Evaluation visit only (1 visit)	2 times per week (8 - 16 visits)	None (0 visits)	None (0 visits)
Reduction of visits under HMOs *	**0 - 3 months**	**15 - 47 visits**	**8 - 40 visits**	**24 - 80 visits**	**1 or 2 visits**
*** Total reduction in visits under HMOs could be as much as 169 visits.**					

HMO philosophy of controlling visits: The majority of contractors (24 of 43) said HMOs have a philosophy on home health care that results in keeping the number of visits low. First, they said that HMOs approve fewer visits and have tighter controls on costs than do physicians who authorize fee-for-service visits. Second, they said HMOs place more emphasis on teaching beneficiaries to independently manage their own care needs.

To illustrate how teaching reduces the number of visits, one contractor provided the following example. A beneficiary has chronic obstructive pulmonary disease, but poor knowledge of the medications and proper management of the disease. Under the fee-for-service system, that person would likely receive 2 to 4 months of visits. During those visits, the contractor would provide care for all the beneficiary's known health problems and gradually teach the patient self-care. Under an HMO, however, the patient would likely receive visits for only 1 to 2 months. During that time, the patient would be quickly taught self-care and expected to become independent.

HMOs often specify the number and type of visits each beneficiary will receive

Determining number of home health visits: Most of the 102 HMOs (about 68 percent) that responded to our survey said HMOs determine the number and type of home health visits a beneficiary will receive. The HMOs said the decision is typically made by physicians and case managers, or by those parties collaboratively. Table 3 shows who determines the number and type of visits made for HMO beneficiaries.

TABLE 3

WHO DETERMINES THE NUMBER AND TYPE OF VISITS HMO BENEFICIARIES RECEIVE

Number and type of visits determined by:	Number	Percent
HMO unilaterally	69	68
HMO jointly with contractors	21	20
Home health contractors	11	11
Hospital discharge planners	1	1
TOTAL	102	100

Most of the 43 home health contractors who responded to our survey verified HMO statements that the HMO typically makes decisions on how many and what type of home health visits a beneficiary receives. About 54 percent of the contractors (23 of 43) said the HMO unilaterally makes the decision on the number and type of visits. Eight (18 percent) said the decision is made jointly by the HMO and the contractor.

The remaining 12 contractors (28 percent) said that contractors decide the number and type of visits each beneficiary receives.

Criteria used in determining number of visits: About 75 percent of the HMOs who responded to our survey questions (77 of 102) provided information on their criteria for determining the number and type of home health visits needed by a beneficiary. Table 4 shows that almost half of the HMOs said they base their decisions on beneficiary needs and response to treatment.

About 72 percent (31 of 43) of the home health contractors we surveyed responded to our question on criteria used by HMOs in determining the number and type of visits. Table 4 also shows that many of the contractors disagreed with HMOs on the extent that certain criteria were used. The contractors recognized that more than one criterion was typically used. However, the contractors said beneficiary needs and response to treatment were used much less than the HMOs said it was used to determine the number and type of visits (21 percent for contractors vs. 48 percent for HMOs). Likewise, the contractors said more of the decisions on the number and type of visits were arbitrary.

TABLE 4

CRITERIA FOR DETERMINING NUMBER AND TYPE OF VISITS

CRITERIA	PERCENT OF RESPONSES*	
	BY HMOs	BY CONTRACTORS
Beneficiary medical needs and responses to treatments or the goals set in their plan of care	48 %	21 %
A predetermined range or number of visits for a specific diagnosis	34 %	33 %
Availability of caregivers and other non-medical demographics	22 %	29 %
Arbitrary limit on visits	1 %	16 %

* The percentages total more than 100 percent because some HMOs and contractors gave multiple responses on this issue.

Beyond the number of visits, several factors potentially influence the cost of home health care

We recognize that factors other than the number of visits might influence the cost of home health care per beneficiary. The following examples illustrate how some factors could influence costs. The list of examples are not intended to be all inclusive. Other factors that our survey respondents did not identify could also affect cost of home health service.

