Accountability for
DME, home health, and hospice use

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Why DME, home health, and hospice?

- Share characteristics that contribute to vulnerability for fraud, abuse, and overuse
- Show patterns of aberrant service use
- In high use areas these services do not appear to substitute for other services
- Greater accountability could decrease inappropriate use and slow Medicare spending growth
Characteristics that may contribute to vulnerability

- Physicians prescribe but others generally deliver the care
- Require little capital investment in facilities
- Cost sharing for DME, no beneficiary cost sharing for home health, very little for hospice
Spending on these services can change the pattern of overall spending

- Spending on HH, DME, Hospice is 14% of total overall
- But is 24% of spending in top 10 MSAs with high spending in these three services
- Increase relative service use most noticeably in high use areas (e.g. Odessa TX MSA 18% above average with these services, has about average use for all other services)
Removing these services flattens high end of distribution

Total service use

Service use not including DME, HH, and hospice

Percent of beneficiaries living in geographic areas with specified level of service use

Percent of national average service use, 2006

Preliminary Data. Source: MedPAC analysis of 2006 OACT county level data and CMS BASF data
Three services show unusual variation across MSAs

<table>
<thead>
<tr>
<th>Sector</th>
<th>Relative price-adjusted spending per capita in MSA</th>
<th>percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>minimum</td>
<td>10th</td>
</tr>
<tr>
<td>DME</td>
<td>0.44</td>
<td>0.7</td>
</tr>
<tr>
<td>Home health</td>
<td>0.18</td>
<td>0.47</td>
</tr>
<tr>
<td>Hospice</td>
<td>0.16</td>
<td>0.52</td>
</tr>
</tbody>
</table>

Preliminary Data.
Source: MedPAC analysis of 2006 CMS BASF data
Variation in DME raises questions

<table>
<thead>
<tr>
<th>South Florida counties</th>
<th>Beneficiaries</th>
<th>DME $ per capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collier</td>
<td>60,112</td>
<td>$220</td>
</tr>
<tr>
<td>Monroe</td>
<td>11,025</td>
<td>260</td>
</tr>
<tr>
<td>Broward</td>
<td>141,283</td>
<td>430</td>
</tr>
<tr>
<td>Miami-Dade</td>
<td>183,754</td>
<td>2,200</td>
</tr>
</tbody>
</table>

Source: CMS Beneficiary annual summary file for 2006 compiled by Acumen, LLC
Home health use, spending, and episodes vary widely

- Price adjusted spending per capita in McAllen TX MSA is over 7 times national average
- In some counties:
  - over 35% of beneficiaries use home health
  - average over 4 episodes per user
  - there are more home health episodes than beneficiaries
- High correlation between % using home health and number of episodes per user
Hospice use patterns differ widely

<table>
<thead>
<tr>
<th>State</th>
<th>Decedents using hospice</th>
<th>Spending (Relative to natl. avg.)</th>
<th>Stays over 180 days</th>
<th>Live discharge rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mississippi</td>
<td>35%</td>
<td>1.9</td>
<td>39%</td>
<td>55%</td>
</tr>
<tr>
<td>Iowa</td>
<td>48</td>
<td>1.1</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>National avg.</td>
<td>39</td>
<td>1.0</td>
<td>18</td>
<td>16</td>
</tr>
</tbody>
</table>

Use of the hospice benefit is very different in these two states

Who should be held accountable?

- The provider of the service?
- Physicians who sign prescriptions for DME, or home health, certify for hospice?
- Beneficiaries?
The provider of the service

- OIG /Department of Justice joint task forces to attack fraud
  - Have had some success
  - But have to chase after rather than prevent
  - Providers switch (DME to home health, other regions)

- Stricter rules on entry (conditions of participation)

- Payment policies (e.g., review if a provider shows aberrant pattern of use)
Physicians

- Home health, DME require prescription
- Hospice requires initial attestation of two physicians, recertification by one
- But physician has little incentive to question use, involvement after service is ordered can vary widely
- Could try to change incentive by:
  - feedback to physician on patient’s use of services
  - requiring greater involvement
Could change incentives for physicians through ACOs or bundling

- Accountable Care Organizations
  - will include primary care physicians
  - will be accountable for all spending including HH, DME, Hospice
  - will have an incentive to keep spending down—refer to responsible providers
- Bundling home health or DME with larger episode could also change incentives
Beneficiaries

- Beneficiaries have been recruited to help in anti-fraud activities (Senior Medicare Patrol)
- Revisit cost sharing for some services
Issues for discussion

- How can payment systems be changed to decrease incentives to overprovide?
- Would more stringent conditions of participation prevent entry of possibly fraudulent or abusive providers?
- Should physicians be held accountable for use of services they prescribe or their patients receive?
- What is the potential for ACOs/bundling to restrain inappropriate use of these services?
- Should we revisit cost sharing for some services?