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

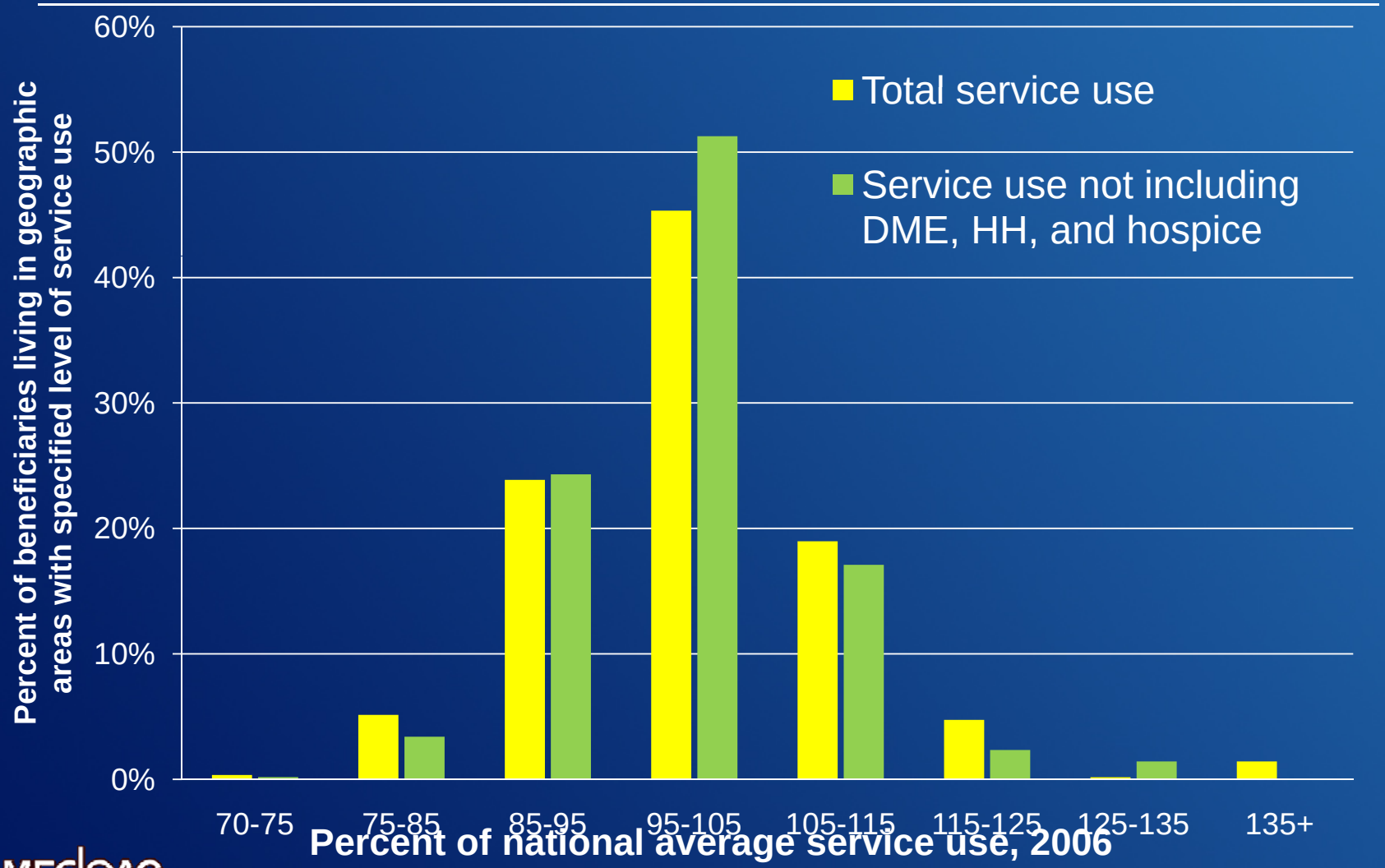
Characteristics that may contribute to vulnerability

- 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



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Preliminary Data. Source: MedPAC analysis of 2006 OACT county level data and CMS BASF data

Three services show unusual variation across MSAs

	Relative price-adjusted spending per capita in MSA				
		percentile			
Sector	minimum	10th	50th	90th	maximum
DME	0.44	0.7	0.96	1.25	3.44
Home health	0.18	0.47	0.82	1.76	7.12
Hospice	0.16	0.52	0.93	1.71	2.92

Preliminary Data.

Source: MedPAC analysis of 2006 CMS BASF data

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Variation in DME raises questions

South Florida counties	Beneficiaries	DME $ per capita
Collier	60,112	$220
Monroe	11,025	260
Broward	141,283	430
Miami-Dade	183,754	2,200

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 heath episodes than beneficiaries
- High correlation between % using home health and number of episodes per user

Hospice use patterns differ widely

State	Decedents using hospice	Spending (Relative to natl. avg.)	Stays over 180 days	Live discharge rate
Mississippi	35%	1.9	39%	55%
Iowa	48	1.1	16	13
National avg.	39	1.0	18	16

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

Preliminary data. Source: MedPAC analysis of CMS data. Spending 2006, use 2007

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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?