

# **Impact of a Further Payment Reduction in the Medicare Home Health Benefit**

by

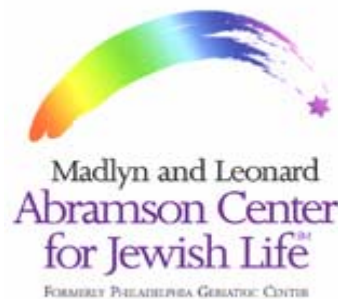
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**March 18, 2002**

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Acknowledgments: This report was sponsored by the American Association for Homecare, 625 Slaters Lane, Suite 200, Alexandria, VA 22314, (703) 836-6263. Barbara Markham Smith, a Senior Program Officer at the Institute of Medicine, provided independent consultation on the report; the Institute of Medicine had no role in the preparation of this report.

## EXECUTIVE SUMMARY

### Introduction\*

Since its inception in 1966, the Medicare home health benefit has provided health insurance coverage to homebound Medicare beneficiaries who need care on a part-time or intermittent basis. Covered services must be provided according to a physician's plan of care and include skilled and home health aide nursing, physical, occupational, and speech therapy, and medical social work services. Consistent with their homebound status, eligible Medicare home care users are older, sicker, poorer, and more disabled than the Medicare population generally. Most are women, and they are more likely to live alone than non-users of home care.

In 1980, Congress changed the home health benefit by expanding access to care for beneficiaries without a prior hospitalization and by eliminating visit limits. However, beginning in 1981, restrictive administrative interpretations of part-time or intermittent care limited spending by denying access. These tightened eligibility standards led to a class action lawsuit, *Duggan v. Bowen*. The 1988 ruling in the case overturned the restrictions while reaffirming Congress' intent to maintain broad access to extended home health services. After the 1988 *Duggan v. Bowen* decision, utilization grew dramatically since many eligible beneficiaries gained access to the benefit. This resulted in two years of very rapid growth in use of the benefit, after which the growth rate fell steadily and in 1997 turned negative.

Concerned with increasing Medicare expenditures and the threat of a depletion of the Part A Trust fund, Congress passed the Balanced Budget Act (BBA '97). The home health provisions in the Act were intended to moderate growth rates rather than reduce net spending and were implemented in a two-tiered process. An interim payment system (IPS) from 1998-2000 was implemented immediately to control spending. Under IPS the limits on per visit payments were dramatically reduced and a new aggregate per beneficiary limit was established. The combined effects of these two limits reduced reimbursements to below 1993 payment levels. IPS payments were not sensitive to variation in patient service intensity levels because it lacked a case-mix adjuster, a disincentive to serving high-cost patients. A prospective payment system (PPS) was mandated to establish a case-mix system that would permanently build efficiency incentives into the payment structure. However, IPS led to unprecedented reductions in spending. Between fiscal year (FY) 1998 and FY 2000, IPS reductions resulted in a 49 percent cut in home health outlays with the expectation of continued further declines through 2002.

In the midst of IPS implementation, providers in 1999 had to put into operation a new national standard patient assessment system called the Outcomes and Assessment Information Set (OASIS). In October of 2000, the implementation of PPS required different administrative and information systems and new staff capabilities.

In the context of payment methodology changes and administrative innovations, an additional 15 percent cut in the home health benefit is due to take effect in October of 2002. Other possible reductions are also pending: a 1.1 percent reduction in the home health market basket update, and elimination of the 10 percent add-on for services to rural beneficiaries set to expire on April 1, 2003—all lingering remnants of BBA '97.<sup>1</sup>

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\* All references are cited in the full report. Only informational footnotes are included in the summary.

<sup>1</sup> At the time of implementation, the effect of IPS on curbing growth rates was unclear. It was also unknown how quickly a PPS system could be established. The further cut was to guarantee that expenditures at the initiation of PPS would be constrained.

The magnitude of the reductions combined with the structural incentives to cut costs for patients requiring intensive services led to concerns that certain high-cost and vulnerable beneficiaries would experience difficulty obtaining and sustaining access to care. This study examines the likely impact of an additional 15 percent cut on access to care and on industry capacity and infrastructure.

## Study Methods

This report analyzes legislation and regulations relating to Medicare home health care, findings from published empirical studies, and data reflected in studies and government reports. In addition, it assesses the limitations of the known data and identifies additional information required for informed decision-making.

## Key Findings

### *Expenditure Effects of IPS and PPS*

- The interim payment system (IPS) dramatically reduced utilization and home care spending significantly below the intended savings that were anticipated with the inclusion of the 15 percent cut. Thus, the savings sought from the original proposed 15 percent reduction have already been realized. Home health spending dropped from \$16.8 billion in 1996 to \$9.0 billion in 2000. Additionally visits plunged 55 percent and beneficiaries served declined 24 percent, nearly 800,000. Declines in beneficiaries served in different states ranged from 10 to 38 percent.
- The home health industry has contracted substantially. Between 1997 and 2001 there has been a 36 percent reduction in the number of participating providers. Staffing infrastructure of home health agencies has also experienced contraction. Some reports indicate reductions as high as 42 percent. Nationwide, 60,000 non-supervisory positions in the industry were lost between 1997 and the second quarter of 2000. At the same time, the remaining workers have seen much smaller wage increases than their peers in other health care sectors.
- CBO projected home health expenditure reductions of \$16.2 billion over 5 years, FY '98 - FY '02. The actual expenditure reductions for 3 years, FY '98 to FY '00, were \$35.8 billion. Current projected reductions for the remaining 2 years, FY '01 and FY '02, total an additional \$35.3 billion yielding total expected reductions of over \$71.1 billion over the 5-year span.

### *Access to Care Following BBA '97*

- The reductions under IPS disproportionately and adversely affected the sickest eligible beneficiaries with the most intensive needs, an effect that has been sustained over time. Studies suggest that BBA '97 had a concentrated adverse effect on eligible high-cost/high need users, limiting both initial access to care and sustained adequacy of care.
- There is no evidence that these eligible beneficiaries have been returned to previous levels of access or that the holdover effect of IPS has been mitigated by the implementation of PPS.

### *Residual Effects of BBA '97*

- The administrative and technological enhancements required during the period of payment reductions may have substantial beneficial quality and payment effects over the long term, but they required additional infrastructure investment and operating costs from home health providers. In addition to the need for improved technologies and staff capabilities for OASIS,

separate administrative and technology investments have also been required to receive payment under IPS and PPS and assure compliance with other requirements. These costs further reduce available funds for furnishing covered services to eligible Medicare beneficiaries.

- It is likely that a significant percentage of providers remain financially vulnerable, particularly in rural areas. Nearly 60 percent of the nation's home health agencies exceeded the payment limits established under IPS. As a result many of these agencies are currently operating under repayment debt to Medicare.
- Nationwide staff shortages combined with wage restraints necessitated by payment reductions have complicated agencies' ability to rebuild their staffing.

#### *Effects of PPS*

- The number of agencies has appeared to continue to decline under PPS and has not been met with new market entry. This suggests that agencies are not now being overpaid. It also suggests that the trends put in place by IPS are not being mitigated by PPS. Moreover, depending on the distribution of this continuing decline, more generalized access could be adversely affected if additional reductions are implemented. Additional information is required on the number of beneficiaries being served, referrals to other providers, and access to high intensity services before additional reductions are considered.
- How agencies will actually be paid under PPS remains unclear as a result of a number of unresolved technical factors including adjustments in payment for partial and low utilization and the operation of outlier and therapy thresholds. These uncertainties make it difficult for agencies to develop plans that assure a predictable level of services. This uncertainty, particularly with respect to the operation of outlier payments, creates greater risks that any further reduction will eliminate access to covered services for an even greater proportion of higher cost beneficiaries.

#### *Additional Regulatory Burdens*

- As agencies are adjusting to the new administrative conditions imposed by PPS, they have also been facing an array of new regulatory mandates. Attending to both simultaneously increases the demand for both personnel and resources. New and continuing regulatory mandates include:
  - Implementation of two new billing systems for IPS and PPS with no recognition of start-up costs and implementation of the OASIS system and its electronic transmission requirements with initial start-up costs estimated at \$44.4 million and annual recurring costs of \$22.0 million;
  - Implementation of new compliance standards such as the Home Health Advance Beneficiary Notice;
  - Preparation to comply with HIPAA Transaction and Privacy Standards with costs to the industry estimated at \$625 million over ten years;
  - Preparation to comply with 2003 Outcome Based Quality Improvement (OBQI) standards.

*Likely Provider Reactions to an Additional Cut*

- The reaction of many providers is likely to mirror the reactions to the implementation of IPS. IPS induced an agency survival response that limited access to the benefit for more costly and vulnerable patients. A further cut under PPS is likely to compel similar survival responses. Because the cut will be across-the-board rather than tailored to clinical need, it compounds concerns about access to care for beneficiaries with complex service needs arising out of multiple chronic conditions.
- Some additional agency closures are likely. Of particular concern are agency closures in areas already lacking sufficient coverage such as some rural areas. Moreover, efficient providers will be penalized the most under across-the-board cuts and are more likely to close.

**Conclusion**

The evidence suggests that any additional cut in payments for Medicare home health services risks exacerbating the access concerns and possibly further jeopardizes the quality of services for the most vulnerable beneficiaries. Existing evidence does not indicate that access problems have been mitigated under PPS or that payments are excessive. In fact, it appears that significant retrenchment in provider capacity may be ongoing. Since the savings goals of BBA '97 have already been met and exceeded, prudence would suggest a period of payment stability to enable providers to adjust to new payment methodologies and implement innovations that may improve quality of care and efficiency over the long term. After such a period of stability, effects on access to care, quality, and markets can be better assessed. Accordingly, the pending reduction should be permanently eliminated rather than just postponed. A postponement would prolong uncertainty, making it harder for providers to plan for the future and forcing them into survival mode in anticipation of further cuts. Refinements in PPS should be considered once reliable data from the system becomes available.

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## INTRODUCTION

Since its inception in 1966, the Medicare home health benefit has provided health insurance coverage for skilled and home health aide nursing, physical, occupational, and speech therapy, and medical social work to Medicare beneficiaries who are homebound.<sup>2</sup> These services are provided on a “part-time or intermittent” basis which principally distinguishes this benefit from the full-time care provided under the Medicare skilled nursing facility benefit. The care must also be certified by a physician as medically “reasonable and necessary” and may not be “custodial” in nature.<sup>3</sup>

As might be expected from their homebound status, home care beneficiaries tend to be older than the Medicare population in general, with 26 percent over 85 years of age, and more disabled. Ninety percent have at least one limitation in Activities of Daily Living (ADL), and 79 percent experience three or more ADLs. Most are women, and most are poorer and sicker than the Medicare population generally.<sup>4</sup> Reflecting their poorer health status, they consume more of all types of Medicare services than the Medicare population generally. Like the Medicare program in general, the increases in chronic illness and medical complexity have consumed a more dominant share of home care spending.<sup>5</sup>

As a result of statutory expansions in the program, the home health benefit in Medicare has grown over the years from a post-acute program to a component of the health care continuum available to beneficiaries needing more intense care over a longer period of time. In response to increases in spending from the changes in eligibility, population growth, and industry growth following the statutory expansions, the Balanced Budget Act of 1997 (BBA ‘97) implemented substantial payment revisions.<sup>6</sup> These revisions were designed to reduce the future rate of growth in spending both on an interim basis and permanently by providing incentives to the home health industry to reduce costs. Although the intent was to reduce the rate of growth; the changes resulted in a 49 percent net reduction in spending from FY ‘98 to FY ‘00.<sup>7</sup> An additional 15 percent reduction in the benefit is scheduled to take effect in October 2002<sup>8</sup> and additional reductions are scheduled to take place in FY 2003.<sup>9</sup>

This analysis will explore the growth of home care, the effects on beneficiaries and the industry of the interim payment system, and the implementation and known effects of the permanent prospective payment system now operating for more than one year. It will then examine interactions of such a cut with the adaptations made by the home health industry to date and whether additional reductions will exacerbate or alter existing trends in access to care. Finally, it will evaluate whether and to what extent an additional cut is warranted.

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<sup>2</sup> Eligibility definitions are included in a detailed legislative history of the home care benefit at Appendix A.

<sup>3</sup> The Social Security Amendments of 1965, Health Insurance for the Aged Act, P.L. 89-97, 79 Stat. 286. See 42 U.S.C. 1395y(a)(1)(A).

<sup>4</sup> Leon, J. Parente, S., Neuman, P. (1997) Understanding the growth in Medicare’s home health expenditures. Menlo Park, CA: The Henry J. Kaiser Family Foundation

<sup>5</sup> Mauser, E. and Miller, N. (1994). A Profile of Home Health Users in 1992. Health Care Financing Review. 16:1. p. 17-33; Feder J. and Lambrew, J. (1996). Why Medicare Matters to People Who Need Long-Term Care. Health Care Financing Review. 18:2. p.99-112.

<sup>6</sup> Balanced Budget Act of 1997, P.L. 105-33, 111 Stat. 251, Title IV, Subtitle G, Secs. 4601-4616

<sup>7</sup> Congressional Budget Office. CBO Baseline Estimates, March 1997, March 1998, March 1999, March 2000, April 2001. Washington, DC: Author.

<sup>8</sup> The actual amount of the cut is determined by estimating the amount that would have been cut from the benefit if cost reimbursement had continued through the first year of PPS and the per visit and per beneficiary cost limits had been reduced by 15 percent. 42 U.S.C. 1395fff(b)(3)(A)(i)(III)

<sup>9</sup> These include an end to the 10 percent rural add-on and market basket updates for home care in general. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. 106-554, 114 Stat. 2763, 42 USC Section 1395; The Balanced Budget Refinement Act of 1999, P.L. 106-113, 113 Stat. 1501, 42 USC Section 1395.

## SECTION 1

# LEGISLATIVE HISTORY OF MEDICARE HOME HEALTH PRIOR TO BBA '97

### BACKGROUND

Initially conceived as an acute care insurance program to offset the high costs of hospitalization, the Medicare home health benefit was modified in 1980 to improve access to the benefit for chronically ill, medically complex, and disabled beneficiaries.<sup>10</sup> See Appendix A for a detailed legislative history of the Medicare home health benefit.

#### *The Drive Towards Expansion*

In 1972, eligibility for Medicare and thus the home health benefit was expanded to the non-elderly disabled and home care copayments were eliminated.<sup>11</sup> The interest in responding to chronic illness and disability resulted in significant expansions of access to the Medicare home health benefit in the Omnibus Budget Reconciliation Act of 1980 (OBRA '80).<sup>12</sup> OBRA '80 eliminated the 3-day prior hospitalization requirement, the 100 visit limit on home care visits, and all beneficiary cost-sharing through deductibles and copayments. The eligibility requirements that beneficiaries be homebound, in need of part-time or intermittent skilled care, have a physician-certified plan of care, and receive care from a Medicare certified home health agency remain in effect. The OBRA '80 changes created access to the benefit for a large spectrum of chronically ill and disabled beneficiaries needing skilled services for extended periods of time.<sup>13</sup>

After enactment of these changes, utilization of Medicare home care increased moderately (see Exhibit 1.1). In fact, between 1983 and 1987 the growth rates for home health utilization declined<sup>14</sup>. Between 1981 and 1986 the Centers for Medicare and Medicaid Services (CMS, then known as HCFA) implemented a new interpretation of the original "part-time or intermittent" coverage criteria thereby eliminating access to the benefit for many beneficiaries who needed medical care for more than 4 days per week. These policies eliminated access to the home health benefit for thousands of Medicare beneficiaries suffering from conditions that had been routinely covered since 1966.<sup>15</sup> CMS' more restrictive interpretation led to a class action law suit in 1987. The court in *Duggan v. Bowen* overturned these policies on grounds that they violated the express language of the statute, original Congressional intent and CMS' own application of the statute since 1966.

The net effect of the *Duggan* decision and OBRA '80 is that the Medicare home health benefit became available to more beneficiaries with more chronic or medically complex conditions and who needed care for longer periods of time.<sup>16</sup> The legislation also paved the way for a significant increase in

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<sup>10</sup> Keenan, J. Fanale, J. Ripsin, C. and Billows, L. (1990). A review of federal home-care legislation. *Journal of the American Geriatrics Society*, 38:9. p. 1041-1048.

<sup>11</sup> Social Security Act Amendments of 1972, P.L. 92-603, 42 USC section 1395, et. seq.

<sup>12</sup> Omnibus Budget Reconciliation Act of 1980, P.L. 96-499, 94 Stat. 2599, 42 USC section 1395, et. seq.

<sup>13</sup> Medicare Gaps and Limitations Hearing before the Subcommittee on Health and Long Term Care, Committee on Aging, U.S. House of Representatives, (October 18, 1977), 95th Cong., 1st Session, Comm. Pub. 95-116; Proposed Amendments to the Medicare Program. Hearing before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 95th Cong., 2nd Session 92 (August 4, 1978); Medicare and Medicaid Home Health Benefits hearings before the Subcommittee on Health, Committee on Finance, U.S. Senate, 96th Cong., 1st Session May 21 and 22, 1979.

<sup>14</sup> Benjamin, A. (1993). An Historical Perspective on Home Care Policy. *The Millbank Quarterly*, 71:1. p.129-165.

<sup>15</sup> *Duggan v. Bowen*, 691 F-Supp. 1487 (DDC 1988) p. 1500

<sup>16</sup> General Accounting Office (1996). Medicare: Home Health Utilization Expands While Program Controls Deteriorate. GAO/HEHS-96-16 Washington, DC: Author; Feder J. and Lambrew, J., supra note 5.

the number of agencies by permitting the certification of proprietary agencies in states lacking licensure laws, creating greater access to providers and services.<sup>17</sup> As a result, the number of Medicare beneficiaries served per year increased significantly, from just under 1 million in 1980 to just over 1.7 million in 1989, to 3.6 million in 1996. Part of this growth was driven by an increase in size of the Medicare population in general as well as by restored access to the home health benefit for categories of beneficiaries who had been denied access throughout the mid-1980s.<sup>18</sup>

**Exhibit 1.1****Medicare Home Health Utilization, 1974-1999**

Calendar year	Persons served		Visits		Expenditures		
	Total (thousands)	Per 1,000 enrollees	Total (millions)	Per person served	Total (billions)	Per person served	Per visit
1974	393	16	8.07	21	\$0.1	\$359	\$17
1976	589	23	13.34	23	\$0.3	\$493	\$22
1978	780	28	17.35	22	\$0.4	\$558	\$25
1980	957	34	22.43	23	\$0.7	\$691	\$30
1982	1,172	40	30.79	26	\$1.1	\$943	\$36
1983	1,351	45	36.84	27	\$1.4	\$1,035	\$38
1984	1,516	50	40.34	27	\$1.7	\$1,099	\$41
1985	1,589	51	39.74	25	\$1.8	\$1,116	\$45
1986	1,600	50	38.36	24	\$1.8	\$1,122	\$47
1987	1,565	48	36.09	23	\$1.8	\$1,145	\$50
1988	1,602	49	37.71	24	\$1.9	\$1,215	\$52
1989	1,725	51	47.26	27	\$2.4	\$1,410	\$51
1990	1,967	57	70.27	36	\$3.7	\$1,888	\$53
1991	2,243	64	99.83	45	\$5.4	\$2,394	\$54
1992	2,506	70	132.22	53	\$7.4	\$2,951	\$56
1993	2,874	79	164.23	57	\$9.7	\$3,384	\$59
1994	3,179	93	208.62	66	\$12.7	\$3,982	\$61
1995	3,469	102	249.39	72	\$15.4	\$4,436	\$62
1996	3,600	107	264.80	74	\$16.8	\$4,658	\$63
1997	3,558	108	258.17	73	\$16.2	\$4,554	\$63
<b>Fiscal year</b>							
1997	3,296	101	259.8	79	\$16.2	\$4,969	\$63
1998	2,953	92	183.5	62	\$11.8	\$4,052	\$65
1999	2,518	80	116.3	46	\$9.1	\$3,110	\$67

**Sources:** 1974 to 1996 expenditure figures are from Health Care Financing Review 1999 Statistical Supplement. Calendar year 1997 expenditure figures are from the Center for Medicare and Medicaid Services (CMS) Office of the Actuary, National Statistics Group. Visits and persons served from calendar years 1974 through 1997 are from Health Care Financing Review 1999 Statistical Supplement. Fiscal year 1997 to 1999 data are from McCall et al., "Medicare Home Health Before And After The BBA," Health Affairs 20(3): 189-198

These changes also helped the benefit adapt to changing medical practices including shorter hospital stays and technological advances that were keeping people alive longer without equivalent gains in morbidity.<sup>19</sup> New treatment options (drug therapies and medical technologies) have allowed an increasing array of conditions to be treated at home. At the same time, the Medicare population has aged, and an increasing share has disabilities. The share of all beneficiaries who have a disability or end-stage

<sup>17</sup> Estes, Swan and Associates. (1993). The Long Term Care Crisis: Elders Trapped in the No-Care Zone. Sage Publications: Newbury Park, CA.

