Order Code RL31420

Medicare's Home Health Benefit: The Fifteen Percent Payment Cut

Updated October 17, 2002

Carolyn L. Merck
Specialist in Social Legislation
Domestic Social Policy Division

Medicare's Home Health Benefit: The Fifteen Percent Payment Cut

Summary

Medicare spending for home health care increased from $2.0 billion in 1988 to about $18 billion 1996. This spending growth reflected increases in the number of beneficiaries served, in the number of visits per user, and in the number of Medicare-certified home health agencies (HHAs).

In the Balanced Budget Act of 1997 (BBA 97), Congress sought to curtail rising home health spending by requiring implementation of a prospective payment system (PPS) under which HHAs would be paid fixed amounts per episode of care for an individual beneficiary. Because the PPS was not ready for implementation when the BBA 97 was enacted, Congress mandated interim changes to lower payments to HHAs, and these, and other measures, including fraud and abuse surveillance, resulted in a decline of about 50% in Medicare home health spending by 2000.

PPS payments for FY2001 were to be calculated so that, in the aggregate, home health spending would not exceed total spending under the previous system *but with the per visit and per beneficiary limits of the previous system cut by 15%*. Cutting those two payment limits by 15% would reduce all PPS payments by only about 7% because lower-cost HHAs would not be affected by the 15% cut in the limits. (That is, it would have been a 15% cut in limits, not necessarily in payments.) The home health spending declines that preceded the PPS caused Congress to postpone the 15% cut to October 1, 2002. *In the absence of data on detrimental effects of the new PPS, Congress took no action to stop implementation on October 1, 2002, of the cut in payments.* The effective rate of the reduction was 7%, but a simultaneous payment update of 2.1% made payments in October 2002 only 4.9% below the previous rates.

Evaluations of the reductions in Medicare spending and in the supply of home health care resulting from BBA 97 do not indicate that beneficiary access to care has been compromised. Although the number of participating HHAs dropped by 35% from 1996 to 1999, the supply of agencies has remained stable since October 1, 2000, when the PPS began. Hospital discharge planners report little difficulty in placing beneficiaries with an HHA. The General Accounting Office (GAO) reported that, in the first 6 months of 2001, PPS payments to HHAs were about 35% higher than estimated agency costs for providing care and recommended that Congress allow the so-called 15% reduction to be implemented. The Medicare Payment Advisory Commission (MedPAC) recommended repeal of the reduction, noting that spending and utilization reductions sought by BBA 97 were achieved without it and that HHAs might be unable to make firm business plans were the threat of payment reductions to continue. The Administration indicated that retaining the authority to reduce payments on October 1, 2002, provided a tool for containing spending if need be.

The Congressional Budget Office (CBO) estimated that repeal of the 15% reduction would have eliminated $5.2 billion in savings for the 5-year period FY2003 through FY2007, and $16.4 billion over the 10-year period FY2003 through FY2012. If the reduction had been delayed by one year, $800 million in savings would have been added to program spending.

Contents

Medicare's Home Health Benefit: The Fifteen Percent Payment Cut

Recent Developments. *On October 1, 2002, the cuts in Medicare payments to home health agencies discussed in this report went into effect. The across-the-board reduction in PPS amounts was 4.9%, calculated as an average reduction of 7% offset by a 2.1% increase to update payments for inflation. The reduction was scheduled by law to take effect on that date; only congressional action could have stopped or changed its implementation. The reduced payment amounts apply to 60-day episodes of beneficiary care that begin on or after October 1, 2002. Both H.R. 4954 (passed by the House on June 28, 2002) and S. 3018 (introduced in the Senate on October 1, 2002) would eliminate the home health payment cuts.*

Home health services covered by Medicare for homebound beneficiaries include intermittent or part-time skilled nursing care, physical therapy, and speech therapy. For beneficiaries receiving at least one of these types of care, Medicare also covers the services of home health aides and medical social workers. Occupational therapy may be covered during and after receipt of skilled nursing care or physical or speech therapy. Services must be medically necessary and carried out under a plan of care prescribed and reviewed by a physician.

