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Medicare Home Health — Benefits and Payments

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Summary

Medicare pays for unlimited care in the home as long as the following criteria are met: the beneficiary is "homebound," in need of skilled care on an intermittent basis, and under the care of a physician. Beneficiaries do not have any cost sharing requirements for home health services.[1]

Medicare pays home health agencies (HHA) using a prospective payment system (PPS). Under home health PPS, Medicare makes a payment for every 60-day episode of care that an eligible beneficiary receives. This episode payment is adjusted to reflect the intensity of beneficiary care needs using home health resource groups (HHRGs).

Congress, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) made a number of changes to home health agency payments including changing the update time frame from a federal fiscal year basis to a calendar year (CY) basis. HHA payments are increased by the full market basket percentage (3.3%) for the last quarter of 2003 (October, November, and December) and for the first quarter of 2004 (January, February, and March). The update for the last three quarters of CY2004 is the market basket minus 0.8 percentage points. MMA also provided a temporary payment add-on of 5% for home care provided to beneficiaries in a rural area beginning April 1, 2004 and ending March 31, 2005. This report will be updated as warranted.

Background

Medicare's home health benefit has specific statutory eligibility criteria: a beneficiary must be confined to his or her home (that is, be "homebound"), under the care of a physician, and need skilled nursing care on an intermittent basis or skilled therapy care. A homebound individual is defined as one who cannot leave home without a considerable and taxing effort, or who requires the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that

[1] For a complete discussion of cost sharing in Medicare home health, see CRS Report RL31628, *Medicare's Home Health Benefit: Cost Sharing Issues and Options*, by Carolyn Merck.

leaving the home is medically contraindicated. Absences from home may occur infrequently for short periods of time for purposes such as to receive medical treatment, attend certain adult day care programs, or attend church.[2] Skilled care includes skilled nursing or therapy (physical, speech/language, occupational) services delivered under the care of a physician and in accordance with a plan of care periodically reviewed by a physician.

For beneficiaries meeting the qualifying criteria, Medicare's home health benefit covers the following services:

- Part-time or intermittent nursing care provided by or under the supervision of a registered nurse;[3]
- Physical or occupational therapy or speech-language pathology services;
- Medical social services;
- Part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;[4]
- Medical supplies (excluding drugs and biologicals) and durable medical equipment (DME);
- Medical services provided by an intern or resident in training under an approved training program with which the agency may be affiliated; and
- Certain other outpatient services which involve the use of equipment that cannot readily be made available in the beneficiary's home.

Home health care is covered by Medicare as long as the care is medically reasonable and necessary for the treatment of illness or injury. Although the number of home health visits a beneficiary may receive is unlimited, services must be provided pursuant to a plan of care that is prescribed and periodically reviewed by a physician. In general, Medicare's home health benefit is intended to serve beneficiaries needing acute, *skilled medical care*. It was never envisioned as providing coverage for nonmedical supportive care or personal care assistance needed by chronically impaired persons. It is not a long-term care program for the disabled or the frail elderly.

Home Health Utilization and Spending

From 1987 to 1997, the number of beneficiaries receiving home health services more than doubled and the number of visits per home care patient increased more than threefold, from 23 visits in 1987 to 73 in 1997 (**Table 1**). During this time period, the

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[2] Sections 1814(a)(2)(c), 1814(a), and 1861(m) of the Social Security Act.

[3] "Part-time or intermittent" is defined in the statute Section 1861(m) of the Social Security Act) as "less than eight hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as the need for care, less than eight hours each day or 35 or fewer hours per week)."