<sup>18</sup> See Exhibit 1-1

<sup>19</sup> Komisar, H. and Feder, J. (1998). The Balanced Budget Act of 1997: Effects on Medicare's Home Health Benefit and Beneficiaries Who Need Long Term Care. New York, NY: The Commonwealth Fund.

renal disease rose from 8 percent in 1974 to 13 percent in 1996,<sup>20</sup> and the number of beneficiaries who are over 85 years of age increased from 8 percent in 1978<sup>21</sup> to 11 percent in 1994.<sup>22 23</sup>

Predictably, the number of older adults in need of home health care increased. From 1989 to 1996, the annual number of persons served increased from 1.7 million to 3.6 million, while the number of persons served per 1,000 Medicare beneficiaries increased from 51 to 107. This represented an increase from 5.1 percent of the Medicare population to 10.7 percent.<sup>24</sup> The mean number of visits per user also grew significantly, from 27 visits per person served in 1989 to 74 visits in 1996, while costs per visit increased an average of 3.06 percent per year.<sup>25</sup>

Parallel with the change in demographics of the Medicare population, a growing share of expenditures for the home health benefit came to be associated with a small percentage of high-cost users with a large number of visits. The 10 percent of home health users who had more than 200 visits in the year accounted for 43 percent of total expenditures in 1994 and 60 percent of the growth in home health spending between 1991 and 1996.<sup>26</sup> On average, each such user incurred \$17,420 in home health costs in 1994.<sup>27</sup> The increases during this time period in visits and expenditures per person served reflect longer episodes of care. In 1990, 14 percent of all home health episodes lasted 166 days or more. By 1995, this figure had increased to 20 percent. However, while more expensive than shorter episodes, these longer episodes tended to have a greater proportion of lower-cost aide visits.<sup>28</sup> Because of the higher proportion of aide visits that are designed to be supportive of the skilled services that form the core of the benefit, concerns grew that the Medicare home health benefit was increasingly being used to finance long-term care.<sup>29</sup>

While 9 in 10 high users of Medicare's home health benefit have ADL limitations and 79 percent have limitations in three or more ADLs,<sup>30</sup> an analysis of utilization has shown that high use of home health care cannot be explained only by the need for long-term care. Of the non-institutionalized Medicare beneficiaries with long-term care needs, more than half did not use any home health services in 1996. Only 16 percent of long term care users with limitations in three or more ADLs were high users of home health services. These facts led to the conclusion that "most high home health users appear to have multiple, often complex, medical needs requiring a range of acute as well as long-term care services."<sup>31</sup>

These trends resulted in a rapid growth in Medicare home health spending. In FY1989, total program expenditures were \$2.4 billion; by 1996, the year of the highest expenditures, this figure had grown to \$16.8 billion. While the average annual growth rate for total Medicare spending was only 11 percent from 1990 to 1996 the average annual growth rate for home health care was 33 percent in that same time period.<sup>32</sup> However, most of that growth occurred from 1989 to 1991 in the aftermath of *Duggan*. Between 1989 and 1990 the program grew by 54 percent and between 1990 and 1991 it grew by

<sup>20</sup> Health Care Financing Administration. *Profiles of Medicare: 30<sup>th</sup> Anniversary of Medicare*. Baltimore, MD: U.S. Department of Health and Human Services, 1996.

<sup>21</sup> Health Care Financing Administration. *Medicare and Medicaid Statistical Supplement, 1995*. Baltimore, MD: U.S. Department of Health and Human Services, 1995.

<sup>22</sup> Gornick, M. "Thirty Years of Medicare: Impact on the Covered Population." *Health Care Financing Review* 18(2): 179-232, Winter 1996.

<sup>23</sup> Feder, J. and J. Lambrew, *supra* note 5.

<sup>24</sup> Komisar, H. and Feder, J., *supra* note 19.

<sup>25</sup> See Exhibit 1-3

<sup>26</sup> Feder and Lambrew, *supra* note 5. Prior to the 1980 amendments, it would not have been possible for beneficiaries to receive 200 visits because of the limits on service duration.

<sup>27</sup> Feder and Lambrew, *supra* note 5

<sup>28</sup> Jones, N. "Access to Home Health Services under Medicare's Interim Payment System." Issue Brief no. 744. Washington, DC: National Health Policy Forum, July 13, 1999.

<sup>29</sup> Komisar, H. and Feder, J., *supra* note 19; Leon, *supra* note 4.

<sup>30</sup> Leon, *supra* note 4.

<sup>31</sup> Komisar, H. and J. Feder. *supra* note 19

<sup>32</sup> Komisar, H. and J. Feder. *supra* note 19

almost 46 percent. From 1991 to 1996, the growth rate steadily declined (see Exhibit 1.2) down to a low of 9 percent. By 1997, home health expenditures experienced a negative growth rate of 3.5 percent.

The growth of the home care industry and its responses to the changing characteristics of the Medicare population may have reduced costs in other sectors by preventing or reducing nursing home placement. According to the National Center for Health Statistics not only did the proportion of elderly residing in nursing homes decline between 1985 and 1995 (from 4.6 to 4.1 percent) but the average stay decreased by 18 percent.<sup>33</sup>

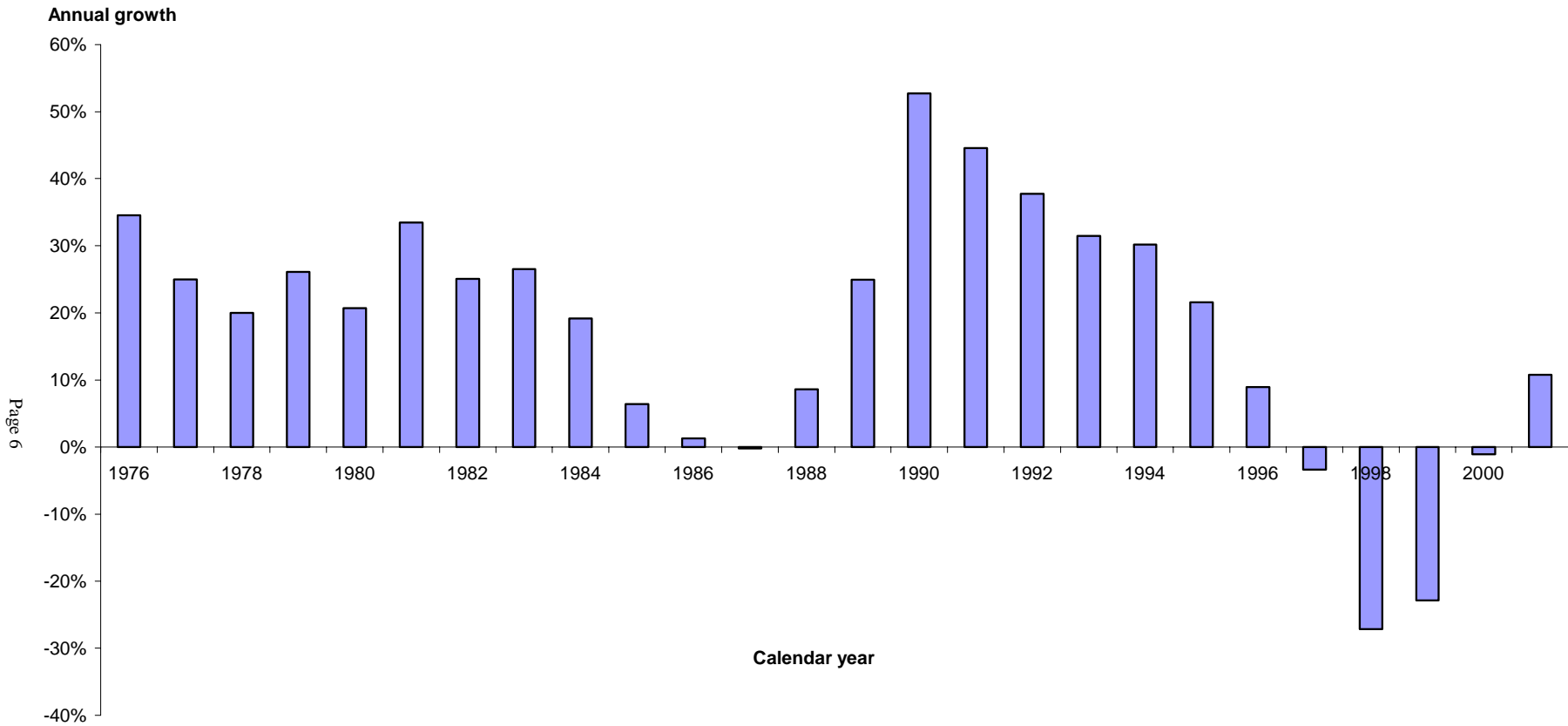
### ***The Reaction to Expansion -- Constraining Costs***

During deliberations in 1995-97, Congress addressed concerns over rising health care costs generally, their increasing share of GDP, potential depletion of the Hospital Insurance Trust Fund, and budget deficits. The home health industry and many members of Congress advocated the abandonment of cost-based reimbursement and adoption of a home care prospective payment system that would increase incentives for efficiency. After reductions in the per visit limit and a two-year freeze in the market basket update for the limit, Congress remained concerned about the “unsustainable” rate of growth in Medicare home health expenditures, concentrating on the dramatic growth rates that occurred immediately following *Duggan v. Bowen* rather than the declining rates of growth that started in 1991 and was approaching zero by 1997.

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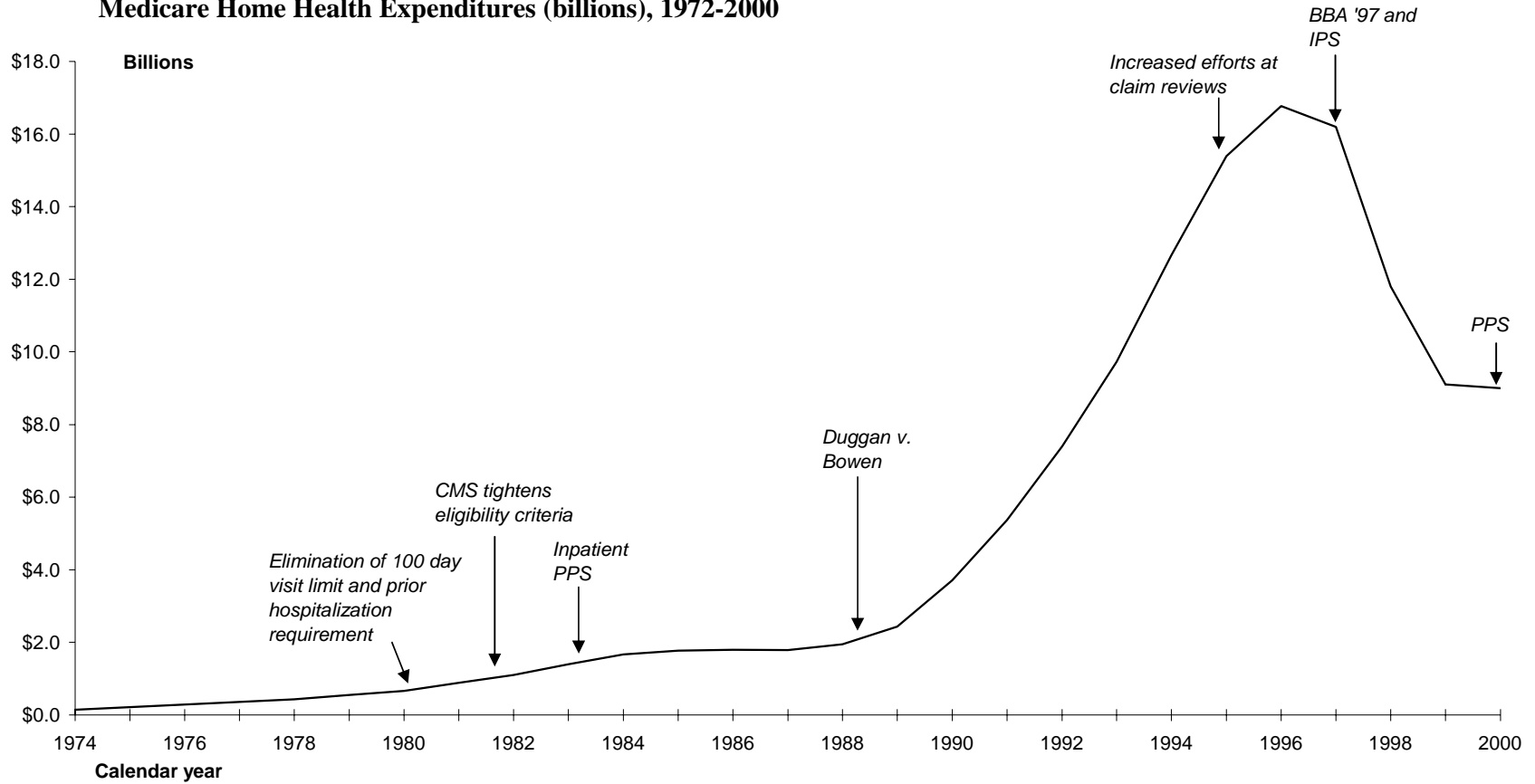
<sup>33</sup> Komisar, H. and J. Feder. supra note 19

### EXHIBIT 1.2 Medicare Home Health Expenditure Growth rate



**Sources:** 1974 to 1996 data is from Health Care Financing Review 1999 Statistical Supplement. 1997 to 2000 data is from the Center for Medicare and Medicaid Services (CMS) Office of the Actuary, National Statistics Group. Year 2000 data is a CMS Office of the Actuary estimate. Year 2001 data is a Congressional Budget Office forecast.

### EXHIBIT 1.3 Medicare Home Health Expenditures (billions), 1972-2000



**Sources:** 1974 to 1996 data is from Health Care Financing Review 1999 Statistical Supplement. 1997 to 2000 data is from the Center for Medicare and Medicaid Services (CMS) Office of the Actuary, National Statistics Group. Year 2000 data is a CMS Office of the Actuary estimate.

## SECTION 2

### THE BALANCED BUDGET ACT OF 1997

The Balanced Budget Act of 1997 (BBA '97) generated substantial changes in the Medicare program in the way health care providers would be reimbursed and was designed to achieve substantial reductions in program spending.<sup>34</sup> Early estimates of overall program savings due to the BBA reached as high as \$116.4 billion over the first five years and \$393.8 billion over ten years.<sup>35</sup> The majority of these savings came from changes in the fee-for-service program.<sup>36</sup> Savings in the home health care benefit, which accounted for approximately 10 percent of all Medicare spending, were expected to generate \$16.2 billion over five years (FY '98 to FY '02)—about 14 percent of the total projected savings. Over ten years the changes to the home health benefit were originally projected to save \$49.6 billion.<sup>37</sup>

The key changes in the home health care provisions of BBA '97 relevant to this discussion included creation of an interim payment system (IPS) to immediately decrease the future growth in home health spending and the establishment of a home health prospective payment system (PPS). See Appendix A for a discussion of other revisions to home health. BBA '97 further required that any reductions in home health expenditures resulting from IPS would continue with the implementation of the new PPS. In addition to the carry-over of savings, expenditures would be reduced by an additional 15 percent when the PPS went into effect. The 15 percent cut was considered necessary in order for CBO to score the home health provisions as achieving savings of \$16.2 billion.<sup>38</sup> Thus, the 15 percent cut was grounded in budgetary concerns rather than clinical data.

#### THE STRUCTURE AND OPERATION OF IPS

There were two main goals behind the creation of the IPS. The first goal was to begin to restrain further growth in expenditures immediately within the home health program by controlling volume of services per person. Second, it would allow time for CMS to develop the prospective payment system. Under the IPS, home health agencies would be reimbursed based on "the lowest of: (1) actual costs; (2) reduced per visit limits; or (3) a blended, agency-specific per beneficiary annual cost limit".<sup>39</sup> Aggregate per visit limits were set at 105 percent of the median national visit limits, down from 112 percent of the mean national costs.<sup>40</sup>

The per beneficiary limit under IPS was the first time that Medicare established a cap on reimbursements at the beneficiary level. This limit was calculated using 98 percent of 1994-94 costs and was based on 75 percent of the agency's individual aggregate average per beneficiary costs and 25 percent of the regional average costs.<sup>41</sup> Because the statute required payment at the lowest of the three options, most agencies would fall under the per beneficiary limit and would at a minimum be cut 2

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<sup>34</sup> Moon, M. and Gage, B. (1997). Key Medicare Provisions in the Balanced Budget Act of 1997. *The Public Policy and Aging Report*. 8:4, p.1-5.

<sup>35</sup> Congressional Budget Office (1997). *Budgetary Implications of the Balanced Budget Act of 1997* December. Washington, DC: Author

<sup>36</sup> Supra note 34

<sup>37</sup> Supra note 35

<sup>38</sup> Testimony by CMS Administrator before Subcommittee on Health and Environment, House Committee on Commerce, No. 105-14, at 33 (March 5, 1997)

<sup>39</sup> BBA, 1997, p.87-88, supra note 6.

<sup>40</sup> The Omnibus Consolidated Emergency Supplemental Appropriations Act of 1999, P.L. 105-277 increased this to 106 percent of the median after October 1, 1998.

<sup>41</sup> Berke, D. (1998) The Balanced Budget Act of 1997 - What it Means for Home Care Providers and Beneficiaries. *Journal of Long Term Home Health Care*. 17:3 p. 2-9; Forster, T. (1998). Home Care, the Balanced Budget Act of 1997, and IPS. *Caring Magazine*. 17:2. p. 8-13; and Scanlon, W. (1998). *Interim Payment System for Home Health Agencies*. Washington, DC: U.S. GAO/HEHS-98-238.

percent below expenditures generated in 1993-94.<sup>42</sup> Since the reductions mandated by the per beneficiary limit were not case mix adjusted, they fell hardest on the highest cost patients treated by the most cost-effective agencies.

The IPS was supposed to be replaced by the PPS beginning in 1999, but Congress postponed the start date of the PPS until October 2000 because CMS was not prepared to implement the new system.<sup>43</sup> This meant that agencies had to operate under the more stringent IPS which lacked a case mix adjuster for one year longer than originally intended.

One serious flaw in the design of the IPS was that those agencies that had been operating efficiently in 1993-94 would end up with a lower reimbursement under IPS than an agency that had higher utilization patterns before the BBA.<sup>44</sup> Since the per-beneficiary limit was based on a blended average of agency-specific (75 percent) and regional costs (25 percent), agencies that had lower costs in 1993-94 would receive lower reimbursements under the IPS. This would not only affect efficient providers, but agencies with high-cost patients in those regions that had historically lower reimbursements would be penalized as well. Thus, some of the agencies that were pushed out of business due to these changes may not have been abusing the system but simply operating with case mixes that limited their ability to reduce costs to conform to regional averages. Any agency that added more costly services after 1994, such as high-tech care components would also have difficulty continuing that service after the BBA. Agencies that experienced an increase in case-mix acuity after 1994 would also be more adversely affected by the reimbursement cuts.<sup>45</sup>

Other agency types were likely to be penalized by the IPS. Small agencies serving a large number of high-use/cost patients would be unable to balance lower cost patients under the per-beneficiary limits since they would not be able to increase their total census. Agencies that saw losses of another provider in their service area (especially in rural areas with few alternatives) might be forced to add more high-use patients, thus resulting in an unfavorable change in their case mix from that of their 1993 basis. GAO stated that agencies that could not control or modify their patient mix were more likely to go out of business.<sup>46</sup>

## COMPLICATING INTERACTIONS

The use of 1993 cost data to establish the limits alone would have reduced payments to agencies by as much as 15-22 percent.<sup>47</sup> Other factors multiplied the impact of the payment design.

### *Agency Retrenchment*

An added element that contributed to the additional reductions was agency reaction to the revised payment structure. Agencies strongly retrenched, especially with the first implementation of IPS, for several reasons. First, the per-beneficiary limits were published after the IPS took effect. The limits for cost-reporting periods beginning on or after October 1, 1997 were published in the *Federal Register* on

<sup>42</sup> After OCESAA, supra note 40, established agencies (those with full year participation in MC before FY 1994) falling below the national median would have their per-beneficiary amount increased by 1/3 of the difference between their amount (lesser) and the national median. Agencies established between 94-98 would receive per beneficiary caps based on 100 percent of FY 94 costs rather than 98 percent. Brand new agencies, created after October 1, 1998 would receive 75 percent of the national median based on 98 percent of FY 1994 costs.

<sup>43</sup> Supra note 40, P.L. 105-277

<sup>44</sup> The Lewin Group. (1998). Implications of the Medicare Home Health Care Interim Payment System of the Balanced Budget Act. Washington, DC: The National Association for Home Care; Scanlon, W., supra note 41; Komisar, H. and Feder, J., supra note 19.

<sup>45</sup> Ibid

<sup>46</sup> Scanlon, W., supra note 41.

<sup>47</sup> Berke, D. Supra note 41; Forster, T. Supra note 41

March 31, 1998, three months later than the BBA required. Therefore, agencies were operating blindly for several months, facing the prospect of refunding overpayments based on the new limits from money that had already been spent on care before agencies knew what the spending limits would be. In fact, many agencies found themselves owing CMS or incurring debt because they exceeded the per-beneficiary limits prior to notification<sup>48</sup>.

### *Fear of Additional Cuts*

Another factor that may have contributed to the impact of BBA '97 was the fear of additional cuts, particularly the mandated 15 percent additional reduction scheduled to take effect in 1999.<sup>49</sup> The across the board operation of this proposed reduction would have intensified the lack of a case-mix adjuster under IPS since agencies that cared for sicker and more costly patients would have been the least able to sustain further reductions. Agencies appeared to have avoided accepting patients that they could not afford to treat or who they thought they might have to discharge due to further significant cuts.

### *Implementation of OASIS*

In addition to actual and impending cuts, agencies were being asked to implement added requirements for data collection. BBA '97 required CMS to develop a case mix adjuster for the PPS. Congress also granted CMS the authority to "require all home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system".<sup>50</sup> Accordingly, in 1999 CMS required that all agencies use the Outcome and Assessment Information Set (OASIS) instrument. The OASIS assessment consists of 79 data elements covering functional abilities, diagnoses, medical history, financial, physical assessment, living arrangements and social supports and others. Such an assessment must be completed by agencies at admission, discharge, transfer to inpatient facility, perceived change in patient condition and at recertification points. The assessments can only be conducted by professional staff, including nurses and therapists. In addition, the new process requires access to a modem to transmit data electronically. Not only would more staff time be required for these assessments and recertifications, but many agencies would need to invest in new technology in order to remain in the Medicare system. Therefore, at a time of severe cutbacks, agencies were required to devote increasing financial resources to develop technology and administrative innovations.<sup>51</sup>

The decline in expenditures resulting from IPS was far deeper than anyone had expected and went far below what Congress had intended. CBO believed that the home health provisions of BBA '97 would drive home health spending for FY 2000 down from \$25.3 billion to \$21.2 billion. In reality, actual expenditures for FY 2000 turned out to be approximately \$9 billion.<sup>52</sup>

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<sup>48</sup> Davitt, J. (2001). The Balanced Budget Act: Exploring Home Health Care Policy and Access. Paper presented at the Gerontological Society of America, 54th annual meeting.