Home Health Issues Leading up to the Balanced Budget Act of 1997

Medicare spending for home health care in 1988 totaled $2.0 billion; by 1996 it had grown to about $18 billion, for an average annual increase of 31% during that time. This spending growth reflected both increasing numbers of beneficiaries served and more than a three-fold increase in the average number of visits per user. In addition, the number of Medicare-certified home health agencies (HHAs) that furnish this type of care increased by 9% a year during most of the 1990s.[1]

During this period of rapid growth in Medicare spending for home health care, Medicare paid HHAs during a year based on estimated costs, and made final settlements after the year when actual allowable costs were determined. Final payments were based on an agency's reasonable allowable costs limited to a capped dollar amount per visit by visit type (e.g., skilled nurse, nurse aide, or therapist). The maximum amount an agency could be paid in a year was the sum of the cap amounts for individual services times the number of visits of each type the HHA provided. If an HHA's total costs for one type of visit were more than the cap, those costs

---

[1] For detailed information on Medicare's home health benefit, see *2000 Greenbook, Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means*. Ways and Means Committee print 106-14, October 2, 2000. p. 131-141.

could, at least to some extent, be compensated by payments for another type of visit for which the HHA's costs were below the payment cap. Because there was no limit on the number of visits of any type a beneficiary could receive, this system provided incentives for HHAs to maximize the number of visits made as long as their actual costs were less than the payment limits.[2]

The Balanced Budget Act of 1997

In the Balanced Budget Act of 1997 (BBA 97), Congress included a number of provisions aimed at curtailing home health spending growth. These provisions included a requirement for implementation of a prospective payment system (PPS) under which HHAs would be paid predetermined, fixed amounts per episode of care for each individual beneficiary served, and the amount of the payment would reflect the type and intensity of care furnished. Because the PPS was not ready for implementation at the time BBA 97 was enacted, Congress included in the law an interim payment system (IPS) which lowered the caps on payments per visit and introduced a third tier to the payment system, the so-called "per beneficiary" limit on payments. Thus, under the IPS, payments to HHAs would be the lowest of (a) their reasonable costs, (b) payments based on the limits per visit, or (c) payments based on the new "per beneficiary" formula.

The "per beneficiary" amount was calculated for each HHA by multiplying its average Medicare payment per beneficiary in 1994 (updated for home health cost inflation) by the total unduplicated count of Medicare beneficiaries the HHA was serving in the year to which the limits were applied. That produced an aggregate annual Medicare spending limit for each HHA; it did not limit payments on behalf of any individual home health patient. For 79% of HHAs, the new "per beneficiary" formula proved to be more restrictive than payments based on the capped amounts per visit. HHAs not affected by the per beneficiary limit were those for which the aggregate amount payable based on payment caps per visit or on actual costs were lower than the amount generated by the per beneficiary formula.

In addition to changing the home health payment system, BBA 97 eliminated venipuncture (the drawing of a blood specimen) as the sole home health service qualifying an individual for home care, and that change contributed to the reduction in visits and in program spending for home health care.

Other policies that affected the volume of home health services provided after 1996 included the Health Insurance Portability and Accountability Act of 1996 which provided for the imposition of civil money penalties on physicians who falsely certify that a beneficiary needs home health care, a provision some say has had a chilling effect on physician referrals. And, officials at the Centers for Medicare and Medicaid Services (CMS) note that at about the same time the IPS went into effect, the

---

[2] The caps were 112% of the national average cost of each type of visit. The caps on the payments per visit did not affect agencies for which costs per visit were less than 112% of the national average. BBA 97 reduced the payment cap per visit to 105% of the national median cost of a visit (later raised to106%).