[4] Home health aide visits include "hands-on personal care to the beneficiary or services that are needed to maintain the beneficiary's health or to facilitate treatment of the beneficiary's illness or injury." (42 *CFR* 409.45(b)(1)) Covered aide services include personal care such as bathing, grooming and dressing of the patient; simple dressing changes that do not require the skills of a licensed nurse; and assistance with medications that ordinarily are self-administered and do not require the skills of a licensed nurse.

number of HHAs participating in Medicare also increased sharply, growing from 5,686 agencies in 1989 to 10,492 in 1997. This dramatic growth resulted in similarly dramatic increases in Medicare spending for home health. Home health spending rose from $1.9 billion in 1987 to about $17.5 billion in 1997, an average annual increase of almost 27% (**Table 1**). This growth led to the imposition of new cost limits on HHAs in the Balanced Budget Act of 1997 (BBA), that attempted to control growth in number of visits paid by the program until a prospective payment system could be implemented (the interim payment system). The growth also led to scrutiny by the Department of Health and Human Services (HHS) Office of the Inspector General and the General Accounting Office (GAO) regarding fraudulent practices by some home health agency operators. The Center for Medicare and Medicaid Services (CMS) changed a number of practices regarding home health agencies and initiated a moratorium on allowing new HHAs to enter the Medicare program from September 1997 through January 1998.

Table 1. Medicare Home Health Agency Payments, People Served, and Visits, Calendar Years 1987-2003

Year	Payments (in millions)	Percent change	People served			Visits		
			Number (in thousands)	Per 1000 enrolled	Percent change	Number (in thousands)	Per person served	Percent change
1987	$1.9		1,564.5	48		35,589	23	
1988	2.1	8.5	1,601.7	49	2.1	37,129	23	1.9
1989	2.6	24.3	1,724.9	51	4.1	46,296	27	15.8
1990	3.9	51.7	1,967.1	57	11.8	69,386	35	31.4
1991	5.6	43.5	2,242.9	64	12.3	98,643	44	24.7
1992	7.9	39.4	2,506.2	70	9.4	132,499	53	20.2
1993	10.3	31.6	2,874.1	79	12.9	167,802	58	10.4
1994	13.8	33.1	3,179.2	93	17.7	218,790	69	17.9
1995	16.3	18.2	3,469.4	102	9.7	264,178	76	10.6
1996	17.7	8.6	3,599.7	107	4.9	281,887	78	2.8
1997	17.5	-1.2	3,557.5	108	0.9	260,162	73	-6.6
1998	11.0	-36.8	3,061.6	95	-12.0	159,247	52	-28.9
1999	8.4	-24.3	2,719.7	85	-10.5	112,866	41	-20.2
2000	8.5	1.5	2,461.2	75	-11.8	107,941	44	-5.7
2001	9.2	8.3	2,402.5	71	-5.3	66,172	28	-37.2
2002	10.1	9.5	2,550.3	NA	NA	69,184	27	-1.5
2003	10.0	— 0.3	NA	NA	NA	72,247	NA	NA
Average annual percent change:								
1987-1997 (pre-BBA)		24.9			8.4			12.2
1997-2003 (post-BBA)		-8.8			NA			NA

Source: Centers for Medicare and Medicaid Services, Office of the Actuary and Office of Information Services.
Notes: Payments are on an incurred basis. NA — not available.

After the BBA, Medicare payments to HHAs decreased sharply falling 37% in the first full year the interim payment system was in place and an additional 24% in the second year. The number of beneficiaries served decreased about 10% a year for the three years after BBA passed. This decrease was due to the stepped up program integrity activities directed at HHAs and a change in a qualifying service by BBA[5]. The average number of visits per beneficiary served also decreased dramatically falling almost 30% in the first full year after BBA due to the application of new payment limits.

After implementation of the home health prospective payment system (HHPPS) in October 1, 2000, payments increased by 8.3% in 2001 and by 9.5% in 2002. Payments fell slightly in 2003 due to the impact of the so-called 15% reduction.[6] The number of visits and, to a lesser degree, the number of beneficiaries served, continued to decline immediately after the implementation of PPS. In 2001, the average number of visits per person dropped to 28 and the number of beneficiaries served per thousand dropped to 71. However, in 2002, the number of beneficiaries served increased and in both 2002 and 2003 the number of visits increased.