<sup>49</sup> Implementation of the 15 percent cut was delayed by the OCEA of 1999 (supra note 40) until October 1, 2000. It was further delayed by the BBRA of 1999 (supra note 9) until one year after implementation of the PPS which would mean October, 1, 2002.

<sup>50</sup> BBA '97, supra note 6

<sup>51</sup> The BBRA of 1999 (supra note 9) provided an additional \$10 payment per client to help defray costs incurred for conducting the OASIS assessments.

<sup>52</sup> CBO, supra note 7.

### **SECTION 3**

## **IMPACT OF BBA '97 ON AGENCIES AND BENEFICIARIES**

The operation of IPS both in the size of the reductions and in agency adaptations to the reductions produced substantial consequences for beneficiaries, particularly high-cost medically complex beneficiaries, and the home health industry. By 1999, the number of beneficiaries receiving home care services had dropped by 840,000 – almost one-third of the total Medicare home care population in 1997.<sup>53</sup> The number of home health agencies dropped 36 percent from 1997. The structure of IPS with the absence of risk adjustment combined with the decline in census and providers led to concerns about whether Medicare legally eligible beneficiaries have been able to maintain access to care for needed services.

### **EFFECT ON ACCESS TO CARE**

Early research demonstrated support for concerns regarding patient access to care. MedPAC conducted a survey of home health agency directors in 1999. Fifty-six percent of the directors reported that they had decreased the number of patients served due to the IPS. A majority of directors (71 percent) said that they had decreased the total number of visits per patient. Another 39 percent said that they had chosen not to serve certain kinds of patients and 31 percent said that they had discharged patients due to the IPS.<sup>54</sup> In another survey of agency directors, 68 percent reported limiting the proportion of high-cost patients through screening, marketing and staff changes.<sup>55</sup> Almost all of the directors in this study reported more aggressive discharge efforts. The types of patients mentioned as problematic included diabetic patients, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) patients. In fact, 57 percent of agencies in this study reported more aggressive screening of diabetics while 21 percent admitted "overtly excluding or severely limiting" the number of patients with chronic conditions or who required two or more visits per day.<sup>56</sup> Studies also found that there was greater evidence of cost-shifting to pay for extended care.<sup>57</sup>

The General Accounting Office (GAO) conducted surveys of discharge planners and aging service providers. Sixty-six percent of discharge planners and 33 percent of aging service providers reported difficulty getting home health services for certain kinds of patients, such as, patients with intensive skilled needs and with a "significant number of visits over a long period of time".<sup>58</sup>

Studies of hospital discharge planners confirm the picture painted by the home health agency representatives. In a survey of 41 hospitals in eight states, 68 percent of the discharge planners reported increased difficulty in obtaining home health services for Medicare beneficiaries. Sixty-one percent said that it was harder to obtain the sufficiency or intensity of services they sought in the initial placement. Fifty-six percent reported increases in the number of beneficiaries referred to substitute care such as nursing homes, in lieu of home health services, a departure from the trend of declining SNF admission rates prior to the BBA. Forty-one percent reported increased hospital readmission rates among those

<sup>53</sup> Centers for Medicare and Medicaid Services (CMS) Customer Information System (HCIS). Latest available statistics cover 1999.

<sup>54</sup> MedPAC, (1999). Report to the Congress: Selected Medicare Issues. Washington, DC: Author.

<sup>55</sup> Smith, B.M. et al. (1999). An Examination of Medicare Home Health Services: A Descriptive Study of the Effects of the Balanced Budget Act Interim Payment System on Access to and Quality of Care. Washington, DC: Center for Health Services Research and Policy, The George Washington University

<sup>56</sup> Ibid.

<sup>57</sup> Ibid.; Davitt, supra note 48.

<sup>58</sup> Scanlon, W. (1998) Medicare Home Health Benefit: Impact of Interim Payment System and Agency Closures on Access to Services. Washington, DC: GAO/HEHS-98-238. p. 13

discharged to home health care. The type of beneficiaries most affected, the discharge planners reported, were those with short-term high intensity needs, beneficiaries needing two visits per day, beneficiaries needing complex wound care, and beneficiaries with chronic diseases such as pulmonary disease, cardiac disease, and diabetes. The discharge planners attributed these increased difficulties to changes in agencies' admission and practice patterns, changes in staffing patterns, or agency closures. No discharge planner reported any difficulties obtaining home health services for beneficiaries with short-term, low intensity needs.<sup>59</sup>

GAO also examined patterns of agency closures and interviewed agency administrators, state survey agency officials and hospital discharge planners. Again, agency administrators reported changes in operation that, in the words of the GAO, "may create future access barriers for beneficiaries who need intensive or long-term skilled care."<sup>60</sup> Agency administrators reported that they were being more careful about accepting expensive, long-term patients. Wound care and diabetic patients unable to administer insulin themselves were the patient groups most frequently mentioned as patients that agencies were reluctant to accept.<sup>61</sup>

A similar survey by the Medicare Payment Advisory Commission (MedPAC) concluded that the IPS was "likely to have a negative effect on beneficiaries." The financial impact of the IPS had led agencies to cost-cutting measures such as avoiding or discharging certain types of Medicare patients, typically long-term chronic, and/or diabetic patients. The analysis concluded, "when these patients lose their home health care, they are fortunate to find care elsewhere, such as in a nursing home."<sup>62</sup>

In order to evaluate the claim that delays in placing beneficiaries had become more common, the OIG compared pre- and post-IPS hospital lengths of stay for patients in the top 12 diagnosis related groups (DRGs) commonly discharged to home health agencies. While average lengths of stay did not increase significantly, the review found that the proportion of discharges to home health agencies among patients with certain diagnoses had changed, sometimes markedly. Most striking, the admission rates to home health agencies of complex coronary bypass patients dropped from 2.2 percent of all discharges in 1997 to only 0.1 percent of the discharges in 1999 and 2000, a 95 percent decline.<sup>63 64</sup>

Taken together, these studies suggest that the BBA had a concentrated effect on high-cost home health beneficiaries, both in terms of initial access to care and sustained adequacy of care. Ironically, this was precisely the category of Medicare patients that the 1980 amendments were designed to benefit. The disproportionate impact on this subset of beneficiaries not only reflects the payment incentives in IPS and provider reaction to substantial reductions but also operates in the context of the industry upheaval that followed the enactment of the BBA.

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<sup>59</sup> Smith, B.M. et al. "An examination of Medicare home health services. A descriptive study of the effects of the Balanced Budget Act interim payment system on hospital discharge planning." Washington, DC: The George Washington University Medical Center for Health Services Research and Policy, September 1999.

<sup>60</sup> Scanlon, W. (1999). Medicare Home Health Agencies: Closures Continue, with Little Evidence Beneficiary Access is Impaired. Washington, DC:GAO/HEHS-99-120.

<sup>61</sup> Ibid.

<sup>62</sup> Stoner, D. et al. "Medicare Payment Advisory Commission (MedPAC) home health agency survey, 1999." Cambridge, MA: Abt Associates, 1999.

<sup>63</sup> Brown, J. "Medicare Beneficiary Access to Home Health Agencies: 2000." OEI-02-00-00320. Washington, DC: Office of Inspector General, September 2000.

<sup>64</sup> One limitation of the OIG analysis—beyond the fact that they, again, were only examining the minority of home health users coming from hospitals—is that they failed to examine data for patients requiring daily services such as injections.

## EFFECT ON AGENCY OPERATIONS

The magnitude of the reductions had a dramatic impact on the home health market. The number of certified agencies decreased from 10,807 in 1997 to 9,330 in 1999 and fell to 7,160 by the end of 2000. The trend continued through the first year of PPS in December, 2001, as the number of home health agencies declined to 6,881.<sup>65</sup> Although a few new agencies entered the market in those years, over 4,000 agencies have ceased serving the Medicare population—a 36 percent decline in the number of agencies in only three years. The number of beneficiaries served decreased by about 840,000 from 1997 to 1999, visits per person served declined from about 80 to 46, and expenditures per person served fell from about \$5,000 to \$3,100, a drop of nearly 40 percent. Total expenditures declined from \$16.2 billion in 1997 to \$9.0 billion in 2000, a 44 percent reduction in three years. Verifiable data for later years is not yet available.<sup>66</sup>

### Exhibit 3.1

#### Medicare Home Health Utilization Statistics, By Quarter, 1996-1999

Quarter	Users per 1,000 beneficiaries	Visits per user			Payments per user	
		All types	Skilled Nursing	Other skilled*		
Prior to BBA						
1996-Q1	52.7	35.7	14.8	3.6	17.3	\$2,201
1996-Q2	53.6	36.7	15.1	3.7	17.9	\$2,274
1996-Q3	53.3	37.1	15.2	3.7	18.2	\$2,310
1996-Q4	53.5	36.9	15.2	3.7	18.0	\$2,316
1997-Q1	55.1	36.1	14.8	3.8	17.5	\$2,266
1997-Q2	54.7	36.8	15.0	3.9	17.9	\$2,323
1997-Q3	53.0	36.9	14.9	3.9	18.0	\$2,338
IPS phase-in						
1997-Q4	50.5	36.0	14.9	3.9	17.2	\$2,310
1998-Q1	48.0	31.3	13.7	3.7	13.8	\$2,042
1998-Q2	43.0	30.1	13.8	3.9	12.4	\$1,993
1998-Q3	38.9	28.3	13.2	3.9	11.2	\$1,864
IPS fully implemented						
1998-Q4	37.1	26.6	12.6	4.0	10.0	\$1,750
1999-Q1	37.1	25.3	12.2	4.1	9.0	\$1,691
1999-Q2	35.9	25.2	12.1	4.3	8.8	\$1,713
1999-Q3	33.3	25.3	12.4	4.3	8.6	\$1,751
1999-Q4	32.7	24.9	12.0	4.4	8.5	\$1,749

**Source:** McCall et al. analysis of Center for Medicare and Medicaid Services (CMS) 1 Percent Denominator and Home Health Standard Analytic Files (McCall et al., "Medicare Home Health Before And After The BBA," Health Affairs 20(3): 189-198)

\*Includes physical therapy, occupational therapy, speech language pathology, and medical social services

<sup>65</sup> CMS Office of Information Services, February 2002

<sup>66</sup> It is worth noting that the post-BBA decline in Medicare home health expenditures does not appear to have been compensated by growing outlays for home health care by other sources such as Medicaid or private out-of-pocket expenditures. Private fund expenditures for home health care increased slightly between 1997 and 2000, from 14.8 billion to 15.5 billion. State and local expenditures increased from 3.9 billion to 4.3 billion. However, given the huge declines in Medicare home health expenditures in the same period, this was not nearly enough to keep the monetary inflow into the home care industry for services rendered constant; total home health expenditures by all financing sources declined from 34.5 billion in calendar year 1997 to 32.4 billion in 2000 (CMS 2000 National Health Expenditures tables).

The decline in the number of home health agencies, home health beneficiaries, and Medicare home health expenditures that resulted from the BBA is reflected in the employment figures for the home health industry. Nationwide, sixty thousand non-supervisory positions in the industry were lost between 1997 and the second quarter of 2001 (from 655,000 jobs to 595,000 jobs). At the same time, the remaining workers have seen much smaller wage increases than their peers in other health care sectors.<sup>67</sup>

While reductions in the number of home health aides had been anticipated, agencies also reduced their skilled and specialty nursing staff as well as therapists and social workers. The reduced wages made it more difficult to compete for nurses in staffing positions that agencies chose to maintain, aggravating problems created by a more generalized nursing shortage.<sup>68</sup> In addition to the general staffing changes, agencies also changed their mix of services to meet per beneficiary limits. As the IPS was implemented, the number of aide visits declined more sharply than skilled nursing visits (see Exhibit 3.1). The number of aide visits per home health user fell by more than half; skilled nursing visits decreased by about 19 percent; and other skilled visits increased by 13 percent. This resulted in a shift in the mix of services towards skilled care visits.<sup>69</sup>

Some of these changes, such as a greater emphasis on skilled services, may be beneficial and may have produced better outcomes for patients receiving those services.<sup>70</sup> However, what has resulted is a clear contraction in the basic infrastructure supporting home health services at every level affecting basic capacity and flexibility, even as the need for home care can be expected to burgeon with the anticipated large increase in the Medicare population.

## IMPLICATIONS

Available information indicates that agency responses to IPS incentives had a varying impact on beneficiaries depending on their health status. The evidence suggests that because they generated the greatest adverse disparity between costs and payment, the sickest patients most vulnerable to disruptions in care were in fact the beneficiaries who were most likely to experience problems in obtaining and sustaining access to care. Moreover, some evidence indicates that more expensive services such as nursing facility services may have been substituted for home care.

Conversely, it appears that substantial capacity has been eliminated from the home health industry, particularly in staffing infrastructure. This reduction has been associated with changes in the availability and intensity of care. The agencies most likely to survive the transition to IPS were the agencies that historically cared for a mix of patients characterized by low-cost needs that were below their regional averages or were the most agile in adapting to IPS through a number of cost-cutting strategies which may have included avoiding or limiting services to high cost/high need beneficiaries. The surviving agencies' history of response to financial incentives and mandates suggests that an additional cut would multiply the focused effects on access to care seen under IPS. To the extent that the additional payment reductions make it more difficult to maintain more basic operations, a wider range of beneficiaries potentially could be affected.

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<sup>67</sup> CMS Health Care Indicators, Second Quarter 2001, tables 4 and 5.

<sup>68</sup> Smith, supra note 55

<sup>69</sup> McCall et al., "Medicare Home Health Before And After The BBA," Health Affairs 20(3): 189-198

<sup>70</sup> Smith, supra note 55

## SECTION 4

# THE REALITY OF THE PROSPECTIVE PAYMENTS SYSTEM AND THE REGULATORY ENVIRONMENT

## INTENT AND STRUCTURE OF THE HOME HEALTH PPS

Introduction of the Medicare home health prospective payment system (PPS) marked a monumental change in operations for certified home health agencies. Some have referred to the change as ‘seismic’.<sup>71</sup> Although original enabling legislation in the Balanced Budget Act of 1997 (BBA ‘97) included a gradual transition to PPS from the interim payment system, the new system became an immediate reality for all providers and beneficiaries on October 1, 2000.

The intent behind PPS is the implementation of a payment system that ties payment to expected service levels needed by beneficiaries. It is built on incentives to encourage providers throughout the country to efficiently deliver appropriate and uniform levels of care to home health patients with similar care needs. The new payment system is part of an overall effort by CMS to link patient assessment, care planning, service delivery, and payments to patient outcomes and quality improvement efforts.<sup>72</sup> The potential of such a comprehensive approach will move service providers toward learning how to monitor and improve the quality of care they provide. It should result in the delivery of similar quantities and combinations of services to similar patients and result in predictable patient outcomes. However, at present the PPS system operates strictly through controlling payments for classes of patients where payment levels, once adjusted for local variation in wage levels are nationally uniform.<sup>73</sup>

The PPS has not changed the eligibility requirements for receiving the home health benefit nor has it changed the types of services covered under it. Under PPS, eligible beneficiaries must be confined to home, in need of skilled nursing or therapy services on an intermittent basis, and under the care of a physician who certifies the plan of care. Covered services continue to be the six services traditionally provided: (1) skilled nursing, (2) home health aide services, (3) occupational therapy, (4) physical therapy, (5) speech therapy, and (6) medical social services. Although the eligibility requirements and covered services remain unchanged, PPS has decidedly changed the methods under which agencies are reimbursed for the care they provide.

Home health payments under PPS are based on expected service levels associated with different categories of patients over a standard period of service referred to as a 60-day episode. Under the cost-based system, the critical unit of service was the visit, but under PPS, the critical unit of service is the episode. Under the cost-based system, the elements that drove program expenditures were the costs for each type of visit and the number of visits delivered. Under PPS, program expenditures are driven by the payment level associated with the 60-day episode and the ultimate number of episodes delivered. Under the previous cost-based system, service provision was based on whatever was determined to be clinically necessary with no incentives to be particularly efficient. Under PPS, there are predetermined expectations of how much care is required based on the results of a standardized assessment, and the responsibility of delivering the care in an efficient manner rests with the agency’s ability to manage the care where the incentive is to be as efficient as possible. Under the cost-based system, reimbursement was based on agency costs; under PPS, payments are based on a national standard rate.

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<sup>71</sup> MedPAC Jan. 16, 2002 Meeting

<sup>72</sup> 65 *Federal Register* 41168 (July 3, 2000)

<sup>73</sup> 65 *Federal Register* 3748-3763 (January 25, 1999)

Under PPS, beneficiaries may receive an unlimited number of episodes so long as the need for care is certified by a physician as medically necessary, but the payment for the episode is a predetermined amount based on the combination of different patient characteristics. Under the consolidated billing requirements of PPS, the predetermined amount is expected to cover all costs of services furnished during the episode including routine and non-routine medical supplies and therapeutic services provided under an established plan of care. Non-routine medical supplies include those *unrelated* to the plan of care. The only exception to the consolidation is the use of durable medical equipment (DME) including oxygen and oxygen supplies.<sup>74</sup> To deal effectively under the new payment system requires sophisticated management systems and expertise.<sup>75</sup>

The agencies that comprise the Medicare home health industry vary greatly in their levels of management sophistication. Although there are large corporate home health providers, much of the industry is comprised of small agencies, particularly in rural areas. Thus, the capacities to meet the management challenges introduced by PPS vary.<sup>76</sup> Management expertise was required under the cost-based system and compounded by the aggregate visit and beneficiary cost limits imposed by IPS. Many agencies could not or chose not to survive the challenge. Even more sophisticated management expertise and information analysis is required under PPS.

Under PPS, agency management has to continue tracking visits per patients, but must have the added capacities to integrate clinical, service utilization, medical supply, and financial information so as to understand the costs of providing care within an episode for different categories of patients. Built into the effort must be the capacity to continually monitor these various aspects both for individual patients as well as for the agency as a whole. This capacity entails considerable costs for establishing and maintaining sophisticated management systems and expertise.<sup>77</sup> Understanding the complex array of procedures that govern the new reimbursement system is a critical challenge to management that is compounded by tremendous uncertainties built into the present PPS system.

A basic understanding of PPS as a payment system is necessary in order to appreciate its impact on providers and patients. The principal components are (1) the episode of care; (2) Home Health Resource Groups or HHRGs which are used to classify patients into payment categories; and (3) the national standardized 60-day episode payment rate, referred to in this report as the '*NSPR-60*.' Appendix C: A PPS Primer provides additional detailed information on the mechanics of PPS.

## THE BASIC STRUCTURE OF HOME HEALTH PPS

### *Episodes of Care*

Under PPS the service unit is the 60-day episode. The initial 60-day episode begins with the first billable visit and ends 60 days later. Any consecutive episode begins on the 61<sup>st</sup> day and then extends an additional 60-day period.<sup>78</sup> As previously noted, payments are based on episodes and there is no limit on the number of episodes.

<sup>74</sup> 64 *Federal Register* 3748-3763 (January 25, 1999)

<sup>75</sup> Fazzi, R. et al. (2000) "the National PPS Expert Design Project: Final Report," *Caring Magazine*, October, pp. 36-50., p. 40.

<sup>76</sup> *Ibid.*

<sup>77</sup> *Ibid.*

<sup>78</sup> Grimaldi, P. (2000), "Medicare's New Home Health Prospective Payment System Explained," *Healthcare Financial Management*, p. 46-55.

### ***Home Health Resource Groups and OASIS***

The payment rate for each episode is predetermined based on the classification of beneficiaries into case-mix groupings derived from their predicted resource use (HHRGs).<sup>79</sup> The patient categories are derived from the use of the previously mentioned standardized assessment tool, OASIS.<sup>80</sup> Use of OASIS as the standard assessment tool became a “Condition of Participation” for Medicare home health agencies in 1999.<sup>81</sup>

### ***OASIS as a Basis for Classifying Home Health Beneficiaries***

Algorithms called ‘case-mix groupers’ categorize patients using 23 of the 79 OASIS items distributed across three domains: (1) clinical severity, (2) functional status, and (3) service utilization characteristics. There are four clinical severity levels (0-3),<sup>82</sup> five functional levels (0-4), and four service utilization levels (0-3) resulting in 80 HHRGs. A patient is assigned into one of the 80 categories by combining the severity levels from the three dimensions where: C represents clinical; F represents functional; and S represents service utilization. Thus COFIS2 designates a beneficiary with low levels of medical needs (C0), with moderate functional impairment (F1), and higher needs for rehabilitation services (S2).<sup>83</sup>

### ***The National Standardized 60-Day Episode Payment Rate (NSPR-60)***

The basic elements that underlie the ‘NSPR-60’ are either directly mandated or implied by legislation. The BBA ’97 required the Secretary to establish a home health PPS that pays for all covered services including medical supplies based on a prospective amount. Legislation also required that the total expenditures for the prospective payment system at its inception (FY ’01) be budget neutral to “what would be expended under the interim payment system [IPS].”<sup>84</sup>

The *NSPR-60* represents the national average cost for a 60-day episode of care adjusted to be budget neutral. The budget neutrality targets were modified under legislation<sup>85</sup> so there were two *NSPR-60s*, covering FY ’01:<sup>86</sup> \$2,115.30 for episodes between October 1, 2000 and April 1, 2001 and \$2,161.84 for episodes between April 1, 2001 and October 1, 2001.<sup>87</sup> For FY ’02 the rate is \$2,274.17.<sup>88</sup>

### ***The Basis for Payment Levels***

Under PPS, episode payment levels are adjusted by case-mix as represented by the HHRG and by local wage levels. Each HHRG has a derived numeric value<sup>89</sup> that indicates how much the cost for a particular HHRG differs from the overall *NSPR-60*. The 60-day payment level for each HHRG is calculated by multiplying the *NSPR-60* by the value associated with each HHRG. The agency payment is adjusted for the wage levels in a local area where the patient is served by adjusting labor-related portion

<sup>79</sup> 64 *Federal Register* 3748-3763 (January 25, 1999)

<sup>80</sup> OASIS is an acronym for Outcome and Assessment Information Set.