Administration required claims processors to implement an intensified case review process as well as stepped-up fraud and abuse detection activities.

The "15%" Reduction. BBA 97 required the PPS to be implemented on October 1, 1999 (later moved to October 1, 2000). The Act laid out the basic design of the PPS and required payment amounts to be determined so that, in the first year of the PPS, total Medicare spending for home health would be the same as it would have been had the previous system (the IPS) remained in effect *but with a 15% reduction to caps on the amount HHAs could be paid per visit and on agency-specific limits per beneficiary*.

Application of the 15% reduction to the "per visit" and "per beneficiary" limits would not result in an across-the-board 15% reduction in all PPS payments. This fact appears to be widely misunderstood. According to program officials, the effect of reducing the cap on payments per visit and per beneficiary by 15% would be an effective reduction in payments under the PPS of 7%. The reason the reduction would be less than 15% is that some HHAs were not affected by the "per beneficiary" limit (because their payments were lower based on either the "per visit" limit or their actual costs), and some agencies were not affected by the "per visit" limits (because their costs were below the limit). Thus, a cut in per beneficiary limits would have no effect on some HHAs, and a cut in per visit payment caps would have no effect on other HHAs. The 7% overall reduction in PPS payments was estimated assuming implementation of the reduction in FY2001, simultaneous with the PPS. Although the law implies that the reduction should be recomputed using projections of spending under the IPS and under the PPS for FY2003, officials at CMS chose to use the estimate that was prepared for FY2001, largely because of the difficulty in projecting payments under the old system that was replaced by the PPS nearly 2 years before the effective date of the cuts.

Implementation of the PPS

When the PPS was implemented on October 1, 2000, home health spending had declined precipitously from previous levels. In 1996, before implementation of the IPS and other changes, Medicare home health spending had grown to about $18 billion; in 1999, spending had dropped by nearly half, to $9.3 billion. This spending drop reflected a two-thirds reduction in the number of home visits provided, from 284 million visits in 1996 to 97 million in1999.

In January 1998, the Congressional Budget Office (CBO) projected that the home health care provisions of BBA 97 would result in savings of almost $75 billion over 10 years. In March 1999, CBO re-estimated the effects of BBA 97, and the new projections showed an additional $56 billion in savings. CBO's revised estimates included changes in their underlying economic assumptions as well as revised estimates of the spending-reduction effects of BBA 97.

Delay in the "15%" Payment Reduction

The 15% reduction in the "per visit" and "per beneficiary" tiers of the IPS was to have been applied at the time the PPS was implemented in order to benchmark aggregate payments in the first year of the PPS to a system under which total spending included those reduced payment limits. However, because Medicare home health spending had declined substantially by the time the PPS was implemented on October 1, 2000, Congress delayed the reduction in these two payment limits until 12 months after implementation of the PPS (that is, until October 1, 2001) and required the Secretary of Health and Human Services (HHS) to report no later than 6 months after implementation of the PPS on the need for a 15% or other reduction in base payment amounts for the PPS. (These provision were included in the Balanced Budget Refinement Act of 1999 ("BBRA," P.L. 106-113).) Aggregate payments under the home health PPS in its first year of operation (FY2001) were set to equal the amount Medicare would have spent if the IPS had continued in that year.

Congress enacted further changes to the Medicare program in the Benefits Improvement and Protection Act of 2000 ("BIPA 2000," P.L. 106-554). The President signed this legislation on December 21, 2000, less than 3 months after the home health care PPS had been implemented. Home health spending had remained low throughout FY2000, but, although the PPS was designed to contain spending, the effects of the new system were uncertain. Thus, rather than repealing the 15% reduction, Congress again delayed its application, putting it off until October 1, 2002, when there would be 2 years of experience with the PPS, and required the Comptroller General, as head of the General Accounting Office (GAO) (rather than the Secretary of HHS), to submit, by April 1, 2002, a report analyzing the need for the 15% or other reduction. (See below.)