Cost per visit: The average cost per visit for home health care provided through HMOs was about $20 more than the cost of such care provided under the fee-for-service system. The average cost per visit was $79 for all types of home health care provided by HMOs. The average cost per visit under the fee-for-service system was $59.

Further, the cost of skilled home health care provided by HMOs is higher than that under fee-for-service. The average cost per visit for skilled nursing visits provided through an HMO was $88. The average cost for such visits under fee-for-service was $70.

Depending on the number of visits per beneficiary, HMOs' higher cost per visit potentially increases their cost per beneficiary for home health care. Yet, as shown earlier, the overall cost of home health care in HMOs is lower. This tends to highlight the cost impact of HMOs' practice of keeping the number of visits low.

Health status comparability: Some studies have concluded that HMO costs are lower than fee-for-service costs because HMO beneficiaries are generally healthier. Other studies showed the health status of HMO members to be comparable to that of fee-for-service patients. Therefore, the issue remains open for debate. The HCFA is currently studying the comparability issue.

Duration of care: Some observers argue that HMOs may terminate home health care early because they can continue to give therapy and other outpatient care as long as is needed. In this way, HMOs may be able to keep the number of home health visits low without adversely affecting patient care. Conversely, home health agencies might provide care to fee-for-service beneficiaries for longer periods of time because therapy typically is terminated upon discharge. The overall effect of the two practices on patient health and cost of home health care is not clear.

Extent of skilled and unskilled care: HMOs give considerably fewer home health aide visits, but more skilled nursing visits proportionately than are provided under fee-for-service. HMOs provide beneficiaries an average of 3 aide visits, compared to 28 under the fee-for-service system. The 3 aide visits represent 22 percent of all HMO visits, while the 28 fee-for-service visits represent 47 percent.

HMOs provide an average of six skilled home health visits per beneficiary. This represents about 54 percent of all visits to HMO beneficiaries. Conversely, beneficiaries under fee-for-service receive an average of about 25 skilled home health visits per beneficiary. This represents about 43 percent of all their visits.

Homebound requirement: About 50 percent of the HMOs said they base home health visits on individual medical needs rather than on a beneficiary's homebound status. They said they provide home services when it is cost effective and beneficial to do so. For example, some HMOs provide home health care to prevent or slow the progression of diseases which might otherwise result in hospitalization. Occasionally, HMOs approve visits as a practical response to a beneficiary's lack of transportation, need for care on a weekend, or inability to leave home because of severe weather.

Slightly less than 50 percent of the home health contractors that responded to our survey supported HMOs' statements on eligibility determinations. They said HMOs do not always impose the homebound requirement. To the extent this practice is followed, it could affect the cost per beneficiary in HMOs.

Many HMOs We Surveyed Provided Home Health Care For About One-Fourth What It Would Cost Under the Fee-For-Service System

Forty-nine of the 102 HMOs (48 percent) that responded to our survey provided cost data in response to our questions. The 49 HMOs reported that their home health care costs were $882 per beneficiary, on average, in 1994. This is about 25 percent of the average cost of $3,464 per beneficiary Medicare paid to 7,966 home health agencies for home care under the fee-for-service system in 1994[3].

The 49 HMOs that provided cost data to us represent about 48 percent of the 102 HMOs that responded to our survey. This is also about 37 percent of the 132 HMOs we surveyed. Our analyses showed that respondent and non-respondent HMOs served a comparable number of enrolled Medicare beneficiaries. This indicates limited possibility that our cost data are biased by any significant difference between the size of HMOs that provided cost data and those that did not. See Appendix A for our non-response analysis.

Further, the cost per beneficiary for home health care provided through HMOs was corroborated by 13 of the 43 home health contractors (30 percent). The cost data provided by the 13 contractors showed that home health care they provided for HMO beneficiaries cost, on average, about 23 percent of the cost to Medicare for home health care provided under the fee-for-service system. That is, those contractors reported that they received almost four times more per beneficiary for Medicare fee-for-service patients than for HMO patients.