<sup>81</sup> Conditions of Participation are the requirements that an home health agencies must meet to participate in Medicare.

<sup>82</sup> Higher numbers indicate greater severity.

<sup>83</sup> Example given in Grimaldi, *supra* note 78.

<sup>84</sup> 65 *Federal Register* 41130 (July 3, 2000)

<sup>85</sup> Section 502 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 restored the full home health market basket update for home health services for FY01

<sup>86</sup> CMS Transmittal Notice A-01-06, January 16, 2001.

<sup>87</sup> Section 502 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 restored the full home health market basket update for home health services for FY ’01, CMS Transmittal Notice A-01-06, January 16, 2001.

<sup>88</sup> MedPAC Report to the Congress: Medicare Payment Policy, March 2002, p. 94.

<sup>89</sup> Called its *relative cost weight* and represents the expected level of resource use required by the patient

of the payment (77.668 percent of the total).<sup>90 91</sup> An example in Appendix C illustrates how the 60-day episode payment is calculated.

## PAYMENT UNCERTAINTIES UNDER PPS

Under the old system agencies could expect a level of cash flow somewhat commensurate with their costs of operations. Agencies billed Medicare monthly or received a standard periodic interim payment referred to as a PIP. Under the old system, payments and claims were eventually settled through a process of balancing over- and underpayments.

Under PPS, payments are exclusively based on episode payments. After conducting an OASIS assessment and establishing a HHRG an agency submits a *request for anticipated payment*, referred to as a RAP. The total anticipated payment amount for the RAP is based on the categorization of the patient into a HHRG. Under PPS, Medicare pays for the episode in two payments. An agency receives a partial payment of 60 percent after submission of the RAP. It then receives a final payment (40 percent) at the close of the 60-day episode after the agency submits its claim. Although the expected period of service is the 60-day episode and the expected payment amount is the NSPR-60 adjusted for case-mix (HHRG) and local wage rates, there are potential adjustments to the standard payment amount for special circumstances that create payment uncertainties for the agency in trying to anticipate revenue.

Medicare pays less than the expected 60-day episode rate if there are interruptions in the plan of care (partial-episode payments or PEPs) or if service levels delivered during the episode fall below threshold levels. Episodes with fewer than 5 visits are paid under a low-utilization payment adjustment or LUPAs. Under LUPAs, the agency is not paid the per episode amount, but rather, is paid based on the actual number and type of home health visits provided. The payments are based on national standardized per-visit rates, and adjusted for local wage-rates.<sup>92</sup> Episodes with fewer than expected therapy visits may also be adjusted if the actual number of visits delivered in the 60-day episode is below the therapy threshold, defined as 10 visits and referred to as the 10-visit therapy threshold. Intermediaries in reviewing final episode payments check to make sure that the specified number of therapy visits in the plan of care were actually delivered during the 60-day episode. In the event that the actual number delivered is below the threshold, the 60-day episode payment is adjusted downward to reflect the actual number of visits.

Episode payments may also increase if patients during an episode experience a significant change in condition (referred to as SCIC) that requires a change in the plan of care and increased levels of service or if costs exceed the amount covered by a HHRG. The SCIC must be sufficient to require a new OASIS assessment and results in classification of the patient into a new HHRG. Reflecting the increased use of services, the new 60-day episode payment would be larger than previously expected and represents the prorated amounts between the two different HHRGs.

<sup>90</sup> 65 *Federal Register* 41183 (July 3, 2000)

<sup>91</sup> Because labor-related rates are not available for home health, payments in FY01 are adjusted by Medicare's hospital wage index for the geographic area where the beneficiary receives care.

<sup>92</sup> Final standardized per visit payment amount per 60-day episodes for FY 2001 for LUPA episodes were adjusted under the provisions of Section 502 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 to reflect full market basket costs. The following amounts represent the per visit rates for FY01 before and after April 1, 2001.

Home Health Aide	\$43.37	\$44.32
Medical Social Services	\$153.55	\$156.93
Occupational Therapy	\$105.44	\$107.76
Physical Therapy	\$104.74	\$107.04
Skilled Nursing	\$95.79	\$97.90
Speech-Language Pathology	\$113.81	\$116.31

Source: *Federal Register*, supra note 74

Medicare also adjusts payments for patients who generate unusually high treatment costs during a 60-day episode. Referred to as ‘outlier payments,’ they apply to patients with standard 60-day episodes, PEPs, and for those with SCICs. Such payments are made when patient costs exceed a preset threshold. The actual outlier payment adjustment is 80 percent of the difference between the threshold amount and the costs incurred in serving the patient, derived by multiplying the number of the discipline-specific visits by the per-visit rates under LUPA adjusted for local wage rates. Payment to the agency for the patient is the sum of the adjustment plus the original HHRG amount. CMS describes this adjuster as a ‘share loss’ situation because providers share the loss with the Medicare program for serving very expensive patients at home. Because of the use of the high preset threshold, the outlier payment adjuster would discourage agencies from taking on patients likely to exceed typical payment levels. Appendix C provides an example of how an outlier payment adjustment is calculated.

Outlier payments also pose significant problems for agencies regarding cash flow and revenue recognitions because of the extraordinarily high threshold level used by CMS and because the actual adjustments, made automatically in the processing of the claim, do not meaningfully offset the actual costs (see example in Appendix C).<sup>93</sup>

Although formal studies are absent, anecdotal reports from the industry have indicated that the length of initial visits have increased resulting from both the need for the new more comprehensive assessments required under OASIS and because more efforts are made directed toward patient and informal caregiver education and training.<sup>94</sup> Lengthier initial visits clearly carry high per visit costs and ‘front load’ the costs of providing service. Under the PPS incentives, the costs of the lengthier initial visits can be offset by fewer subsequent visits. For patients whose 60-day episodes are truncated, the non-reimbursed cost of the initial more intensive care is borne by the agency. This problem is intensified when delivered services do not meet anticipated threshold levels, such as when delivered therapy visits during an episode do not reach the expected 10 visit threshold or those cases that result in low utilization payment adjustments (LUPAs).

## **COMPLIANCE WITH REGULATIONS GOVERNING OASIS DATA**

By regulation and in an attempt to standardize procedures, there are specified triggers for completing an OASIS assessment as well as specific time frames for when the assessments must be completed. Assessments are to be routinely completed at the start of an episode of care (including follow-up episodes) and updated after 60 days, the typical end of an episode. Completion of these routine assessments must be accomplished within 5 days of the start and end dates. Assessments are also to be completed if any of the following occur: transfer to an inpatient facility, resumption of care following an inpatient stay, transfer to another home health provider, discharge including death at home, and if a patient has an unexpected change in condition that results in a change in the patient’s HHRG. These assessments are to be completed within 48 hours of the event, and are to be accompanied by a plan of care certified by a physician. There are also requirements that all OASIS assessments be entered into a computer using a standard computer program and locked into the computer system within seven days of completion of the assessment. Prior to the seven-day lock, assessments may be reviewed and edited within the agency. Locking the assessments prevents any further editing of a particular assessment.

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<sup>93</sup> Grimaldi, *supra* note 78, p. 46-55, p. 53.

<sup>94</sup> Preliminary findings from a study of Pennsylvania home health agency operations under PPS (Leon et al., “A Comparison of the Effects of New Medicare Reimbursement Methodologies on Home Health”)

Under the Conditions of Participation, home health agencies are required to complete OASIS assessments on all of their patients, including those not participating in either the Medicare or Medicaid program.<sup>95</sup> CMS estimates that about 46 percent of home health patients are Medicare beneficiaries while another 23 percent are Medicaid beneficiaries.<sup>96</sup> Services for the remaining 31 percent of the patients are covered privately.

There are also requirements that all OASIS assessments for Medicare and Medicaid patients be transmitted to designated state agencies that compile state-level data and transmit it to CMS or a designated intermediary.<sup>97</sup> Agencies are to transmit their OASIS data to state survey agencies on a regular schedule. Home health agencies began submitting OASIS data in August, 1999.<sup>98</sup>

## **COSTS OF COMPLYING WITH REGULATIONS GOVERNING OASIS DATA**

No nationally representative studies have been undertaken to estimate how long it takes to conduct OASIS assessments, but results from a June 2001 survey of 141 home health agencies indicate an assessment conducted at the start of care takes 2 hours and 40 minutes, while a re-certification assessment takes 1 hour and 40 minutes.<sup>99</sup>

As required by statute, CMS estimated that there would be sizable additional aggregate agency costs associated with the collection and reporting of OASIS data both in terms of initial start-up (\$44.4 million) and annual recurring costs (\$22.0 million).<sup>100</sup> Of these agency expenditures, Medicare is expected to offset the start-up costs by \$15.1 million and the on-going costs for reporting by \$10.1 million, leaving the agencies to absorb the remaining \$29.3 million and \$11.9 million respectively.<sup>101</sup> The cost offsets in implementation are partly due to subsequent legislation. As previously indicated, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 made a \$10 payment to offset the costs incurred in conducting OASIS assessments for the transition period to PPS (1999-2000). The continuing offset results from an amount added to the case-mix adjusted episode payment levels to account partially for OASIS costs.

Despite the offsets, an average agency will have incurred \$2,792 of non-reimbursed expenditures as a result of complying with the implementation of OASIS collection and reporting requirements and will incur on an ongoing basis at least \$1,134 annually.<sup>102</sup> Additional non-reimbursed costs will be incurred by agencies under PPS because OASIS assessments are required on all patients including non-Medicare home health patients. The costs for these assessments are either absorbed by the agency or, where possible, passed on to private insurers or to the patient. In some states, the Medicaid program may absorb the cost of conducting OASIS assessments for its recipients.

<sup>95</sup> 64 *Federal Register* 3748-3763 (January 25, 1999)

<sup>96</sup> *Ibid.*, page 3760.

<sup>97</sup> Home health agencies are required to submit their OASIS assessments using a software program called Home Assessment Validation Entry (HAVEN). Designed for CMS the software program runs the OASIS data set through a series of standard editing routines that checks for missing elements and makes it transmission-ready.

<sup>98</sup> Grimaldi, *supra* note 78.

<sup>99</sup> Home Health Line (November 2001). "PPS Benchmarks Handbook." Rockville, MD: Author, p. 58.

<sup>100</sup> *Federal Register* 3782 and 3760 (January 25, 1999)

<sup>101</sup> These estimates are likely to be somewhat overstated given that the estimated number of agencies CMS used in estimating these costs was high, since IPS resulted in the closing of approximated 3,500 agencies.

In estimating the costs, CMS estimated that there would be 10,492 home health agencies in 1999/2000. Since the number of agencies actually declined to 7200 in 1999. Some the estimates of the actual impact is somewhat less than what these numbers would reflect.

<sup>102</sup> *Supra* note 95, pages 3782 and 3760.

## OTHER REGULATORY MANDATES

Associated with the costs of collecting and reporting OASIS information, home health agencies are also expending resources to comply with other new regulations and regulatory burdens. The advent of PPS introduced entirely new procedures for the submission of data. As a result, agencies were required to make significant changes in process, organization, and staffing in the area of claims and information management.

While Medicare encourages electronic claims submission, Medicare regulations do not require the submission of electronic claims. However, because the Medicare Conditions of Participation since 1999 have required the collection and electronic transmissions of OASIS data, all home health agencies must comply with regulations established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) governing electronic transmission of data. CMS estimated that as many as one-half of agencies did not have computers prior to OASIS.<sup>103</sup> With implementation of OASIS and electronic submission of data all home health agencies now fall under HIPAA. Compliance will require substantial changes in the policies, processes and administration governing patient specific health information. Similarly, it will require updates of all information systems that use or collect patient data and will require the introduction of new features and functions.

Additionally, to participate in the Medicare program, agencies must comply with the standards established by CMS under the Medicare Integrity Program that includes routine audits and the medical review process. Such procedures check the accuracy of claims and billing information as well as insure service quality. They also operate to prevent and detect fraud, waste, and abuse.

Recent and pending compliance standards confronting agencies include home health advance beneficiary notifications and new data compliance requirements under Health Insurance Portability and Accountability Act (HIPAA). Another major new compliance requirement called Outcome Based Quality Improvement (OBQI) will go into effect in FY 2003. Regulations are currently being drafted. This new compliance requirement will become a Condition of Participation. State surveyors will use the new quality improvement standards to identify and target "problem" home health agencies.<sup>104</sup>

***Home Health Advance Beneficiary Notice.*** An Advance Beneficiary Notice (ABN) is a written notice given to Medicare beneficiaries before items or services are furnished, when the provider believes that Medicare will not pay for some or all of the items or services because it is anticipated that the items or services will not meet coverage criteria. The ABN is of particular importance when care is ordered by a physician but determined by the agency to not be covered by Medicare. Such instances may include situations where the patient is no longer deemed homebound and thus no longer eligible for Medicare home health services. The notice informs patients that they will be liable for any resulting costs in the delivery of services. Agencies are required to get advance beneficiary notices signed and dated by the beneficiaries before the delivery of care under the new payment arrangements. Without such documentation, the agency becomes financially liable for the costs of the care, even if the physician orders require them.<sup>105</sup>

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<sup>103</sup> Supra note 100.

<sup>104</sup> This new regulatory mandate was unveiled by CMS on February 22, 2002.

<sup>105</sup> CMS Transmittal No. A-99-38.

### ***Health Insurance Portability and Accountability Act (HIPAA) Requirements***

HIPAA established data compliance requirements covering the collection, storage, and transmission of electronic health and health insurance information. The regulations set standards for the coding of information and for administrative transactions and transmission, referred to as HIPAA Transaction Standards. There are also standards regarding the proper handling of identifiable health information to insure the privacy of that data. These are referred to as HIPAA Privacy Standards.

Beginning October 26, 2003, home health agencies are required to be in compliance with the HIPAA Transaction Standards. It is also anticipated that meeting Transaction Standards will continue over an extended period of time. It has been estimated by CBO that meeting these Transaction Standards will cost the home health industry upwards of \$184 million between 2002 and 2011.<sup>106</sup> Beginning in April 2003, the home health industry will also need to comply with the HIPAA Privacy Standards. It has been estimated by Small Business Administration that compliance with the standards will cost the industry \$73 million in the initial year plus \$441 million over the next ten-years (2003 – 2012).<sup>107</sup> All costs associated with meeting these standards are assumed by home health agencies. The cost of implementing these standards is spread equally across individual agencies, regardless of the size. Subsequent costs associated with actual storage and transmission of data will vary with the size of the agencies' caseloads.

The Federal government and Medicare fiscal intermediaries have become more vigilant in their review of Medicare reimbursements to home health care providers generally and are preparing to conduct reviews of a greater number of health care claims with an increased focus on clinical procedures and related documentation.<sup>108</sup> State and Federal enforcement officials also have increased their scrutiny of providers and are applying an increasingly expansive view of activities they believe to be fraudulent or abusive.<sup>109</sup> Changes in the law and regulations as well as new interpretations enforced by the relevant regulatory agencies have a material adverse effect on the agency operations and the cost of doing business.<sup>110</sup> Agencies must comply with additional oversight whether they are good or bad actors.

It is clear that there are substantial costs associated with the collection and processing of both OASIS and claims data. The initial start-up costs are a much greater burden to the smaller home health agencies since they have fewer cases over which to distribute these administrative costs. Under the previous cost-based system, increased administrative costs could be passed along as higher per visit costs. However, under PPS, with its fixed reimbursement rates, higher administrative costs must be absorbed by the agency or passed along to other payment sources.

Systematic studies of these costs have not been undertaken, but anecdotal evidence indicates the costs are substantial. Even before implementation of PPS or the compliance requirements mandated under HIPAA, some home health agencies indicated that regulatory mandates, including compliance with CMS Program Integrity Standards, OIG audits, OASIS, medical reviews, and billing procedure requirements increased the average cost per home health visits by 10.4 percent.<sup>111</sup> There is also testimony that these burdens fall disproportionately on smaller agencies in general, and particularly hard on small, rural, free-standing agencies.<sup>112</sup> Under PPS, the costs of regulation become part of the fixed costs of doing business which are not offset by increases in PPS rates.

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<sup>106</sup> 65 *Federal Register* 50356 (August 17, 2000)

<sup>107</sup> 65 *Federal Register* 82788 (August 17, 2000)

<sup>108</sup> Herbert, W. (2000) "PPS- How Will It Impact Your Agency and Your Practice," *Home Health Nurse*, Vol. 18, No. 2, pp. 94-97.

<sup>109</sup> *Ibid.*

<sup>110</sup> Gent, R. et al. (2001) "Feeling the Effects of PPS – One Year Later," *Caring Magazine*, November, pp. 18-19.

<sup>111</sup> *Supra* note 105

<sup>112</sup> *Supra* note 105

## PPS CLAIM SUBMISSION AND PAYMENTS, AGENCY OPERATIONS, CASH FLOW, AND REVENUE RECOGNITION

The overall flow of the claims process has not changed under PPS from the previous system. Home health agencies submit claims to the Regional Home Health Intermediary (RHHI) who in turn processes the claim and remits payments back to the agency. However, under PPS there are new computer software requirements both for the agencies and the intermediaries, as well as changes in submission, processing, and payment procedures.<sup>113</sup> These changes have imposed new administrative tasks on the agencies and have complicated overall agency operations, particularly regarding cash flow and revenue recognition. For example, payments are also adjusted downward in instances where the number of therapy services delivered during an episode does not meet anticipated therapy thresholds.<sup>114</sup>

Proper documentation continues to be of importance and failure to comply with requirements carries considerable repercussions. Without the proper documentation, CMS has the authority to reduce or disapprove requests for anticipated payments. Without the submission of the fully documented claim within the designated reporting period<sup>115</sup> “the RAP will be canceled and payments recovered from the agency.”<sup>116</sup> The claim’s process can be further complicated by a number of other contingencies. One problem can arise as a result of the home health PPS consolidated billing requirement stipulating that during any 60-day episode of care there can be only one ‘primary’ home health agency provider of record. Primacy in this context is established by recorded submission date of the RAP and continues in force until either the episode ends or there is a properly documented discharge prior to the end of the 60-day episode. Processing requirements stipulate that a provider, prior to submission of a RAP is responsible for verifying that the beneficiary is not currently under a 60-day plan of care established by another home health provider. This inquiry is referred to as a Health Insurance Query for HHAs (HIQH).

To assist agencies, CMS has established a computer-based information system with remote access for conducting this verification, called the Common Working File (CWF). The system is designed to show whether a current RAP for a given beneficiary has been submitted and is in force. However, the CWF-based inquiry system is not currently available to all agencies, so some agencies must rely on access through contact with their financial intermediary. CMS has stated that it believes that these “systems will provide the appropriate information in a timely manner.”<sup>117</sup> However, numerous complaints have resulted from agencies claiming they have received “incorrect information about the episode status of beneficiaries.”<sup>118</sup> In the event of dual billing for an overlapping period, only the primary agency receives payment. A non-primary agency that submits a RAP may receive an initial payment that is later recovered. If a patient is formally discharged from the primary agency before the end of the 60-day episode, the second agency will receive a partial episode payment proportional to the time remaining in the 60-day episode. Without primacy, the secondary agency carries the liabilities for the services rendered.

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<sup>113</sup> CMS, Home Health Manual

<sup>114</sup> 65 *Federal Register* 41163 (July 3, 2000)

<sup>115</sup> The greater of 60 days from the end of the episode or 60 days from the issuance RAP

<sup>116</sup> *Supra* note 117, p. 41141.

<sup>117</sup> *Supra* note 117.

<sup>118</sup> *Supra* note 117.

## MEDICAL REVIEW UNDER PPS

Under the cost-based system and continuing under PPS, medical review of claims are required to supplement the technical audits of records to ensure that payments are proper. As under the cost-based system, the goal of medical review is to determine whether services provided are reasonable and necessary, delivered and coded correctly, and appropriately documented. CMS contracts with insurance carriers, fiscal intermediaries (FIs), and program safeguard contractors (PSCs) to perform medical review functions.

According to guidelines, medical reviews are “conducted on [both] a random and targeted basis.”<sup>119</sup> Random reviews are based strictly on statistical parameters. “Random review will allow RHHIs to identify normal provider billing practice patterns as well as potential payment errors under the new system. The information gained is used to formulate educational interventions, and aid in developing further review strategies.”<sup>120</sup> These analyses will include billing information as well as data from internal and external sources including provider audits, fraud and abuse concerns, as well as complaints from beneficiaries and other sources.<sup>121</sup> In some instances, supporting medical record is requested from the agency. Such documents could include copies of a plan of care, physician orders, OASIS assessments, medical records including clinical notes, treatment and flow charts, and records of vital signs.<sup>122</sup> The full strategy for conducting medical reviews under PPS is still being developed. One aspect of the review process that has changed under PPS focuses on whether the OASIS information is supported by the medical record documentation.<sup>123</sup> How the medical review process will interpret medical necessity under the new system and particularly the medical necessity of home health aide visits remain unclear.

Although there are currently no published studies of denial rates under PPS resulting from medical reviews, the determination can result in payment rescission. For example, HHRG codes can be changed based on medical review of claims.<sup>124</sup> Until more uniform procedures are established for medical reviews under PPS, agencies operate with a degree of financial uncertainty. Under PPS home health agencies continue to have all appeal rights previously associated with home health claims.