Home Health Prospective Payment System

Begun October 1, 2000, HHPPS groups patients according to the type and intensity of services the patients require and sets a payment rate for each payment group. The basic unit of payment is for a 60-day episode of care and is adjusted for the wages of the area in which the beneficiary resides. Payment for the 60-day episode covers skilled nursing and therapy visits, aide visits, and medical supplies needed by the beneficiary. Physician services, durable medical equipment and osteoporosis drugs are not included in the HHPPS. The 60-day episode base payment, called the "national standardized 60-day episode rate" is based on actual, audited average FY1997 per visit home health costs that have been trended forward for inflation. There is no distinction between urban and rural base payment amounts.

The payment amount is then adjusted for the care needs of the beneficiaries by using HHRGs. Each of these represent specific amounts of nursing and therapy care. Care information is obtained through the initial assessment of the patient's care needs using the Outcome and Assessment Information Set (OASIS). Like other PPSs that pay health care providers for care to Medicare beneficiaries on the basis of predetermined fixed amounts, Medicare payments to HHAs are intended to pay the HHA for its Medicare beneficiary

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[5] BBA removed venipuncture services from the list of skilled services that was used in determining beneficiary eligibility for the home health benefit. Because venipuncture is a covered Part B service beneficiaries could continue to receive that service.

[6] BBA required that PPS payments be calculated so that, in the first year of PPS, home health spending would be the same as under the previous cost-reimbursement system, but the cost of the old system would be calculated as though the cost limits under the interim payment system were reduced by 15%. Delayed until Oct. 1, 2002 — two years after the start of PPS, the reduction in actual payments amounted to approximately 7% (because HHAs are paid the lesser of their actual costs or their costs subject to the limits, reduced 15%) and when coupled with the update in payments that also occurred Oct. 1, 2002, HHA payments were actually reduced by approximately 4.9%. See CRS Report RL31420, *Medicare's Home Health Benefit: The Fifteen Percent Payment Cut*, by Carolyn L. Merck.

costs on average. That is, although the payment is a predetermined rate, an agency's actual costs may be above or below that amount for an individual patient. Agencies have an incentive to manage costs so that, on average, costs do not exceed the PPS average amounts. HHAs that provide services at lower costs than the Medicare payment are able to keep the difference.

HHAs are paid 60% of the wage-and case mix-adjusted payment after submitting a request for anticipated payment (RAP). The RAP may be submitted at the beginning of a beneficiary's care once the HHA has received verbal orders from the beneficiary's physician and the assessment is completed. The remaining payment is made when the beneficiary's care is completed or the 60-day episode ends. Depending upon the circumstances additional adjustments may be made to the payment:

- **Outliers.** Outlier payments are made for extraordinarily costly episodes whose estimated costs exceed a threshold amount for each HHRG. Five percent of total home health payments are set aside for outlier payments.
- **Significant Change in a Beneficiary's Condition.** An HHA's payments can be modified within a patient's 60-day episode when a significant change in a beneficiary's condition occurs. Payment will be an amount that is proportional between the HHRG prior to the change and the HHRG after the significant change in condition.
- **Partial Episode Payment.** If a beneficiary transfers from one HHA to another during a 60-day episode, the first HHA to provide care will have its payment reduced to a portion equal to the amount of time during the 60-day episode in which care was provided. The second HHA will conduct an assessment, and a new, 60-day episode of care will begin.
- **Low Utilization Payment Adjustment.** The PPS payment for an agency is adjusted if a beneficiary's care is delivered in four or fewer visits. The payment is a standardized, service-specific per-visit amount multiplied by the number of visits actually provided during the episode.