Issues

The Size of the "15%" Reduction. In statements made during March 2002, the Administration noted that Medicare spending for home health care may be rising under the PPS; therefore they were not inclined to seek repeal of the authority to impose a payment reduction. However, the Administration said that, if implemented, the reduction would be only 4.9%, not 15%. The 4.9% is based on an estimated effective payment reduction of 7%, offset by a 2.1% payment increase under the routine update in payment amounts FY2003 (effective October 1, 2002). Some say that the routine payment update on October 1, 2002, should not be counted as offsetting a payment reduction.

The Budget. Because the law called for the so-called 15% reduction to go into effect on October 1, 2002, budget projections assumed Medicare home health spending would be reduced starting in FY2003. Thus, if Congress had repealed the reduction, the budget estimates for Medicare home health spending would have risen. According to the CBO, repeal of the "15%" reduction would have added $5.2 billion in net Medicare spending for the 5-year period FY2003 through FY2007, and $16.4 billion over the 10-year period FY2003 through FY2012.[3] (The increased spending

[3] BBA 97 shifted certain home health spending from Medicare Part A to Part B and required (continued...)

would reflect elimination of the savings attributable to implementation of the cut.) If the reduction had been delayed again by one year, budget estimates would have included an $800 million spending increase.

The FY2003 Budget Resolution that passed the Senate Budget Committee on March 21, 2002 (S.Con.Res. 100) contained a non-binding "sense of the Senate" statement that the Administration and Congress should work to "avoid the 15% reduction in the prospective payment system for home health care." (This resolution has not passed the Senate.) The Budget Resolution passed by the House of Representatives on March 20, 2002 (H.Con.Res. 353) did not address the issue.

Effects of BBA 97 Changes. The reduction by more than half in Medicare home health spending from 1996 to 1999 reflects a 20% reduction in the proportion of beneficiaries who use home health care; a 40% reduction in the average number of visits per user; a 35% reduction in participating HHAs; and about a 9% reduction in the number of HHA employees.[4]

Four organizations have evaluated the effects of the post-1996 Medicare home health changes. The Office of the Inspector General of HHS (OIG) addressed the extent to which the reductions that have already occurred in the supply of and payments for home health services have affected beneficiary access to care.

The Medicare Payment Advisory Commission (MedPAC) noted that the goals of BBA 97 have been achieved already with regard to containing Medicare spending for home health care and considered how the lack of Medicare payment stability in recent years has affected the industry.

The GAO compared payments to HHAs under the PPS with estimated agency costs for serving Medicare beneficiaries in order to determine payment adequacy under the PPS.

An evaluation commissioned by the home health industry compared the current supply of HHAs and staffing levels of HHAs with the supply of HHAs and personnel available before the IPS and the PPS. It used the change in the supply of available services as a measure of access to care.

OIG Findings. In July 2001 the HHS OIG published *Access to Home Health Care After Hospital Discharge 2001* (OEI-02-01-00180), and in October 2001 published *Medicare Home Health Care Community Beneficiaries* (OEI-02-01-00070).

---

[3] (...continued)
that beneficiary premiums for Part B reflect the inclusion of home health spending, phased in. The CBO spending increase from elimination of the "15%" reduction is net of the increase in beneficiary Part B premiums attributable to home health care.

[4] Medicare Payment Advisory Commission. *Medicare Payment Policy, Report to the Congress*, March 2002. p. 93-98; and Edward and Ester Polisher Research Institute. *Impact of a Further Payment Reduction on the Medicare Home Health Benefit*, March 18, 2002. p. 13-14.

The first report reflects the first 6 months of experience with the PPS. The OIG assessed the extent to which hospital discharge planners experienced difficulty in finding an HHA to serve Medicare beneficiaries, reviewed trends in the number of HHAs participating in Medicare, and analyzed the length of hospital stays by diagnosis related group (DRG) to determine if patients experienced longer inpatient stays due to delays in finding home care.