## RESIDUAL EFFECTS OF IPS COMPOUNDING THE IMPLEMENTATION OF PPS

Anecdotal evidence indicates two lingering effects from IPS that weaken many agencies’ ability to meet the extra administrative challenge imposed by PPS and any additional reduction. One is the obligation to repay accumulated Medicare liabilities accrued during the IPS period. The other is the rebuilding of agency staff reductions that resulted from the dramatic and extensive downsizing that occurred during IPS<sup>125</sup>

### *Overpayment Debt*

Although there are no published studies documenting how many agencies have overpayment liabilities, by the CMS’s estimate, nearly 60 percent of the nation’s home health agencies exceeded the payment rates instituted under IPS. It is unlikely that 60 percent of currently operating home health

<sup>119</sup> Home Health Manual, 2002, p3.

<sup>120</sup> Medicare Home Health Prospective Payment System Training Guide, Chapter V. The Blue Cross and Blue Shield Association, July 3, 2000, p. 2.

<sup>121</sup> Supra note 123, p. 3.

<sup>122</sup> Supra note 123, p. 10.

<sup>123</sup> Hood, F.J. (2001) “Medicare’s Home Health Prospective Payment System,” Southern Medical Journal, Vol. 94, No. 10, pp986-989.

<sup>124</sup> CMS, Home Health Manual, 66.10

<sup>125</sup> Testimony Before the Finance Committee, United States Senate, Impact of 1997 BBA Provisions on the Medicare Fee-for-Service Program, by Mary Suther, June 10, 1999.

agencies carry overpayment burdens since many of the agencies with the greatest burdens are likely to have closed. Nonetheless a considerable portion of the industry may still be operating under substantial repayment debt arising from late notification of IPS limits and by mistakes by FIs. Recent testimony from the home health industry indicates that repayment liabilities from the IPS period continue to be wide spread.<sup>126 127</sup> CMS has not released nationwide statistics on overpayments, but one fiscal intermediary reported that for 1998, 84 percent of its \$1 billion plus in overpayments were attributable to IPS. Most agencies facing large-scale payback liabilities have negotiated extended payback agreements with CMS, some extending through 2005.

### ***Staffing Reduction***

Staffing shortages appears to be another major lingering effect because the IPS payment reductions were so deep and implemented so quickly. The decline is reflected in the employment figures for the home health industry. As previously reported there was a 9.2 percent drop in non-supervisory employment in the home health industry between 1997 and 2001.<sup>128</sup> This reduction is confirmed by case studies on agency reactions to IPS.<sup>129</sup>

Evidence has been presented that during IPS, agencies reduced their staff by as much 42 percent.<sup>130</sup> Evidence from other sources indicates that the staffing cutbacks were wide spread. Conclusions from a study examining the across-the-board impacts of BBA '97 in six states, Iowa, Kentucky, Mississippi, Montana, Pennsylvania, and Texas, highlighted substantial reductions in home health staffing and services.<sup>131</sup> Two OIG reports examining access to care under PPS in the 10 states<sup>132</sup> with the highest number of home health beneficiaries also discovered access problems related to home health staff shortages for both recently discharged hospital patients and for patients being admitted from the community. In interviews with hospital discharge planners, about one quarter reported home health staffing shortages in their areas contributed to delays in placement. These discharge planners most commonly attributed the home health staff shortages as arising from the effects of IPS.<sup>133</sup> In a study examining home health care patients admitted from the community, interviews were conducted with aging network representatives, home health agencies, physicians, and home health hotline representatives. Results from the interviews indicated that staffing problems at home health agencies contributed to problems in gaining access to care.<sup>134</sup> Thus, the weight of the accumulated evidence points to significant staffing problem across the home health industry. IPS may have magnified workforce shortages experienced by the industry because of the salary reductions it triggered. The evidence suggests that staff shortages at agencies appear to directly affect patient access to care. There is no evidence that these shortages have abated or that the ability of agencies to compete for skilled personnel has improved under PPS.

<sup>126</sup> William A. Dombi, National Association for Home Care, "Rural Health Care Services: Has Medicare Reform Killed Small Business Providers?" Prepared Remarks to the House Committee on Small Business June 14, 2000.

<sup>127</sup> Testimony Before the Finance Committee, United States Senate, Impact of 1997 BBA Provisions on the Medicare Fee for Service Program, by Mary Suther, June 10, 1999.

<sup>128</sup> CMS Health Care Indicators, Second Quarter 2001, tables 4 and 5.

<sup>129</sup> Smith, *supra* note 55

<sup>130</sup> Testimony Before the Subcommittee on Health of the House Committee on Ways and Means Hearing on Medicare Balanced Budget Act Refinements, Pamela Bataillon, Vice President, Visiting Nurse Associations of America, and Vice President of Business Development, Visiting Nurse Association of the Midlands Omaha, Nebraska, October 1, 1999.

<sup>131</sup> Hart, G. (2001) "Impact of the 1997 Balanced Budget Act (BBA) on Rural Hospitals," WWAMI Rural Health Research Center, a paper presented at National Rural Health Association Meeting, October 7, 2001.

<sup>132</sup> California, Florida, Illinois, Louisiana, Massachusetts, Michigan, New York, North Carolina, Pennsylvania, and Texas.

<sup>133</sup> Office of Inspector General. (2001) "Access to Home Health Care After Hospital Discharge, 2001." OEI-02-01-00180. Washington, DC: Author, July.

<sup>134</sup> Office of Inspector General. (2001) "Medicare Home Health Care Community Beneficiaries 2001." OEI-02-01-00070. Washington, DC: Author, October.

Access to care will continue to be affected by worker shortages regardless of whether they are directly the result of IPS. Finding and recruiting home health personnel requires considerable resources. Agencies whose financial viability had been impaired as a result of IPS have less flexibility and will find it more difficult to compete for workers. Moreover, recruitment and retention of quality staff, including both the direct care, support, and management staff will play a significant part in the future success of transforming home health under the opportunities afforded by PPS. The lingering effects of IPS could adversely affect the quality and range of services agencies provide as well as the ability of CMS to determine accurately the level of services actually needed by beneficiaries. Some agencies will be unable to serve eligible beneficiaries because they do not have appropriate skilled staff. In other circumstances, agencies with reduced staffing may avoid serving patients with intensive needs because of the added pressures imposed by patients with heavy care needs. These effects could distort data received through PPS.

**SECTION 5**

**THE POTENTIAL IMPACT OF  
A FURTHER PAYMENT REDUCTION**

**INTRODUCTION**

On October 1, 2002 an additional reduction in reimbursement for Medicare home health is scheduled to take effect. Although initially mandated for October 1, 1999, since implementation of PPS was delayed for one year, the implementation of the budget neutrality requirements of PPS were also delayed until October 1, 2000.<sup>135</sup> In addition to delaying the start of PPS, the amending legislation also changed the contingency language regarding the 15 percent reduction by linking the reduction directly to PPS payments.<sup>136</sup>

In reaction to growing concerns that the real effects of the IPS expenditure curbs were greater than anticipated, the implementation of the 15 percent cut was postponed until one year after PPS implementation (October 1, 2001)<sup>137</sup> and delayed for an additional year under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), from October 1, 2001 to October 1, 2002.<sup>138</sup>

Highlighting the concerns about the level of payment cuts imposed under IPS, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), which originally postponed the cut from 2000 to 2001, also stipulated that the Secretary should report “within 6 months of implementation of PPS on the need for the 15 percent reduction.”<sup>139</sup> In postponing implementation of the 15 percent cut from 2001 to 2002, BIPA ‘00, although maintaining the report requirement, shifted the responsibility for the report from the Secretary to the Comptroller General. Due by April 1, 2002, the report is to analyze the need for the 15 percent or other reduction.<sup>140</sup> The legislation also restored the full home health market basket update for FY ‘01. As previously indicated this restoration of the full market basket update increased both the NSPR-60 that underpins the reimbursement rates for HHRG payment episodes and the per visit rates used in the determination of payments for LUPAs and for outlier payments.<sup>141</sup> In addition, BIPA provisions reflecting the concerns of the payment reductions imposed by IPS on small rural agencies, also mandated a temporary 10 percent payment increase for home health services furnished to beneficiaries in rural areas extending over a 24-month period ending April 1, 2003.<sup>142</sup> This provision again increased payment rates for all types of episode payments.

Considering the necessity of the cut, there are basically three overriding questions. First, is the cut still necessary in light of the dramatic expenditure reductions imposed by IPS and maintained as a result of the budget neutrality requirements governing the implementation of PPS? Second, to avoid waste and misuse in the system, do payment rates need reductions as a

<sup>135</sup> Supra note 6, section 1895(b)(3)(A)(ii)

<sup>136</sup> The 1999 Omnibus Consolidated and Emergency Supplemental Appropriations Act, (OCESAA): “the standard prospective payment limitation amounts be budget neutral to what would be expended under the current interim payment system with the limits reduced by 15 percent at the inception of the PPS on October 1, 2000.”

<sup>137</sup> The Balanced Budget Refinement Act of 1999 (Public Law 106-113), Section 302

<sup>138</sup> Ibid., section 501

<sup>139</sup> Ibid., section 302

<sup>140</sup> Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), section 501

<sup>141</sup> Ibid., section 502

<sup>142</sup> Ibid., section 508

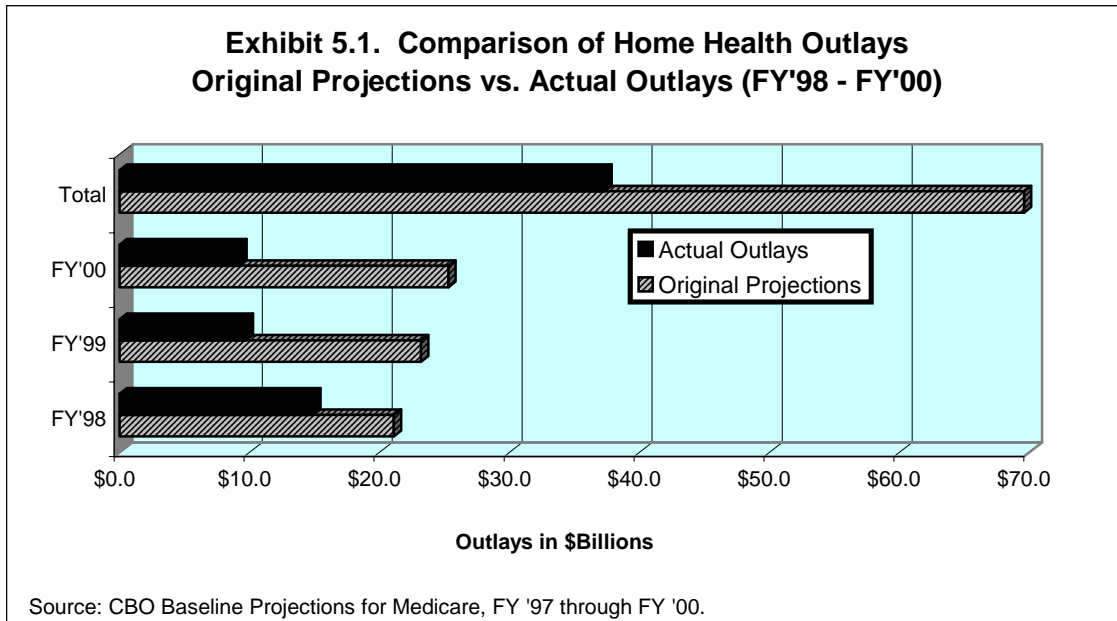
result of changes either in the case-mix needs of the beneficiaries or in the patterns of care delivered? Finally, what impact would a reduction in the payment rates have on access to care?

**NECESSITY OF THE CUT: CONGRESSIONAL INTENTION**

The intent of Congress in enacting the BBA '97 was primarily to curb costs in the Medicare program. Prior to the implementation of the expenditure limits imposed by IPS, the Congressional Budget Office's FY '97 baseline projections of home health expenditures show that CBO expected a 9.1 percent annual growth rate in Medicare home health outlays between FY '98 and FY '02, going from \$21.1 to \$29.9 billion respectively, an increase of 41 percent.<sup>143</sup> In their 1997 analysis of the expected impact of the home health provisions under BBA '97, CBO projected total payment reductions of \$16.2 billion for this period which included the expected 15 percent reduction.<sup>144</sup>

Exhibit 5-1 compares the original projected home health outlays to actual outlays for FY '98 to FY '00. Projected outlays for FY '98 to FY '00 were expected to total \$69.6 billion. Actual outlays totaled \$37.3 billion, a 46 percent reduction. In FY '98 reductions equaled \$6.2 billion; in FY '99, \$13.5 billion, and in FY '00 \$16.1 billion. For the 3-year period total actual expenditure reductions were \$35.8 billion. IPS in three years resulted in reductions in expenditures that were twice the amount expected for the entire five-period. Thus, after three years, the savings achieved by IPS already exceeded the stated objective of IPS and the 15 percent cut combined.

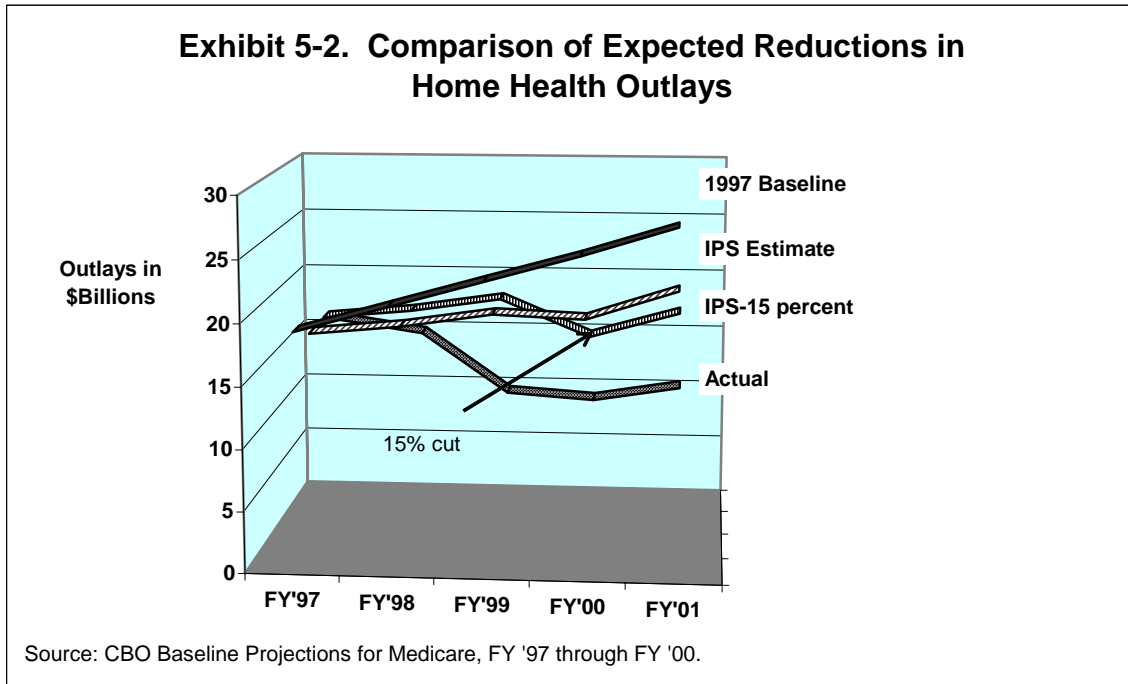
Current projected reductions for the remaining two years, FY '01 and FY '02, total an additional \$35.3 billion yielding total expected reductions of over \$71.1 billion over the 5-year span. If the current projected reductions are realized, by FY '02, total reductions will exceed the original \$16.2 billion by nearly four-fold.



<sup>143</sup> Congressional Budget Office. CBO Baseline Estimates, January 1997. Washington, DC: Author.

<sup>144</sup> CBO, supra note 35

Exhibit 5.2 shows graphically just how deep the actual reductions have been over the five years spanning the IPS period and the first year of PPS (FY '97 through FY '01). It compares actual home health outlays to the projected baseline outlays and outlays of the expected effects of IPS both with and without an additional 15 percent cut implemented in FY '00. Thus, across the five-year span, the intended total reduction of IPS with and without the additional 15 percent cut reaches \$20.8 and \$26.7 billion respectively. However, neither figure approaches the now anticipated reduction of \$54.5 billion.



It seems apparent that the anticipated savings goals for home health mandated by BBA '97 have been surpassed even with the imposition of an additional 15 percent cut. The most dramatic declines in home health occurred in FY '98 and FY '99. According to the March 2000 Congressional Budget Office (CBO) baseline, Medicare home health payments fell by almost 35 percent in FY 1999, and this was on top of a 15 percent drop in FY 1998. CBO cites this "larger than anticipated reduction in the use of home health services" as the primary reason that total Medicare spending dropped by one percent in FY '99 a disproportionate share of the reduction burden by the sector that accounted in 1997 for 10 percent of Medicare spending.<sup>145</sup> To paraphrase from a recent hearing of the Medicare Payment Advisory Commission (MedPAC), evidence suggests that the short-term intent of BBA '97 "has been substantially achieved."<sup>146</sup>

In the absence of cost reports from agencies under PPS to quantitatively analyze the appropriateness between current costs and current payment levels, MedPAC has used movement into and out of the sector as a secondary indicator of whether costs and payments are out of balance where large movement into the sector would indicate excessive payment levels.

<sup>145</sup> Congressional Budget Office. CBO Baseline Estimates, March 2000. Washington, DC: Author.

<sup>146</sup> Testimony before the Medicare Payment Advisory Commission, Public Meeting December 13, 2001, transcript p. 6

“The fluidity of this market makes entry and exit a reasonable indicator of the relationship of payments to costs . . . In the past we have seen substantial movement of providers in and out of this program. However, in the past two years the number of agencies participating in the program has stabilized.”<sup>147</sup>

Thus, it appears that payment under PPS is not generous enough to draw new market entrants.

In addition to controlling spending, the larger purpose in establishing the home health PPS is to set into place a case-mix program that has the capacity to allow gradual refinement in adjusting the level of payments to the level of care required with the eventual goal of developing clinical standards for care based on the use of expected levels of outcomes for patients with particular illness profiles. This quality improvement effort has already begun with the transformation of the Professional Review Organizations (PROs) into Quality Improvement Organizations (QIOs). However, the development of practical clinical standards will require considerable historical data from the existing OASIS assessments and claims files. It makes sense to conclude that it will take a considerable period of stable operations to compile the wealth of data that will be necessary to develop clinical standards and the quality improvement measures. If there is continual tinkering with the payment incentives built into the system, the resulting accumulated data will not reflect the natural process of providing services under the most efficient incentives, thus hampering the ability to develop clinical standards for home health care. In the absence of definitive data that PPS payment levels are grossly out of line with the actual costs of providing care, and in the absence of clinical standards to determine the adequacy of care, it seems ill advised to cut payments beyond the unprecedented reductions already observed.

## IMPACT OF AN ADDITIONAL PAYMENT REDUCTION ON ACCESS TO CARE

The question is whether an additional cut will further reduce access to covered home health services for those who have a right to receive them. Evidence from studies from OIG and MedPAC indicate that in general access is not limited under PPS.<sup>148</sup> However, evidence presented both in these reports as well as other studies suggests that access for subgroups of patients was a problem under IPS and may continue to be a problem under PPS. Patients with complex care needs, like wound care, or those with serious, chronic conditions, such as COPD or CHF, have seen their access to this benefit reduced in recent years.<sup>149</sup> GAO similarly suggested that the IPS created incentives for agencies to serve low-cost patients.<sup>150</sup> The types of patients experiencing access problems reflect the increasing numbers of disabled elderly who have multiple chronic health conditions that require combinations of skilled and related supportive services. The question of what impact on access the additional cut will have revolves around two basic concerns: (1) will general access be curtailed?, and (2) will access for the sub-groups of patients who have historically experienced access problems be further curtailed?

<sup>147</sup> Ibid., p. 5

<sup>148</sup> OIG Report, “Medicare Home Health Care Community Beneficiaries 2001,” October, 2001, OEI-02-01-00070; OIG Report, (2001) “Access to Home Health Care After Hospital Discharge, 2001,” July, 2001; Medicare Payment Advisory Commission, Report to the Congress: Medicare in Rural America, June 2001

<sup>149</sup> Smith, B.M., supra note 55; Davitt, supra note 48.

<sup>150</sup> GAO, supra note 60

Without having PPS data for analysis, these questions as to whether an additional across the board cut in the benefit would exacerbate the problems created by the IPS remains empirically unanswerable at this time. There is not enough available experience with PPS to even model the likely effects.

Any data that might be available from the earliest period under PPS is unlikely to be reliable due to the way PPS was introduced. All current patients on October 1, 2000 began new 60-day episodes of care.<sup>151</sup> Since a significant proportion of these cases were already receiving care, and some for a substantial period prior to the PPS start date, the resulting episodes of these patients would actually reflect abbreviated episodes with artificially reduced numbers of service visits supplied during these episodes. These episodes could be expected to be substantially different when compared to episodes of new patients starting new episodes

However, it is possible to anticipate the likely effects given what is known about the present capacities of home health providers to withstand an additional cut and their previous reactions to broad-based cuts under IPS.

### **PROVIDER CAPACITIES TO WITHSTAND AN ADDITIONAL CUT**

The issue of capacity for any given provider let alone the provider community rests on assessing three broad factors: (1) the residual vulnerabilities from IPS; (2) agencies' capacities to cope with the new complexities and uncertainties imposed by PPS regardless of the spending cut; and (3) the capacity of agencies to function under the increased regulatory environment associated with, but not limited to, PPS. Decisions about these concerns could be more fully informed through studies of representative samples of providers. In the absence of such studies, anecdotal evidence from various sources points to the following general conclusions.