Current Issues

MMA. MMA contained a number of provisions affecting HHAs and provided for two home health demonstration projects. The MMA changed the time frame for the home health update from the federal fiscal year to a calendar year basis beginning with 2004. HHA payments are increased by the full market basket percentage for the last quarter of 2003 (October, November, and December) and for the first quarter of 2004 (January, February, and March). The update for the remainder of calendar year 2004 and for all of calendar years 2005 and 2006 is the home health market basket percentage increase minus 0.8 percentage points. MMA also provides a one-year, 5% additional payment for home health care services furnished in a rural area without regard to certain budget-neutrality requirements. The temporary additional payment begins for episodes and visits ending on or after April 1, 2004 and before April 1, 2005 and is not to be used in calculating future home health payment amounts.[7]

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[7] The Benefits Improvement and Protection Act of 2000 (BIPA) provided a temporary two-year, 10% increase in payments for services furnished in rural areas that expired Mar. 31, 2003.

MMA suspends the requirement that home health agencies must collect OASIS data on private pay (non-Medicare, non-Medicaid) until the Secretary (1) reports to Congress on the benefits of these data, the value of the data compared to the administrative burden of data collection in small agencies, and the use of the OASIS information by both large and small agencies, and then (2) publishes final regulations regarding the collection and use of OASIS. The provision does not prohibit home health agencies from collecting OASIS data on private pay patients for the agencies' own use.

MMA requires two demonstration projects: (1) beneficiaries enrolled in Medicare Part B with specified chronic conditions would be deemed to be homebound in order to receive home health services under Medicare; and (2) an HHA, directly or under arrangement with a medical adult day care facility, provides medical adult day care services to substitute for a portion of home health services otherwise provided in a beneficiary's home.

In addition, MMA requires the Medicare Payment Assessment Commission (MedPAC) to study payment margins of home health agencies paid under the Medicare home health prospective payment system, using cost reports filed by agencies, and examine whether systematic differences in payment margins are related to differences in patient care needs, as measured by home health resource groups, among agencies.

Payment Adequacy. After three years experience of HHPPS, analysis is ongoing to assess the adequacy of Medicare payments. Both the GAO and MedPAC have analyzed available data on HHA costs and Medicare payments. Recently, GAO studied payments to freestanding HHAs for the first two years of HHPPS and concluded that Medicare payments "more than covered aggregate costs" of caring for their Medicare home health patients.[8] GAO found that aggregate Medicare margins for freestanding facilities were 16.2% in 2001 and 17.8% in 2002. Furthermore, MedPAC has estimated that aggregate PPS margins for all HHAs were 16.1% in 2001 and projected margins of 16.8% for 2004.

Quality of Care. Efforts have been underway since the late 1980s to develop and use measures of outcomes in home care in order to eventually use continuous quality improvement techniques. OASIS was developed for that purpose. In demonstrations of these techniques, outcomes were found to improve.[9] In November 2003, CMS launched a national home health quality initiative to provide HHA quality data to consumers, using selected measures from OASIS data. Data on individual HHAs can be obtained on [www.Medicare.gov] or through the 1-800-Medicare phone line. In addition to providing the data to consumers, CMS has offered HHAs assistance in improving the quality of care they provide. A recent MedPac study concludes that there appears to be a very slight increase in the quality of care since PPS began although there is "little difference in the overall quality of care provided" before and after PPS began.[10]

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[8] U.S. General Accounting Office, *Medicare Home Health Payments to Most Freestanding Home Health Agencies More Than Covered Their Costs,* GAO-04-359, Feb. 2004, p. 3.

[9] Peter W. Shaughnessy, et al., *OASIS and Outcome-Based Quality Improvement in Home Health Care: Research and Demonstration Findings, Policy Implications, and Considerations for Future Change*, Feb. 2002. [http://www.cms.hhs.gov/oasis/obqi.asp#vol4]

[10] Outcome Concept Systems, Inc., *The Effect of the Prospective Payment System on Home Health Quality of Care*, Mar. 2004.