The OIG reported that about 90% of discharge planners can place all of their Medicare beneficiaries needing home health care and that there had been no change in their experience since implementation of the PPS. Also, the data showed that "there were no large changes in the types of Medicare beneficiaries being discharged to HHAs in the last 5 years." Despite there being about 35% fewer HHAs in business now compared with past years, 83% of discharge planners said there were sufficient services available and that, on average, they contacted only one or two agencies to place a patient. Medicare data showed that between 1997 and 2001 the average hospital stay *decreased* for all but two of the 13 most common DRGs, indicating that there was no discernable effect on length of hospital stay.

Sixty-one percent of discharge planners said that the patients for whom they experience delays in placement are those who need wound care and expensive supplies, intravenous antibiotics or other expensive drugs that may not be reimbursed under Medicare (often requiring the patient to pay), and those needing several visits per day to monitor intravenous medications.

Overall, the OIG found little evidence that there is a problem with access to care for beneficiaries with a prior hospitalization, but suggested that access should continue to be monitored.

The second OIG analysis focused on beneficiaries using home health care who had no hospitalization or skilled nursing facility stay within 15 days of using care and who therefore had not had the services of a hospital discharge planner. These "community beneficiaries" constituted 38% of Medicare home health care users in 1997 and 41% in 2000. The OIG interviewed physicians, community organizations that assist beneficiaries in finding care, and beneficiaries themselves.

HHAs reported to the OIG that community beneficiaries tend to have chronic rather than acute health problems. Most of the people interviewed reported that care was accessible and that most patients who needed home health care and were eligible for it received it. However, anecdotal reports indicated that patients with certain conditions (e.g., diabetes, wound care, or Alzheimer disease) were unable to obtain care, although it was not clear that these patients met all the Medicare home health care eligibility criteria.

MedPAC Findings. In its March 2002 report, MedPAC documented the substantial increase in the supply of home health care and volume of services furnished between 1987 and 1997 and the decline in services furnished since that

time. It noted that the purpose of the IPS and the home health provisions of BBA 97 had been to reduce utilization and spending and that those goals have been achieved.[5]

MedPAC noted that data on the amount HHAs are actually spending to provide care under the PPS are not yet available, so the adequacy of PPS payments cannot be determined relative to HHA expenditures. Therefore, MedPAC evaluated payment adequacy by the entry and exit of HHAs in the program since implementation of the PPS. Because the number of HHAs participating has remained stable since the start of the PPS, MedPAC suggested that the payment amounts are neither inadequate nor too generous.

MedPAC recommended that Congress repeal the so-called 15% cut because substantial reductions in home health spending and use have already occurred and because leaving the reduction in the law but postponing it repeatedly would just prolong HHA uncertainty about the future of their business. Moreover, at the time of the MedPAC report, the precise amount of the cut was unclear (that is, whether CMS would use the FY2001 estimated reduction of 7%, or revise it for FY2003). The Commission noted that Medicare payment policy for home health has been in flux for several years and should be stabilized; payment adequacy issues can be addressed through the annual payment update process. If it is determined in a future year that payments are excessively high compared with HHA costs, the annual payment increase could be scaled back; if payments are determined to be too low, the increase could be enhanced.

GAO Findings. Because as October 2002 approached no data were available on actual costs incurred by HHAs for providing patient care under the PPS, the GAO estimated HHA average expenditures for care during the first 6 months of 2001 and compared those estimated costs with average PPS payment amounts. (*Medicare Home Health Care: Payments to Home Health Agencies are Considerably Higher than Costs*, GAO-02-663, May 2002.) The report concluded that, on average, payments were about 35% higher than HHA estimated costs for providing care. The GAO noted that the reasons payments were high compared to estimated costs was that patients were receiving fewer visits than had been estimated in the development of the PPS and were being categorized as needing more costly care than had been estimated. Hence, HHAs "save" costs by providing fewer visits while being paid at rates applicable to patients needing more intensive services.