***Residual Vulnerabilities.*** Many agencies are likely to be coping with residual vulnerabilities imposed under IPS. For example, an on-going study of the effects of PPS in Pennsylvania found that among the rural providers in the state, 40 percent remain financially vulnerable under PPS.<sup>152</sup> Many of these vulnerable rural agencies are the exclusive home health provider in their area, 'critical access' home health agencies.<sup>153</sup> Estimates from the study indicate that upwards of 17 percent of the rural Medicare beneficiaries in the state would lose access to Medicare home health services should some of these vulnerable agencies close. The additional cut could be expected to further reduce the number of providers. It should not be assumed that if agencies close, others would or could assume responsibility for providing care in some areas. Even in areas with more than one provider, neighboring agencies may not have the capacity to expand their service coverage or to provide the type of services required. Few small agencies are able to hire the therapeutic professionals now being used in greater number under PPS.

As introduced in previous sections, two additional residual problems from IPS should serve to heighten concerns about general access problems. The first is the issue of reduced staffing and the second is remaining Medicare claim overpayment burdens. Both issues could be expected to affect access. The connections between reduced staffing and access are obvious. Studies on the effects of IPS suggest significant impact from staff reductions among the higher

<sup>151</sup> CMS Transmittal Notice, "Home Health Prospective System (HHPPS) Phase In Plan, Contingency Plan, and Instructions," A-00-59, August 31, 2000.

<sup>152</sup> Data from a study of the Effects of PPS on rural home health agencies, J. Leon, 2002.

<sup>153</sup> Cummings, BD, and Abernethy, L. (2000) "Preserve Access to Rural Health Care with Critical Access HHAs." *Rural Health News*, Vol. 6, No. 2, Winter, 2000

cost professional staff, particularly among physical therapists.<sup>154</sup> Prior even to IPS, few agencies had occupational therapists and speech pathologists as permanent staff. As agencies attempt to rebuild their staffs in light of the new incentives built into PPS, an additional cut in payment rates that would create further reimbursement uncertainties and disincentives could dampened such efforts. Without adequate staffing levels, access would be impeded. Payback of overpayments could be expected to limit the financial resources available to agencies for rebuilding staffing levels as well as a general impediment to infrastructure development. Implementation of the pending cut could be expected to further contain agency efforts in these areas.

***Preparedness to Cope with the New Complexities and Uncertainties Imposed by PPS.*** The payment system mechanics of PPS are complex and contain many uncertainties. The level of preparedness of the agencies to cope with these problems will in general facilitate or impede their adaptation to the new system and their ability to respond to additional changes.

Some larger corporate and non-profit providers have been able to develop a limited amount of centralized expertise to deal with the new reimbursement system, however, many of the smaller agencies are not as prepared. Partly as a result of residual effects of IPS and partly a matter of history and momentum, small rural agencies have had limited financial and technical resources to prepare and now face enormous administrative challenges.<sup>155</sup>

No published studies of agency preparedness are available, but CMS provides an important indicator as to the diversity that exists among providers. In anticipation of preparing agencies to adapt to the implementation of the OASIS requirements, CMS estimated that as late as 1999 as many as one half of the certified home health agencies in the country had yet to have a computer.<sup>156</sup> Many agencies still need to adapt to this new management driven environment and many still lack the resources for this transition.<sup>157</sup> To survive, agencies will need to invest resources into these management systems. To make such investments, agencies need a stable and predictable payment environment in which to plan.

PPS, without the addition of a cut in payment rates, already contains much uncertainty. First, most agencies have very limited experience with the actual mechanics of PPS. Few have any historical experience with OASIS. As a result, they do not have enough operational experience to know how their case-mix profile as defined by PPS is likely to fluctuate over time. This makes it difficult for agencies to engage in sound business planning regarding the allocation of resources and the hiring of staff. Clearly, knowledge of an agency's case-mix profile provides the agency with the ability to potentially anticipate Medicare revenues over time.

However, because there are built-in payment uncertainties in PPS that severely limit agencies' abilities to fully recognize expected revenues, it is imperative for agencies to have a long and stable period in which to gain the necessary experience. As previously discussed, such uncertainties include situations under the control of agencies such as denied claims resulting from coding errors or medical review, while others occur outside of the control of the agency: PEPS, LUPAs, SCICs, and unrealized therapy thresholds. Anecdotal evidence from the benchmarking studies illustrates the realities of these uncertainties. Anywhere from 15 to 19 percent of episodes may result in a LUPA.<sup>158</sup> Regarding the 10-visit therapy threshold, as low as 12 percent and as high as 30 percent of the patients estimated to receive 10+ therapy visits in an episode never

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<sup>154</sup> Smith, B.M., supra note 55

<sup>155</sup> Fazzi, supra note 75

<sup>156</sup> *Federal Register* 3783 (January 25, 1999)

<sup>157</sup> Fazzi, supra note 75

<sup>158</sup> Home Health Line, supra 99, p. 40, 42, 51

receive that many.<sup>159</sup> Outlier payments is another element to consider because of potential agency cost liabilities (see example in Appendix C).

***Facing Additional Regulatory Constraints.*** As agencies are adjusting to the new administrative conditions imposed by the implementation of PPS, they have been also facing an array of new regulatory mandates. Attending to both simultaneously has led to competing demands for both personnel and resources. In considering the imposition of the additional cut, these competing demands need to be recognized and acknowledged. Regulatory mandates, including OASIS and ORT audits, new billing requirements, new compliance standards imposed by CMS and HIPAA, have added to the pressure of doing the agencies' primary job of delivering home health services. Such regulatory mandates have also increased financial and operational burdens on to the agency.

Under the previous cost-based system, such costs could be more easily recouped. Under PPS, they become just another hidden cost of doing business, a cost that must be covered under the episode payment. In considering the capacity of agencies to react reasonably to an additional payment cut, the existence of these additional regulatory costs should not be overlooked. They become yet another reason for agencies to close their doors, become detoured from their primary tasks, or to divert resources from patient care

## **PROVIDER REACTION TO AN ADDITIONAL CUT**

The reaction of many providers is likely to mirror the reactions to the implementation of IPS. Such reactions included looking for ways to immediately curtail costs and to minimize the conditions that add greater uncertainties to their revenue recognition. Under IPS, cost-cutting efforts directly affected access by the sickest beneficiaries. This renews concerns about the access to care for those persons with complex service needs arising out of multiple chronic conditions. PPS outlier payment thresholds are so high that most complex cases requiring service levels greater than normally expected will not usually trigger the outlier adjustment. Moreover, because of the way the outlier adjustments are calculated, even when adjustments are made they do not compensate agencies for the level of costs actually incurred.<sup>160</sup> Given a lack of data on the effects of PPS, any additional cut would subject beneficiaries to uninformed risk. Again, the lack of data and analysis prohibit an accurate estimate of how severe this problem will be, but given the dramatic reactions to IPS, particularly at its inception, the imposition of a further cut is likely to provoke a similar if not a greater response.

The agencies surviving IPS are the agencies most capable of quickly reacting to the incentives or disincentives introduced into the payment system. These agencies are very likely to react quickly and decisively to maintain their financial viability. Eliminating the highest cost patients within each case-mix group remains a highly effective tool for reducing costs, and may be the only course available for providers that have already cut costs as low as possible.

Under PPS, for the first time CMS has a system of data where they can look at outcomes and begin to truly understand the needs of the elderly and the best practices to respond to those needs. Rather than a random cut in payments, a more relevant approach given Congress' intent would be to make adjustments to the PPS as the data indicate. That data is not currently available. Any additional cut at this point may inadvertently eliminate or reduce access to care

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<sup>159</sup> Home Health Line, supra 99, p. 46

<sup>160</sup> Grimaldi, supra 78

for the most needy within the system. This could potentially increase costs to the system later as a result of reduced preventive care and greater reliance on institutional care. More important, however, is the impact such cuts could have on the quality of life for older adults with chronic and complex health care needs.

Tampering with the new payment system at this point in time will skew its ability to generate accurate data necessary to make informed decisions about appropriate adjustments in the future. An additional random cut will further undermine CMS' ability to clearly define the benefit, assure accurate payments, and develop accurate outcome measures for ongoing monitoring, and establishing clinical standards and quality of care indicators.

## *SECTION 6*

# CONCLUSION

**The evidence suggests that any additional cut in payments for Medicare home health services risks exacerbating the access concerns and possibly further jeopardizes the quality of services for the most vulnerable beneficiaries. Existing evidence does not indicate that access problems have been mitigated under PPS or that payments are excessive. In fact, it appears that significant retrenchment in provider capacity may be ongoing. Since the savings goals of BBA '97 have already been met and exceeded, prudence would suggest a period of payment stability to enable providers to adjust to new payment methodologies and implement innovations that may improve quality of care and efficiency over the long term. After such a period of stability, effects on access to care, quality, and markets can be better assessed. Accordingly, the pending reduction should be permanently eliminated rather than just postponed. A postponement would prolong uncertainty, making it harder for providers to plan for the future and forcing them into survival mode in anticipation of further cuts. Refinements in PPS should be considered once reliable data from the system becomes available.**

Analysts have noted that the outlier payment under PPS is very low and thus is a disincentive for agencies to serve high-cost patients in any of the 80 HHRG categories. Since the cut would be applied across the board, without any case-mix adjustment, this disincentive will only be compounded. Therefore, beneficiaries who have multiple, medically complex and/or chronic medical conditions may experience further reductions in access to home health care.

Also beneficiaries in rural areas may suffer disproportionately from such a cut. We have already seen a greater number of agency closures and a sharper decline in utilization in rural than in urban areas. Further cuts might prevent some agencies from continuing to serve those areas, since base costs are higher in rural areas due to travel distance that affects costs directly and indirectly in terms of staff productivity. In some rural areas that are currently being served by one agency this may mean the difference between minimal access to home health care and no access to home health care.

Furthermore, since there is evidence to indicate that payments are not out of line with costs, quality of care is likely to suffer across the board as providers would have to reduce services in order to prevent losses. Just as in the IPS, across-the-board cuts fall most heavily on the most, rather than the least, efficient providers.

The service delivery system has repeatedly demonstrated defensive adaptations when confronted with legislative and administrative changes that do not present predictable consequences. Additionally the service delivery system is still adjusting to the dramatic effects imposed under IPS and many in the industry are just now attempting to rebuild their capacities to adequately manage the new complexities and uncertainties inherent in PPS. These residual concerns are compounded by the need to adapt to many new aspects of the regulatory environment. Given these multiple competing demands on personnel and resources, implementation of the pending across-the-board cut in payments will likely precipitate a survival response that, at least initially, will create barriers that will limit access to care for patients with multiple and complex health care needs.

In the absence of reliable data from PPS, and in the absence of clinical practice standards, all decision-making regarding adjustments to payments is occurring in an information vacuum. Once such data is available CMS will have the opportunity to judiciously refine payment parameters and also have the opportunity to establish clinically justifiable outcome standards and indicators for quality improvement.

Early indicators of market conditions suggest that payments are not excessive. The prospective payment system has now been in place for 17 months. If payments under PPS exceeded costs, one could expect entry of new home health agencies into the Medicare home health market. However, entry is low and the number of home health agencies appears to be stable if not falling. Likewise, agencies are responding appropriately to the cost reduction incentives built into the PPS. They are decreasing the number of visits per beneficiary and the number of visits per episode.<sup>161</sup>

Eliminating the cut would not tie Congress' hands. Should evidence arise that payment levels for certain patient types are incompatible with costs, PPS payment rates can be adjusted. Such adjustments would be far more prudent than an arbitrary across-the-board cut in payments undertaken in an information vacuum. The PPS gives Congress and CMS the first opportunity for sound fiscal management of the program; an opportunity that has been called for since the program's inception. By administering the 15 percent cut, Congress may squander the opportunity to begin to build a comprehensive understanding of home health utilization and quality care outcomes. Instead what is needed is a commitment to study cost and utilization patterns in relation to key outcome indicators to begin to build a PPS that controls costs but is driven by outcomes, not simply historical utilization patterns.

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<sup>161</sup> MedPAC, 2002

## BIBLIOGRAPHY

Balanced Budget Act of 1997, P.L. 05-33

Balanced Budget Refinement Act of 1999, P.L. 06-3.

Ball, R. (1996). What Medicare's Architects Had in Mind. *Generations*. (Summer).

Benjamin, A. (1993). An Historical Perspective on Home Care Policy. *The Millbank Quarterly*. 71:1. p.129-165.

Berke, D. (1998) The Balanced Budget Act of 1997 - What it Means for Home Care Providers and Beneficiaries. *Journal of Long Term Home Health Care*. 7:3 p. 2-9.

Blue Shield Association, (2000) Medicare Home Health Prospective Payment System Training Guide, The Blue Cross and Blue Shield Association, July 3, 2000.

Brown, J. "Medicare Beneficiary Access to Home Health Agencies: 2000." OEI-02-00-00320. Washington, DC: Office of Inspector General, September 2000.

Cheh, V. (2001). "The Final Evaluation Report on the National Home Health Prospective Payment Demonstration: Agencies Reduce Visits While Preserving Quality." Princeton, NJ: Mathematica Policy Research Institute.

Congressional Budget Office (1997). Budgetary Implications of the Balanced Budget Act of 1997 December. Washington, DC: Author

Congressional Budget Office, (1977) Long Term Care Actuarial Cost Estimates. Washington, DC; GAO, (1977). Home Health Care Benefits Under Medicare and Medicaid. Washington, DC.

Congressional Budget Office. CBO Baseline Estimates, March 1997, March 1998, March 1999, March 2001, April 2001. Washington, DC:

Cummings, BD, and Abernethy, L. (2000) "Preserve Access to Rural Health Care with Critical Access HHAs." *Rural Health News*, Vol. 6, No. 2, Winter, 2000

Davitt, J. (2001). "The Balanced Budget Act: Exploring Home Health Care Policy and Access." Paper presented at the Gerontological Society of America, 54th annual meeting.

Duggan v. Bowen, 69 F-Supp. 487 (DDC 1988)

Dummit, L. (1998) Medicare Home Health Benefit: Congressional and HCFA Actions Begin to Address Chronic Oversight Weaknesses. Washington, DC: GAO/T-HEHS-98-7.

Estes, Swan and Associates. (1993). *The Long Term Care Crisis: Elders Trapped in the No-Care Zone*. Sage Publications: Newbury Park, CA.

- Fazzi, R. et al. (2000) "The National PPS Expert Design Project: Final Report," Caring Magazine, October, pp. 36-50.
- Forster, T. (1998). Home Care, the Balanced Budget Act of 1997, and IPS. Caring Magazine. 7:2. p. 8-3.
- Feder J. and Lambrew, J. (1996). Why Medicare Matters to People Who Need Long-Term Care. Health Care Financing Review. 18:2. p.99-112.
- Gent, R. et al. (2001) "Feeling the Effects of PPS – One Year Later," Caring Magazine, November, pp. 8-9.
- Gornick, M. "Thirty Years of Medicare: Impact on the Covered Population." Health Care Financing Review 18(2): 179-232, Winter 1996.
- Grimaldi, P. (2000), "Medicare's New Home Health Prospective Payment System Explained," Healthcare Financial Management, p. 46-55.
- Hart, G. (200) "Impact of the 1997 Balanced Budget Act (BBA) on Rural Hospitals," WWAMI Rural Health Research Center, a paper presented at National Rural Health Association Meeting, October 7, 2001.
- Health Insurance Portability and Accountability Act. P.L. 104-191
- Herbert, W. (2000) "PPS- How Will It Impact Your Agency and Your Practice," Home Health Nurse, Vol. 8, No. 2, pp94-97.
- Home Health Line, "PPS Benchmarks Handbook," (November, 2001) Home Health Line, Rockville: MD.
- Hood, F.J. (2001) "Medicare's Home Health Prospective Payment System," Southern Medical Journal, Vol. 94, No. 0, pp986-989.
- Jones, N. "Access to Home Health Services under Medicare's Interim Payment System." Issue Brief no. 744. Washington, DC: National Health Policy Forum, July 3, 1999.
- Kaye L., and Davitt, J. (1999) Current Practices in High-Tech Home Care. New York: Springer Publishing Co.;
- Keenan, J. Fanale, J. Ripsin, C. and Billows, L. (1990). A Review of Federal Home-Care Legislation. Journal of the American Geriatrics Society. 38:9. 04-048. p.043
- Leon, J. Parente, S., Neuman, P. (1997) "Understanding the growth in Medicare's home health expenditures," Menlo Park, CA: The Henry J. Kaiser Family Foundation
- Leon et al., "A Comparison of the Effects of New Medicare Reimbursement Methodologies on Home Health"
- The Lewin Group. (1998). Implications of the Medicare Home Health Care Interim Payment System of the Balanced Budget Act. Washington, DC: The National Association for Home Care.

Komisar, H. and Feder, J. (1998). The Balanced Budget Act of 1997: Effects on Medicare's Home Health Benefit and Beneficiaries Who Need Long Term Care. New York, NY: The Commonwealth Fund.

Mauser, E. and Miller, N. (1994). A Profile of Home Health Users in 1992. Health Care Financing Review. 16:1. p. 17-33;

McCall et al., (2001) "Medicare Home Health Before And After The BBA," Health Affairs 20(3): 89-98

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2001, P.L. 06-554

Medicare Payment Advisory Commission, Report to the Congress: Medicare in Rural America | June 2001

Medicare Payment Advisory Commission Report to the Congress: Medicare Payment Policy, March 2002.

Medicare Payment Advisory Commission (1999). Report to the Congress: Selected Medicare Issues. Washington, DC: Author

Moon, M. and Gage, B. (1997). Key Medicare Provisions in the Balanced Budget Act of 1997. The Public Policy and Aging Report. 8:4, p.-5.

Office of the Inspector General (2001) "Access to Home Health Care After Hospital Discharge, 200," July, 2001, OEI-02-0-0080.

Office of Inspector General (2001) "Medicare Home Health Care Community Beneficiaries 200," October, 2001, OEI-02-0-00070.

Office of Inspector General (1995). Semi-Annual Report, April , 1995- September 30, 1995. Washington, DC:

Office of Inspector General (1995a). Variation Among Home Health Agencies in Medicare Payment for Home Health Services. Washington, DC: OEI-04-93-00260; OIG.

Office of Inspector General (1995b). Geographical Variation in Visits Provided by Home Health Agencies. Washington, DC: OEI-04-93-00262.

Omnibus Budget Reconciliation Act of 1980, P.L. 96-4199

Omnibus Budget Reconciliation Act of 1993, P.L. 03-66

Omnibus Consolidated Emergency Supplemental Appropriations Act of 1999, P.L. 05-277

Orphan Drug Act (P.L. 97-44).

Scanlon, W. (1999). Medicare Home Health Agencies: Closures Continue, with Little Evidence Beneficiary Access is Impaired. Washington, DC:GAO/HEHS-99-20.

Scanlon, W. (1998). Interim Payment System for Home Health Agencies. Washington, DC: U.S. GAO/HEHS-98-238.

Schore, J. (1994) "Patient, Agency, and Area Characteristics Associated with Regional Variation in the Use of Medicare Home Health Services," Princeton, NJ: Mathematica Policy Research, Inc., September, 1994;

Smith, B.M. et al. (1999). An Examination of Medicare Home Health Services: A Descriptive Study of the Effects of the Balanced Budget Act Interim Payment System on Access to and Quality of Care. Washington, DC: Center for Health Services Research and Policy, The George Washington University

Smith, B.M. et al. (1999) "An examination of Medicare home health services. A descriptive study of the effects of the Balanced Budget Act interim payment system on hospital discharge planning." Washington, DC: The George Washington University Medical Center for Health Services Research and Policy, September 1999.

The Social Security Amendments of 1965, Health Insurance for the Aged Act, P.L. 89-97, 79

Social Security Act Amendments of 1972, P.L. 92-603.

Stoner, D. et al. "Medicare Payment Advisory Commission (MedPAC) home health agency survey, 1999." Cambridge, MA: Abt Associates, 1999.

U.S. Congress, General Accounting Office (1978) Home Health: The Need for a National Policy to Better Provide for the Elderly. Washington, DC: 052;

U.S. Congress, General Accounting Office (1978). Medicare's Cost Reimbursement Procedures for Home Health Care. Washington, DC: 06844

U.S. Congress, General Accounting Office (1974) Home Health Care Benefits Under Medicare and Medicaid. Washington, DC

U.S. Congress, General Accounting Office (1990). Medicare: Increased Denials of Home Health Claims During 1986 and 1987. Washington, DC: GAO/HRD-90-4BR

U.S. Congress, General Accounting Office (1996). Medicare: Home Health Utilization Expands While Program Controls Deteriorate. Washington, DC. GAO/HEHS-96-6;

U.S. Congress, General Accounting Office (1999). Long-Term Care: Projected Needs of the Aging Baby Boom Generation. Washington, DC: GAO/HRD-9-86; GAO, 1996.

U.S. Congress, General Accounting Office (1983) The Elderly Should Benefit from Expanded Home Health Care but Increasing these Services will not Insure Cost Reductions. Washington, DC. GAO/IPE-83-1.

U.S. Congress, General Accounting Office (1999). Medicare Home Health Agencies: Closures Continue, With Little Evidence Beneficiary Access is Impaired. Washington, DC: GAO/HEHS-199-20.

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid, Home Health Manual, Baltimore, MD: 2001.

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Transmittal Notice, "Home Health Prospective System (HHPPS) Phase In Plan, Contingency Plan, and Instructions," A-00-59, August 3, 2000.

U.S. Department of Health and Human Services, Health Care Financing Administration, "The Home Health Outcome Based Quality Improvement (HH OBQI) System" 68 Federal Register / Vol. 65, No. 28 Monday, July 3, 2001 .

U.S. Department of Health and Human Services, Health Care Financing Administration, "Medicare Program, Prospective Payment System for Home Health Agencies, Final Rule," Federal Register, Vol. 65, July 3, 2001.