[3]The fee-for-service costs are based on claims data from HCFA. The data reflect services billed for 3.65 million beneficiaries.

HOME HEALTH CONTRACTOR OPINIONS WERE MIXED ON THE ADEQUACY OF CARE

Fifty-Six Percent Said HMOs Authorize an Adequate Number of Visits

Fifty-six percent of the HMO contractors (24) expressed views that the number of home health visits authorized by HMOs was adequate. Conversely, 42 percent (18) expressed concern about the number of visits authorized by HMOs. One contractor did not express an opinion.

The 24 contractors not concerned about the adequacy of visits under HMOs gave various reasons. Those included: (1) that the contractor was under a capitated arrangement (and thus the HMO had less influence over the number of visits), (2) the contractor's ability to negotiate HMO approval for visits, on a case-by-case basis, and (3) having a long history and a good working relationship with HMOs.

The concerns about the adequacy of HMO-approved visits, as voiced by 18 contractors, were diverse. However, their concerns included that HMOs have a cap on visits--specifically for each type of visit, that HMO physicians under capitation limit visits to protect their interests, and that HMOs only authorize minimal care.

Fifty-One Percent Said HMO Beneficiaries Are Disadvantaged, Compared to Fee-For-Service

About 51 percent of the home health contractors (22) said HMO beneficiaries are disadvantaged in terms of overall home health care, when compared to fee-for-service beneficiaries. Some contractors noted that sometimes beneficiaries are discharged from home health too early--i.e., before they achieve independent living status. Some contractors said HMO case managers do not always take a beneficiary's individual needs into account when approving the number and type of visits. Other contractors expressed concern over HMO practices of rarely approving home health aide visits. Finally, some contractors were concerned that HMOs are so concerned with keeping visits (e.g.,cost) down that patient care could be interrupted, causing patient progress to regress. The contractors noted that home health visits could be interrupted until a contractor could justify additional visits.

Thirty Percent Said HMO Beneficiaries Are Advantaged, Compared to Fee-For-Service

About 30 percent of the home health contractors (13) said beneficiaries receiving home health care through an HMO have an advantage over those served through the fee-for-service system. For example, they said (1) overall care under HMOs is more consistent and thorough, (2) beneficiaries benefit from HMO case management services, and (3) HMOs often do not require a beneficiary to be homebound to receive home health care.

Another contractor, not included in the 13 above, did not like HMO policies for controlling or limiting visits. This contractor admitted, however, that HMO beneficiaries are advantaged because HMOs do not always require a beneficiary to be homebound to receive home health care.

Nineteen Percent Said HMO Beneficiaries Are Neither Advantaged nor Disadvantaged

The remaining 19 percent (8 of 43) of the home health contractors said Medicare beneficiaries receive essentially the same home health care through HMOs and fee-for-service providers. While some of those contractors cited particular advantages and disadvantages, they all concluded that, on balance, the care was about the same.

AGENCY COMMENTS

The HCFA had no comments on this report.

APPENDIX A

ANALYSIS OF RESPONDENTS VS. NON-RESPONDENTS

A consideration in surveys of this type is whether the results may be biased by significant differences between respondents and non-respondents. To determine whether significant differences exist in this survey, we compared average enrollment for those HMOs that responded and those HMOs that did not respond to our survey. Our analysis revealed no significant difference. Therefore, related to HMO size, the possibility of bias in the results of this study due to non-response is limited.

To test further for bias in respondents versus non-respondents, we used the T-test for Large Sample Inferences about the differences between two sample means. In this case the two samples are HMOs that provided cost data and those HMOs that did not. The means we tested were the average enrollment for respondents versus average enrollment for non-respondents. We can conclude through the use of this test that there is not a significant difference in the HMO respondents and non-respondents by size of agency.

The results of the T-test are a Z-score of 0.3110 and a Z-alpha by 2 value of 1.645. With this result, we can be 95 percent confident that we can reject the null hypothesis and conclude that there is not a significant difference, by agency size, between HMOs that provided cost data and HMOs that did not provide cost data.

We are reporting results of our analysis of risk HMOs nationwide.