On the basis of estimated average costs compared with average payments, the GAO asked Congress to consider allowing the so-called 15% reduction to payments to be implemented. However, it warns that a mechanism such as "risk sharing"should be used to protect patients from underservice and to protect HHAs from financial loss if they generally serve high cost patients with complex conditions.[6]

---

[5] *Ibid.* Medicare Payment Advisory Commission.

[6] Under risk sharing, a cap is placed on the amount an HHA may gain from payments in excess of costs and on the amount an HHA may lose as a result of having expenses that are greater than payments.

Home health industry representatives criticized GOA's estimated average costs as being inaccurate and not reflective of current service delivery patterns and costs. They said that, although PPS payments might appear more than adequate *on average*, the distributional effects of an across-the-board payment reduction would drive some HHAs out of the Medicare market. Some critics noted that HHAs could be keeping their costs low in anticipation of the 15% payment cut.

The Administration commented that the GAO's estimates were consistent with its own preliminary analysis of data from the first year of the PPS, but that HHA actual costs could not be known with certainty until Medicare home health cost reports become available. The Administration opposed risk sharing adjustments, saying it is difficult to administer and would result in HHAs not receiving final payments on a timely basis.

Industry Findings. The home health care industry commissioned a study by the Edward and Ester Polisher Research Institute and released it on March 18, 2002, (*Impact of a Further Payment Reduction in the Medicare Home Health Benefit.*[7]) This evaluation focused on the 35% reduction in the number of HHAs participating in the program from before the IPS until implementation of the PPS and on staffing reductions. It suggested that reduction in the supply of agencies and personnel is evidence of reduced access to care and that "any additional cut in payments for Medicare home health services risks exacerbating the access concerns and possibly further jeopardies the quality of services for the most vulnerable beneficiaries." It did not attempt to determine if the reduction in participating agencies has caused eligible beneficiaries needing care to go without services. The report observed that the number of participating HHAs has not changed much since implementation of the PPS, with few agencies leaving the program and few entering. From that observation, it concluded that PPS payments are inadequate if no new HHAs have entered the program.

The report stated that, even if the 15% reduction were postponed and not implemented as scheduled, as long as it remained in the law as a possibility, HHAs would be unable to plan ahead; if the reduction were implemented, agencies might have to reduce services to Medicare beneficiaries.

Conclusion

Arguments supporting the October 1, 2002, implementation of the so-called 15% reduction (effectively, a 4.9% cut to PPS rates) were generally based on preliminary indications that spending for home health care under the PPS was rising, that payment amounts were generous compared with agency costs, and that the industry could absorb a 7% reduction when offset by a 2.1% increase under the annual payment update process. Also, there was little indication that eligible beneficiaries in need of care had been unable to find it.

Those arguing that the reduction should have been postponed, but not repealed, continue to say that it is too early to judge accurately the rate of spending under the

---

[7] Edward and Ester Polisher Research Institute. *Impact of a Further Payment Reduction on the Medicare Home Health Benefit,* March 18, 2002. p. 13-14.

PPS and the ability of the industry to absorb the reduction. By retaining the postponed provision in the law, the Administration would have had available a tool to contain spending should it rise above acceptable levels in the future.

The arguments in favor of repealing the reduction and not letting it go into effect were that home health spending reductions sought by BBA 97 were met and exceeded; the number of participating HHAs has declined to the point that beneficiary access to care could be in jeopardy if payments were reduced further; HHAs would be unable to make long-term business or financial plans if the provision remained in the law; and, if future spending were to rise above acceptable levels, it could be restrained through curtailing future annual payment updates. Nevertheless, until data on HHA expenditures compared with payment amounts and patterns of beneficiary services are available, the distributional effects among HHAs of the across-the-board reduction remain unknown.