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Transmittal Notice A-0-06, January 6, 2001.

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid, Transmittal No. A-199-38.

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid, Health Care Indicators, Second Quarter 2001, tables 4 and 5.

U.S. Department of Health and Human Services, Health Care Financing Administration. Profiles of Medicare: 30th Anniversary of Medicare. Baltimore, MD: U.S. Department of Health and Human Services, 1996.

U.S. Department of Health and Human Services, Health Care Financing Administration. Medicare and Medicaid Statistical Supplement, 1995. Baltimore, MD: 1995.

U.S. Department of Health and Human Services, Health Care Financing Administration, " Medicare Program, Prospective Payment System for Home Health Agencies, Final Rule," Federal Register, Vol. 65, July 3, 2001.

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid, Transmittal Notice A-0-06, January 6, 2001.

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid, Health Care Indicators, Second Quarter 2001.

U.S. Department of Health and Human Services, Health Care Financing Administration, Medicare Bulletin 422, dated March , 1999

U.S. Department of Health and Human Services, Health Care Financing Administration, "Medicare Program, Prospective Payment System for Home Health Agencies" Federal Register, January 25, 1999, Vol. 64, No. 5, 3748-3763

U.S. House of Representatives, Committee on Aging, Hearings before Subcommittee on Health and Long Term Care "Medicare Gaps and Limitations Hearings, (October 8, 1977), 95th Cong., 1st Session, Comm. Pub. 95-6;

U.S. House of Representatives, Hearing before the Subcommittee on Health, Committee on Ways and Means, "Proposed Amendments to the Medicare Program," 95th Cong., 2nd Session 92 (August 4, 1978);

U.S. House of Representatives, Hearing Before the Subcommittee on Health of the House Committee on Ways and Means, "Medicare Balanced Budget Act Refinements," October, 1999.

U.S. House of Representatives, Committee on Aging, "Medicare Gaps and Limitations Hearing before the Subcommittee on Health and Long Term Care," (October 8, 1977), 95th Cong., s Session, Comm. Pub. 95-6.

U.S. House of Representatives, Hearing before the Subcommittee on Health, Committee on Ways and Means, "Proposed Amendments to the Medicare Program," 95th Cong., 2d Session 92 (August 4, 1978);

U.S. House of Representatives, Testimony before the Subcommittee on Health, Committee on Ways and Means, "Hearing on Home Health Care and Skilled Nursing Facility and Other Post Acute Care Payment Policies," March 4, 1997.

U.S. House of Representatives, Hearing before the Subcommittee on Health and Long Term Care, Select Committee on Aging, "Medicare Gaps and Limitations," (October 8, 1977), 95th Cong., Session, Comm. Pub. 95-161.

U.S. House of Representatives, Prepared Remarks to the House Committee on Small Business William A. Dombi, National Association for Home Care, "Rural Health Care Services: Has Medicare Reform Killed Small Business Providers?" June 4, 2001.

U.S. Senate, Hearings before the Subcommittee on Health, Committee on Finance, "Medicare and Medicaid Home Health Benefits," 96th Cong., s Session May 2 and 22, 1979.

U.S. Senate, Testimony Before the Finance Committee, "Impact Of 1997 BBA Provisions On The Medicare Fee-For-Service Program" by Mary Suther, June 10, 1999.

U.S. Senate, Senate Select Committee On Aging, "Hearings On The Home Health Care Outcome And Assessment Information Set (OASIS) Testimony of Jeff Kang., M.D., M.P.H., Director, Office of Clinical Standards and Quality, Health Care Financing Administration, May 24, 1999.

*APPENDIX A:*

**POLICY HISTORY OF MEDICARE HOME HEALTH**

## INTRODUCTION

Medicare, created in 1965 as an amendment to the Social Security Act<sup>162</sup> established the first federal entitlement program providing health insurance for the elderly. Thus anyone 65 or older who had paid into the Social Security System was automatically enrolled in the Hospital Insurance plan (Part A) and they could choose to enroll in Part B, or the Supplemental Insurance Plan which covered physician and outpatient services. The original statute focused on covering older adults' acute health care needs since this was perceived as the area in which the elderly were most financially vulnerable to catastrophic losses at that time. Although focused on acute care the statute also offered post acute care as an appropriate option to meet the healthcare needs of older adults. Both home health care and nursing facility care were included in the original law. However, home health care benefits were fairly restricted at the beginning. Under Part A home health services were limited to patients who had spent at least 3 days in the hospital immediately prior to receiving home care. The home care had to be for the same condition that triggered the hospitalization. Also the patient could not receive more than 100 visits per benefit period. Under Part B, patients were restricted to 100 days per year. They did not have to have the 3-day prior hospital stay, but coverage under Part B required meeting a deductible (\$60 in the beginning) and coinsurance (20 percent).

All patients under either program also had to meet certain eligibility criteria in order to have Medicare pay for home health care. They had to be homebound, in need of intermittent skilled care, have a physician certify and review the care plan, and receive services from a Medicare-certified home health agency. Reimbursements were made on a cost basis and processed through Regional Home Health Intermediaries. The intermediaries were (and still are) responsible for reviewing claims and determining whether specific requests would be reimbursed. Eligibility criteria and the specific services covered by Medicare have changed little since the program's inception.<sup>163</sup>

## MAJOR POLICY SHIFTS AND IMPACT ON THE PROGRAM

As with most entitlement programs the intent behind passing such legislation was that this was the first step in a plan to insure the elderly and others access to a continuum of quality and affordable health care. Medicare was viewed by the early policy makers as a "first step toward universal coverage".<sup>164</sup> In 1972, amendments to Social Security expanded access to the Medicare program to those receiving Social Security Disability Insurance<sup>165</sup> The early pattern was to expand the program to cover people with chronic illnesses. According to Robert Ball "Medicare invented an 'extended care benefit', which reimbursed care in a lower-cost institution for patients who otherwise would have been kept longer in an expensive hospital".<sup>166</sup>

The 1972 amendments also made changes to the home health benefit. The Part B coinsurance requirement was eliminated, and the Secretary (HEW) was required to establish a minimum visit designation by diagnosis. This was an attempt to clarify definitions of reasonable and necessary and to reduce retroactive denials. A waiver of liability was established for such denied claims when the provider or beneficiary was not at fault.<sup>167</sup> The 1972 amendments also

<sup>162</sup> Supra note 3.

<sup>163</sup> Services include: skilled nursing, physical therapy, speech therapy, occupational therapy, medical social work and home health aide.

<sup>164</sup> Ball, R. (1996). What Medicare's Architects Had in Mind. *Generations*. (Summer) p. 13

<sup>165</sup> Social Security Act Amendments of 1972, P.L. 92-603, 42 USC section 1395, et. seq.

<sup>166</sup> Supra note 164, p. 17

<sup>167</sup> Proposed Amendments to the Medicare Program. Hearing before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 95th Cong., 2d Session 92 (August 4, 1978)

established demonstrations to determine whether homemaker services would be an appropriate service under the program.<sup>168</sup>

There was concern even in the mid-1970s that the Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services, needed to better clarify interpretive criteria used by the fiscal intermediaries. Although some limits on the home health benefit had been lifted, utilization of the benefit was not increasing as expected. Many agencies did not seek certification due to the fear of retroactive denials and the inconsistency of intermediary interpretations.<sup>169</sup> In fact utilization actually decreased between 1969 and 1971, where the number of visits fell by 44 percent.<sup>170</sup> Also, the number of Medicare certified home health agencies declined between 1970 and 1975.<sup>171</sup> According to the GAO these patterns in utilization could be attributed to constraints on the benefit, and tight administration by the intermediaries.<sup>172</sup>

### PROGRAM RECONSIDERATIONS 1977-1979

Many supporters of home health care continued the debate regarding the expansion of the benefit to cover chronic health care needs. Several hearings were held on the program in the late 1970s.<sup>173</sup>

"Medicare is oriented to the coverage of acute episodic illness, and yet the illnesses of the elderly tend to be chronic.... Certainly outpatient drugs, preventive medical services, and more flexibility in the delivery of home health care would serve to delay the need for other more costly types of services....Our subcommittee and the full house select committee on aging has been extremely interested in expanding the health care options available to the elderly, thereby reducing the demand for costly inpatient care."<sup>174</sup>

The rationale for expansion rested on three main points. First, home health care was seen as a less costly alternative to institutional care including hospital and nursing home care.<sup>175</sup> Second, home health care was coming to be seen as a more humane way to provide treatment and it was the preference of most older adults to receive care at home if possible. Finally, as the Honorable Claude Pepper stated in his opening remarks to the committee, "the current acute, episodic illness orientation of Medicare denies preventive health services, which could save lives and dollars, and covers only the catastrophic illnesses which occur because we have not done anything to prevent them. Let's face it we do not have health care in this country. We have sick care."<sup>176</sup> Medicare needed to provide a more comprehensive continuum of health care that adequately covered the major health care problem of the elderly -- chronic medical conditions. A witness at that hearing suggested "the increased expenditure is due in part to the steady rise in

<sup>168</sup> Benjamin, supra note 14.

<sup>169</sup> Benjamin, supra note 14.; Estes, supra note 17.

<sup>170</sup> Benjamin, supra note 14.

<sup>171</sup> Estes, supra note 17.

<sup>172</sup> U.S. GAO, (1974) Home Health Care Benefits Under Medicare and Medicaid. Washington, DC

<sup>173</sup> Medicare Gaps and Limitations Hearing before the Subcommittee on Health and Long Term Care, Committee on Aging, U.S. House of Representatives, (October 18, 1977), 95th Cong., 1s Session, Comm. Pub. 95-116.; Proposed Amendments to the Medicare Program. Hearing before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives 95th Cong., 2d Session 92 (August 4, 1978); Medicare and Medicaid Home Health Benefits hearings before the Subcommittee on Health, Committee on Finance, U.S. Senate, 96th Cong., 1s Session May 21 and 22, 1979

<sup>174</sup> Medicare Gaps and Limitations Hearing before the Subcommittee on Health and Long Term Care, Select Committee on Aging, U.S. House of Representatives, (October 18, 1977), 95th Cong., 1s Session, Comm. Pub. 95-116 p. 2

<sup>175</sup> CBO, (1977) Long Term Care Actuarial Cost Estimates. Washington, DC; GAO, (1977). Home Health Care Benefits Under Medicare and Medicaid. Washington, DC.

<sup>176</sup> Supra note 174, p. 3

medical care costs generally, but also is the result of the fact that I think the principal needs of the elderly are not being addressed. ... As medical technology has become more and more successful in managing acute episodes, increasingly our problems become those of slowly progressive chronic disabilities".<sup>177</sup> Home health care was an entitlement, and in the view of its supporters, many more were entitled to the benefit than were currently receiving it, because the benefit was not responding to the true need of the elderly.

Several changes to the home health care benefit were discussed in these hearings.<sup>178</sup> These included elimination of the 3-day hospital stay requirement and the visit limit in Part A and the deductible under Part B. Also discussed was the possibility of eliminating the homebound and skilled care requirements. Likewise additional services were suggested such as adding homemaker support as a reimbursable benefit, making occupational therapy a skilled benefit, and including evaluation and assessment visits as part of the skilled care definition (rather than an administrative expense). Two other suggestions went beyond what services should be delivered and considered how the delivery system needs to operate. There were suggestions to eliminate the state licensing requirement for proprietary agencies and to develop consistent interpretation guidelines for intermediaries to follow.<sup>179</sup> Such inconsistent interpretations, it was feared, were leading to inappropriate denials of service.

Many worried that the lack of standards generated the potential for inappropriate utilization of the system since this severely limited CMS's ability to monitor the program. It was almost impossible to compare utilization across regions or agencies due to multiple reporting systems used by the intermediaries.<sup>180</sup> In fact in one hearing,<sup>181</sup> the chairman of the committee said in his opening remarks that we still need to develop a more effective definition of services and a more effective system for managing the program.

Issues were raised regarding the variation in unit costs for similar services across agencies and the lack of consistent standards in terms of what costs should be allowable for administrative expenses that directly supported patient care. In a 1979 hearing Senator Domenici suggested that legislation should require the Secretary of HEW to "establish a uniform system for billing a home health patient ... [and] establish 'reasonable cost guidelines' for transportation, administrative salaries, fiscal services, legal services, public relations, and other specific line item costs directly related to providing home care".<sup>182</sup> These inconsistencies made it almost impossible to predict total program costs from year to year and therefore it was very difficult to project the financial impact of expansionary program changes. Inconsistencies made it more difficult to identify and penalize fraudulent practices, as well.

## **THE OMNIBUS BUDGET RECONCILIATION ACT OF 1980**

Several key expansionary changes were made to the benefit with passage of the Omnibus Budget Reconciliation Act of 1980.<sup>183</sup> These amendments removed the 100 visit limit, the required 3-day prior hospitalization under Part A and the deductible under Part B. Therefore the

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<sup>177</sup> Supra note 174, p. 10-11

<sup>178</sup> Supra note 173

<sup>179</sup> Supra note 173

<sup>180</sup> GAO. (1978) Home Health: The Need for a National Policy to Better Provide for the Elderly. Washington, DC: Author, 105121; GAO. (1978). Medicare's Cost Reimbursement Procedures for Home Health Care. Washington, DC: Author, 106844

<sup>181</sup> Medicare and Medicaid Home Health Benefits hearings before the Subcommittee on Health, Committee on Finance, U.S. Senate, 96th Cong., 1s Session May 21 and 22, 1979

<sup>182</sup> Ibid

<sup>183</sup> Supra note 14

benefit became available to eligible beneficiaries without a prior hospital stay for an unlimited duration, with no out of pocket expenditures on the part of beneficiaries. Congressional intent in this case was clearly to expand services and to make the benefit more available to more beneficiaries. The law, however, did not establish uniform cost reports nor did it provide additional clarity on the terms homebound, or "part-time or intermittent care".<sup>184</sup>

The 1980 law also opened the door for proprietary providers by eliminating the state licensure requirement for such agencies. For-profit agencies that had been locked out of the Medicare system because they operated in a state without a license process, could now apply for Medicare certification. In 1982 there were 471 for-profit agencies in the country. In 1983 this number increased to 997 and to 1,899 in 1986. The rate of growth of proprietary agencies was 90 percent while non-profits grew by only 21 percent in that same time period.<sup>185</sup>

Home care proponents continued to argue for program expansions. After enactment of the changes, utilization of Medicare home care did increase but not at an alarming rate. "Expansion or revision in the present system is being considered because of: changes in health care demands stemming from growth in the size of the disabled elderly population; the need to reduce high government expenditures for nursing home and hospital care; and a desire to improve the physical and mental health status of the elderly."<sup>186</sup> Early research suggested that some client outcome measures were improved with the receipt of expanded home care, including longevity and satisfaction with life.<sup>187</sup> Likewise, the CBO estimated that potentially 1.7 to 2.7 million people needed home health services but only 300,000 to 500,000 were receiving home care.<sup>188</sup>

## INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS)

Creation of the inpatient prospective payment system in 1983 also altered the health care landscape.<sup>189</sup> This new payment system was established as a way to control hospital-based costs within the Medicare program. Implementation of the IPPS led to earlier patient discharges with sicker patients being released from the hospital in greater need of transitional support.<sup>190</sup> The assumption was that post-acute services, including home health care would increase dramatically due to this policy change. However, there was only a minor increase in the number of users and visits in the two years following PPS (see Exhibit 1.1). The number of users per 1000 enrollees increased from 45 in 1983 to 51 in 1985 and then decreased in 1986 to 50, while the number of visits per 1,000 enrollees also declined after 1984.<sup>191</sup>

The lack of tremendous increases in home care utilization was attributed to: tightened interpretations of eligibility by CMS and the intermediaries stemming from CMS transmittals issued in 1984 and 1986. These transmittals altered the definition of "part-time or intermittent" care for both skilled nursing and home health aide services stating that, "daily care of an indefinite duration will not be considered to meet the intermittent requirement and such services are not covered under the Medicare home health benefit".<sup>192</sup> A second transmittal issued in 1986

<sup>184</sup> Hearing before the Subcommittee on Health and Long Term Care, Select Committee on Aging, U.S. House of Representatives, 96th Cong. 199, August 14, 1979

<sup>185</sup> Estes, supra note 17.

<sup>186</sup> GAO (1983). The Elderly Should Benefit from Expanded Home Health Care but Increasing these Services will not Insure Cost Reductions. Washington, DC. GAO/IPE-83-1, p. i.

<sup>187</sup> Ibid

<sup>188</sup> CBO 1977, supra note 175

<sup>189</sup> Estes, supra note 17; Benjamin, supra note 14.

<sup>190</sup> Estes, supra note 17; Feder, J. and J. Lambrew, supra note 5; Komisar, H. and Feder, J., supra note 19.

<sup>191</sup> Estes, supra note 17.

<sup>192</sup> Supra note 15, p. 1495.

further tightened eligibility criteria by defining daily care as care provided on 5 or more days per week. Therefore, a person needing 1 hour of care per day for 7 days (a total of 7 hours per week) was no longer eligible for the benefit, whereas a person needing 8 hours of care per day for 4 days per week (a total of 32 hours per week) could be eligible for the benefit. This administrative interpretation represented a dramatic shift from the legislative mandate established by Congress. In fact these new guidelines were "significantly more restrictive than the guidelines that prevailed since the program's inception in 1966."<sup>193</sup>

Fallout from this new interpretation could be seen in increased claims reviews with concurrent demand for more detailed documentation on the claims; and increased claims denial rates from 3.1 percent in 1985 to 9.0 percent in 1987.<sup>194</sup> Likewise agencies reacted to these changes by doing less home care under the Medicare benefit. The number of claims filed decreased by 5 percent between 1985 and 1986.<sup>195</sup> "Because home health agencies were financially liable for uncovered claims, the availability of services tended to closely reflect coverage rules."<sup>196</sup> Unless the provider had a low pattern of denials and thus benefited from the waiver of liability they would have to cover the cost of denied claims.<sup>197</sup> In less than one year the percentage of agencies that lost this waiver went from 16 to 32 percent.<sup>198</sup>

## DUGGAN V. BOWEN

The pressure from increased demand for post-acute support due to the inpatient PPS and the tightening of eligibility limits by CMS generated ripe conditions for court challenges to the program. Congress intended to expand the benefit from its inception. However, by not developing specific definitions and guidelines regarding part-time, intermittent and daily care this allowed CMS to set stricter standards for eligibility through administrative transmittals. This culminated in a class action lawsuit filed in 1987, *Duggan v. Bowen*.<sup>199</sup>

The *Duggan* decision required CMS to revise the Medicare manual to make it more in line with the existing statute and Congress' intent to expand eligibility to the benefit. The most important change was that this reopened the benefit to beneficiaries who needed care on 5 or more days, beneficiaries who should have been eligible under the statute but were not due to CMS' arbitrary interpretation. The new manual stated "the determination of whether a beneficiary needs skilled nursing care should be based upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal or expected to extend over a long period of time."<sup>200</sup> CMS also expanded activities considered to be medically reasonable and necessary. Observation and maintenance therapy could now be covered under the benefit. Observation was appropriate when there was a possibility of complications or a need to alter the treatment plan. Therapy could be provided to maintain functional levels rather than simply to improve functional levels. Likewise increasing pressure was placed on intermediaries not to deny claims. Each visit had to be reviewed separately before denying the entire claim.<sup>201</sup>

<sup>193</sup> Supra note 15, p. 1496

<sup>194</sup> GAO. (1990). *Medicare: Increased Denials of Home Health Claims During 1986 and 1987*. Washington, DC: GAO/HRD-90-14BR

<sup>195</sup> Estes, supra note 17.

<sup>196</sup> Feder and Lambrew, supra note 5, p. 105

<sup>197</sup> Waiver of liability was established with the 1972 amendments. It granted agencies with low denial rates and their clients a waiver from covering costs that might be denied by the intermediaries.

<sup>198</sup> GAO, 1990, supra note 194

<sup>199</sup> *Duggan v. Bowen*, supra note 15

<sup>200</sup> Medicare Manual, 1989, as cited in Keenan, J. Fanale, J. Ripsin, C. and Billows, L. (1990). A Review of Federal Home-Care Legislation. *Journal of the American Geriatrics Society*. 38:9. 1041-1048. p.1043

<sup>201</sup> GAO, supra note 16; Komisar, H. and Feder, J., supra note 19.

This added tremendous burden and cost to the intermediary process leading to a dramatic reduction in claims denied.

The net effect of all of these policy changes is that Medicare home health care became available to more beneficiaries for less acute conditions and for longer periods of time, as Congress intended.<sup>202</sup> These changes also helped the benefit adapt to changing medical practices including shorter hospital stays and technological advances that were keeping people alive longer without equivalent gains in morbidity.<sup>203</sup> The changes may have prevented or reduced nursing home placement as well. According to the National Center for Health Statistics not only did the proportion of elderly residing in nursing homes decline between 1985 and 1995 (from 4.6 to 4.1 percent) but the average stay decreased by 18 percent.<sup>204</sup> Given our ability through technology and medical advances to increase longevity, the number of older adults living longer and with greater disability has increased dramatically.<sup>205</sup> Therefore, it would make sense that the number of older adults in need of home health care would increase. For example the number of home care users per enrollees increased from 5.6 percent in 1990 to 9.8 percent in 1996.<sup>206</sup> In addition, given the strict interpretation set by CMS prior to *Duggan v. Bowen*, it is not surprising that utilization would increase dramatically after this decision.

Utilization of the program increased dramatically in the two years after CMS revised the Medicare Manual. While the average annual growth rate for total Medicare spending was only 11 percent from 1990 to 1996 the average annual growth rate for home health care was 33 percent in that same time period.<sup>207</sup> However, most of that growth occurred from 1989 to 1991 in the aftermath of *Duggan*. Between 1989 and 1990 the program grew by 54 percent and between 1990 and 1991 it grew by almost 46 percent. Also the number of users per 1,000 enrollees grew by 11 percent in 1990 up from 4 percent in 1989. Finally, the number of visits per person served grew by 33 percent in 1990 compared with 12.5 percent in 1989 and 4 percent in 1988. However, from 1991 to 1996, the growth rate steadily declined, down to a low of 9 percent. By 1997, the program experienced a negative growth rate of 3.5 percent (see Exhibit 1.2).

Paradoxically, the same incentives created by the changes in the payment system and benefit structure that expanded legitimate coverage may have resulted in the increased provision of unnecessary home health care visits to some beneficiaries.<sup>208</sup> Because the system was still operating under cost-based reimbursement, an agency's payment level increased with the number of visits it delivered. It had no reason to curb volume as long as the cost per visit did not exceed the national average for that visit type.<sup>209</sup> Average annual payment per visit only increased by 3 percent between 1990 and 1996, indicating that agencies were using lower cost visits.<sup>210</sup> Also, considering that the coinsurance and deductibles for home health care had been eliminated, beneficiaries had little incentive to refuse services.

Although escalating expenditures were influenced by legislative expansion of the benefit, it can also be demonstrated that CMS did not have a good handle on the benefit at that point.

<sup>202</sup> GAO, 1996 supra note 16; Feder and Lambrew, supra note 5.

<sup>203</sup> Komisar, H. and Feder, J., supra note 19

<sup>204</sup> Komisar, H. and Feder, J., supra note 19

<sup>205</sup> GAO. (1991). *Long-Term Care: Projected Needs of the Aging Baby Boom Generation*. Washington, DC: GAO/HRD-91-86; GAO, 1996, supra note 40.

<sup>206</sup> Komisar, H. and Feder, J., supra note 19

<sup>207</sup> Komisar, H. and Feder, J., supra note 19

<sup>208</sup> Komisar, H. and Feder, J., supra note 19

<sup>209</sup> At this time each of the six visit limits were based on 112 percent of the national average costs for freestanding home health agencies adjusted for wage and geographic differences. This rate was established by the Omnibus Budget Reconciliation Act of 1986, P.L. 99-509 (supra note 12)

<sup>210</sup> See Exhibit 1.1; CMS, Office of the Actuary, National Statistics Group. Komisar and Feder, 1998, supra note 19.

CMS still had not developed a uniform claims processing system. Each intermediary had their own system which made it almost impossible to gain accurate data on spending patterns and potential misuse of the benefit. There were inconsistent determinations regarding reasonable costs, medical necessity, homebound status, and intermittent care. Insufficient uniformity in cost data made it very difficult to establish accurate upper limits for reimbursements, to better estimate total costs, and to develop accurate outcome measures for both utilization and quality. Combined with minimal penalties for abusive agencies, and incentives to serve an expanded clientele, increased utilization is not surprising. It is likely that lack of consistent program controls contributed to this increase.

After *Duggan v. Bowen*, concerns over rising health care costs, their increasing share of GDP and potential depletion of the Hospital Insurance Trust Fund generated much activity in relation to controlling Medicare costs. Increased utilization in home care logically made it a target for more careful scrutiny by policy makers attempting to control spending and reduce the deficit. It was also becoming increasingly clear that a complete overhaul of the home health care program was in order. In fact, the industry had been lobbying for a prospective payment system for home health care since 1983. They continued to lobby for CMS to study alternative reimbursement methods through the 1980's.<sup>211</sup> As a step in that direction, in 1990 the National Home Health Prospective Payment Demonstration was created. The program consisted of two phases. Phase one, run from 1990 to 1993, tested "the effects of a predetermined per-visit payment rate".<sup>212</sup> The second phase, from 1995 through 1998, tested a per-episode payment system. In the absence of results from the demonstration the first direct attempt at controlling costs consisted of a freeze on the inflation (market-basket) updates for home health care from 1994 through 1996.<sup>213</sup>

Another important concern was the degree of variation in payments and visits across geographic regions and agency types. Studies by the Office of Inspector General (OIG), raised concerns that beneficiary characteristics or regional variation in access to alternative services could not explain such variation.<sup>214</sup> Using 1993 data on four subgroups of agencies OIG, found that "the average reimbursement per beneficiary for the four groups ranged from \$1,534 to \$7,978".<sup>215</sup> They also found wide variation in the average number of visits with a range of 27 visits for the low utilization agencies and 141 visits for the highest agencies. The highest regional average was found in Southeastern states or Region IV.<sup>216</sup> The second highest regional average was found in Region VI.<sup>217</sup> Interestingly, two of the nine intermediaries served the vast majority of agencies with higher than normal utilization patterns. Research noted that some regional variation may be attributed to availability of alternative services.<sup>218</sup> Other research also found that

<sup>211</sup> The original sanction for studying alternative reimbursement methods, including prospective payment, was enacted in 1983 as part of the Orphan Drug Act (P.L. 97-414). These demonstrations were delayed by the OMB in 1985. In OBRA 1987(P.L. 100-203) Congress again instructed DHHS to study prospective payment. This was delayed one year by the Medicare Catastrophic Protection Act of 1988. Finally, OBRA 1990 required DHHS to report to Congress by 1993 on home health care alternative reimbursement demonstrations.

<sup>212</sup> Cheh, V. (2001). *The Final Evaluation Report on the National Home Health Prospective Payment Demonstration: Agencies Reduce Visits While Preserving Quality*. Princeton, NJ: Mathematica Policy Research Institute. p.1

<sup>213</sup> Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, 107 Stat. 312, Title XIII, Part III, Section 13564. 42 USC Sec. 1395 et. seq

<sup>214</sup> Office of Inspector General (OIG), (1995a). *Variation Among Home Health Agencies in Medicare Payment for Home Health Services*. Washington, DC: OEI-04-93-00260; OIG. (1995b). *Geographical Variation in Visits Provided by Home Health Agencies*. Washington, DC: OEI-04-93-00262.

<sup>215</sup> OIG, 1995a, supra note 213, p.7

<sup>216</sup> OIG, 1995b, supra note 213; GAO, 1996, supra note 16; Region IV includes Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

<sup>217</sup> Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

<sup>218</sup> Mauser, E. and Miller, N., supra note 5

patient characteristics could partially explain such variation.<sup>219</sup> For example, beneficiaries in the East South Central region<sup>220</sup> "were more likely to be frail, chronically ill and in poorer health" and located in non-metropolitan counties with high proportions of impoverished elderly.<sup>221</sup> However, OIG and GAO concluded that this was not sufficient evidence to demonstrate a higher need in those areas and continued to attribute such variation to inappropriate utilization. OIG attributed this variation to "the discretion afforded home health agencies to influence the amount of care given to their clients".<sup>222</sup>

## GROWING CONCERNS REGARDING FRAUD AND ABUSE

In 1994, Congress began to focus its energy on uncovering fraud and abuse within the Medicare system. In home health care the assumption was that increased utilization must be due to inappropriate service use, not due to expansion of the benefit or actual increasing and changing need patterns. The first effort was the Medicare home health initiative (begun in 1994), an interagency workgroup established to evaluate several areas including administrative fraud. This was followed, in 1995 by an expanded fraud prevention program called Operation Restore Trust (ORT). This demonstration program covered only 5 states, New York, California, Florida, Illinois and Texas and focused on home health care, nursing homes and durable medical equipment companies. A cooperative effort between various federal, state and local agencies, the program conducted audits, criminal investigations, and established a fraud hotline for consumers to report possible abusive practices

Interestingly, early findings from OIG reported 219 cases (in the five states) of fraud and abuse in 1995. Only 20 percent of these fraud cases were home health agencies and of those cases only 1 conviction and 1 settlement concerned home health providers.<sup>223</sup> Yet when conducting agency-specific audits, OIG found error rates between 19 and 64 percent.<sup>224</sup> OIG identified various practices in these audits including: billing for visits that were not necessary or not delivered; patients who were not homebound; and missing or forged physician authorizations. Fraud and abuse initiatives were continued and expanded by the Health Insurance Portability and Accountability Act of 1996.<sup>225</sup> Some of these efforts may have been successful in curbing misuse within the system as home health care growth began to decline in the mid to late 1990's. It may also be that early patterns of decline were due to a natural leveling off of the benefit. Also a freeze placed on market basket updates between July of 1994 and July of 1996 most likely contributed to this decline.<sup>226</sup>

Congress remained concerned about increasing expenditures in health care. Early projections indicated that the Hospital Insurance Trust Fund would be depleted in 2001.<sup>227</sup> Trust Fund depletion could lead to increased deficit spending; legislative action would be necessary to

<sup>219</sup> Schore, J. (1994). Patient, Agency, and Area Characteristics Associated with Regional Variation in the Use of Medicare Home Health Services. Princeton, NJ: Mathematica Policy Research Inc.

<sup>220</sup> Alabama, Kentucky, Mississippi, Tennessee

<sup>221</sup> GAO, 1996, supra note 16, p.13

<sup>222</sup> Home Health Care and Skilled Nursing Facility and Other Post Acute Payment Policies, hearing before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. 105th Cong. March 4, 1997 p.3, [Http://www.house.gov/ways\\_means/health/105cong/3-4-97/3-4grob.htm](http://www.house.gov/ways_means/health/105cong/3-4-97/3-4grob.htm)

<sup>223</sup> OIG. (1995). Semi-Annual Report, April 1, 1995- September 30, 1995. Washington, DC:

<sup>224</sup> An error rate is defined as "the percent of home health visits paid for by Medicare but which did not meet Medicare guidelines". Hearing on Home Health Care and Skilled Nursing Facility and Other Post Acute Care Payment Policies,. Grob, G Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 4, 1997 p. 2

<sup>225</sup> Health Insurance Portability and Accountability Act. P.L. 104-191, 110 Stat. 1936.

<sup>226</sup> Enacted under the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, Title XIII, Section 13564.

<sup>227</sup> Moon, M. and Gage, B., supra note 34.

curb spending. In a political context of budget cutting and elimination of deficit spending home care was one of the few remaining programs that had not experienced major reimbursement adjustments. Likewise the program had experienced tremendous growth after the *Duggan v. Bowen* decision. Various reasons for this growth were suggested. They included technological advances that kept people alive but with multiple and chronic medical needs, technological advances that allowed many new services to be delivered in the home (e.g. infusion therapy), an increasing Medicare population, increases in the oldest age categories, and preference for community-based care.<sup>228</sup> Such growth, however, would not have been possible without the legislative expansion of the benefit in 1980.

OIG, on the other hand, attributed such growth to problems with the benefit structure and lack of adequate program controls. The rise in the number of users per enrollees and the number of visits per user were cited as evidence of problems with the system. A small number of users (12 percent) who received more than 150 visits accounted for the bulk in home health use (53.1 percent) while a majority of users (53.2 percent) who received less than 30 visits, accounted for less than 10 percent of total visits.<sup>229</sup> Concerns centered around two main assumptions. First, the Medicare home care benefit had been turned into a long term care program which was not the original intent of the statute. Second, rampant fraud and abuse were driving the increase in utilization and this had to be stopped with very severe measures.

The main focus was on developing a payment system that would constrain costs but still enable agencies to provide appropriate services to eligible beneficiaries. The Prospective Payment Assessment Commission (ProPAC) and OIG recommended that Congress should require CMS to establish a Prospective Payment System for home health care. This would enable CMS to more clearly define the home health benefit. "The goal in designing a PPS is to ensure that providers have incentives to control costs and that, at the same time, payments are adequate for efficient providers to furnish needed services and at least recover their costs."<sup>230</sup> However, CMS was still in the preliminary stages of developing the case mix adjuster for a home health prospective payment system. Therefore, the Commission recommended an interim payment system in order to immediately "stem rising expenditure growth".<sup>231</sup>

ProPAC made several key recommendations to Congress on home health reimbursement policies. First, they suggested the continuation of the per visit limits under the interim system but with an added cap on payments per beneficiary. They were concerned that reductions in the per-visit limits would not be adequate to control volume, because many agencies might still be able to provide services for less than the visit limits and simply increase the number of visits to increase their revenue. "Beneficiary payment limits would dampen the incentive to provide more visits because such limits would encourage home health agencies to control the number of visits and adjust the mix of services furnished to each user."<sup>232</sup> They also recommended an outlier payment system to reduce incentives for agencies to avoid high cost or high-use patients. To address the concern around fraud and abuse within the system they recommended reinstating a copayment requirement for home health care subject to annual limits. This could reduce fraud by making beneficiaries more directly aware of costs as well as whether or not a service was delivered.<sup>233</sup>

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<sup>228</sup> Grob, G., supra note 224

<sup>229</sup> Hearing on Home Health Care and Skilled Nursing Facility and Other Post Acute Care Payment Policies, Newhouse, J. Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 4, 1997. p. 7-8.

<sup>230</sup> Hearing on Home Health Care and Skilled Nursing Facility and Other Post Acute Care Payment Policies. Scanlon, W. Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, , March 4, 1997 p.4

<sup>231</sup> Supra note 229

<sup>232</sup> Supra note 229

<sup>233</sup> OIG also made this recommendation, see supra note 224

## THE BALANCED BUDGET ACT

Components of the Balanced Budget Act of 1997 (BBA) were directed at controlling health care expenditures in both the Medicare and Medicaid programs. The BBA generated substantial changes in the Medicare program.<sup>234</sup> These amendments included changes in the way that hospitals, skilled nursing facilities and home health agencies would be reimbursed. It also added the Medicare+ choice program allowing beneficiaries new options for health care coverage. The legislation also required the shifting of some home health expenditures into Part B and including these costs in the calculations for Part B premiums.<sup>235</sup>

The main goal of most of these changes was to delay depletion of the Hospital Insurance Trust Fund. Early estimates of overall program savings due to the BBA reached as high as \$116.4 billion over the first five years and \$393.8 billion over ten years.<sup>236</sup> This would delay depletion of the Part A trust fund until 2007. The majority of these savings came from changes in the fee-for-service program. It was predicted that \$29.6 billion in savings would be generated from changes in hospital reimbursements in the first five years. Savings in the home health care benefit would generate another \$16.2 billion. Over ten years the changes to the home health benefit were originally projected to save \$49.6 billion.<sup>237</sup>

The key provisions relevant to home health care included creation of an interim payment system to immediately decrease the growth in home health spending, the elimination of venipuncture as a qualifying benefit, the creation of a surety bond requirement for providers, and the establishment of a home health prospective payment system (PPS). The act further required that any reductions in home health expenditures resulting from the temporary interim payment system would continue with the implementation of the new PPS. Moreover, the new law not only guaranteed that the new system would be budget neutral compared to the IPS, but that initial expenditures would be reduced by an additional 15 percent when the PPS went into effect.

Elimination of the venipuncture benefit may have been related to the fear that many of the venipuncture-only users were not truly homebound.<sup>238</sup> The surety bond element required providers to have a bond that would protect the Medicare program with relation to overpayments or fraudulent practices. The bond was for \$50,000 or 15 percent of the agency's most recent cost report whichever was greater.<sup>239</sup> This was an added financial burden during a period of severe revenue cuts for agencies. The rationale for the PPS was to both control costs and to build a system which would provide the administrative oversight which had been lacking for so long. A PPS would enable CMS to more closely monitor utilization and patient outcomes, thereby creating a benefit that could be more responsive to patient need while avoiding the perverse incentives of a cost-based system.

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<sup>234</sup> Moon and Gage, *supra* note 34

<sup>235</sup> Moon and Gage, *supra* note 34

<sup>236</sup> Congressional Budget Office (1997). *Budgetary Implications of the Balanced Budget Act of 1997* December. Washington, DC:

Author

<sup>237</sup> *Ibid*

<sup>238</sup> Scanlon, *supra* note 60

<sup>239</sup> The Balanced Budget Refinement Act of 1999, P.L. 106-113, 113 Stat. 1501, 42 USC Section 1395.

revised this to \$50,000 or 10 percent of agency costs from the previous year. It also coordinated the requirement for a bond under both Medicare and Medicaid; one bond would be sufficient for both programs.

## THE INTERIM PAYMENT SYSTEM

There were two main goals behind the creation of the interim payment system (IPS). The first goal was to immediately begin to restrain growth in expenditures within the home health program by controlling volume per person. Second, it would allow time for CMS to develop the prospective payment system, and in particular for the home health Prospective Payment Demonstration to generate enough data to aid in developing the PPS.

The IPS established new reimbursement limits for Medicare-certified home health care agencies. Under the IPS, home health agencies would be reimbursed based on "the lowest of: (1) actual costs; (2) new per visit limits; or (3) a blended, agency-specific per beneficiary annual limit".<sup>240</sup> Aggregate per visit limits were set at 105 percent of the median national visit limits, down from 112 percent of the mean national costs.<sup>241</sup> Early projections indicated that the per visit limits alone could have reduced expenditures by 15-22 percent.<sup>242</sup> The per beneficiary limit was the first time that Medicare established a cap on reimbursement at the beneficiary level. This limit was calculated using 98 percent of 1994 costs and utilized a blended formula incorporating 75 percent of the agency's average per beneficiary payment and 25 percent of the regional average.<sup>243</sup> Most agencies therefore would fall under the per beneficiary limit and would at a minimum be cut below expenditures generated in 1994.<sup>244</sup> The rationale for using 1994 data as the base year for revised limit and per-beneficiary caps was that this would allow the program to recapture the savings generated from a two-year freeze on market basket updates between 1994 and 1996. Thus expenditure limits for home health care after October 1, 1997 would be based on 1993 costs since agencies did not receive inflationary increases in 1994.

The IPS was supposed to be replaced by the PPS beginning in 1999, but the OCESAA of 1999<sup>245</sup> postponed the start date of the PPS until October 2000 because CMS was not prepared to implement the new system. This meant that agencies had to operate under the more stringent IPS which lacked a case mix adjuster for one year longer than originally intended. The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 modified the home health delivery system still further.<sup>246</sup> These changes included a temporary reimbursement increase of 10 percent for rural agencies. The increase would be available from April 1, 2001 until April 1, 2003. This act also delayed implementation of the 15 percent cut for one additional year after implementation of the PPS,<sup>247</sup> and it restored the full market basket update for home health services for fiscal year 2001.

<sup>240</sup> Supra note 6, p.87-88

<sup>241</sup> The Omnibus Consolidated Emergency Supplemental Appropriations Act of 1999 (OCESAA), P.L. 105-277, 112 Stat. 2681, increased this to 106 percent of the median after October 1, 1998.

<sup>242</sup> Berke, D., supra note 41

<sup>243</sup> Berke, D., supra note 41; and Scanlon, W., supra note 41.

<sup>244</sup> After OCESAA, supra note 40, established agencies (those with full year participation in MC before FY 1994) falling below the national median would have their per-beneficiary amount increased by 1/3 of the difference between their amount (lesser) and the national median. Agencies established between 94-98 would receive per beneficiary caps based on 100 percent of FY 94 costs rather than 98 percent. Brand new agencies, created after October 1, 1998 would receive 75 percent of the national median based on 98 percent of FY 1994 costs.

<sup>245</sup> OCESAA, supra note 40.

<sup>246</sup> Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. 106-554, 114 Stat. 2763, 42 USC Section 1395

<sup>247</sup> The 15 percent contingency reduction was first delayed by the OCESAA 1999, supra note 40, until October 1, 2000. This was further delayed by the Balanced Budget Refinement Act of 1999, P.L. 106-113, 113 Stat. 1501, 42 USC Section 1395 until one year after implementation of PPS.

## THE IPS AND AGENCY OPERATIONS

The lack of case-mix adjustment in the IPS was cause for alarm among agency representatives and patient advocacy groups. Such a system might prevent agencies from serving higher cost patients, those needing more care, those further from the agency, or those with expensive care needs.<sup>248</sup> "The adjuster would not only protect access to care but would also help ensure that Medicare was paying agencies appropriately."<sup>249</sup> The Medicare Payment Advisory Commission (MedPAC) recommended in a 1999 report that CMS should in the absence of an adjuster, allow agencies to exclude a small number of their caseload from the per-beneficiary limits, thus enabling agencies to continue serving high-cost patients.<sup>250</sup> Concerns focused on how agencies might react to the new system. Such practices might include discharging patients sooner, not admitting certain types of patients, substituting less costly services; or restricting visits below reasonable levels to adequately address patient needs. The types of patient most likely to have experienced negative effects of this policy shift included: those requiring expensive procedures; those requiring daily or greater contact; those with chronic medical conditions, rural patients, and patients lacking informal caregivers.<sup>251</sup>

Early research demonstrated support for concerns regarding patient access to care. MedPAC conducted a survey of home health agency directors in 1999. Fifty-six percent of the directors reported that they had decreased the number of patients served due to the IPS. A majority of directors (71 percent) said that they had decreased the total number of visits per patient. Another 39 percent of directors said that they had chosen not to serve certain kinds of patients and 31 percent said that they had discharged patients due to the IPS.<sup>252</sup> In another survey of agency directors, 68 percent reported limiting the proportion of high-cost patients through screening, marketing and staff changes.<sup>253</sup> Almost all of the directors in this study reported more aggressive discharge efforts. The types of patients mentioned as problematic included wound care, diabetic, Chronic Obstructive Pulmonary Disease and Congestive Heart Failure patients. Other studies found that there was greater evidence of cost-shifting to pay for extended care.<sup>254</sup> Some directors indicated that they were using endowments, lines of credit, or incurring debt to supplement patient care. Likewise, directors indicated that they were making greater referrals to the Medicaid waiver program. Many directors indicated that they may have cut services too drastically at the beginning of IPS.<sup>255</sup> Agencies may have been overly cautious in their response to these changes or they may have misinterpreted the per-beneficiary limits as individual limits rather than aggregate limits. Such agency reactions are understandable considering that agencies are left to cover the cost for unreimbursed care and since they did not have actual per-beneficiary limits until several months after implementation of the IPS.

The GAO conducted surveys of discharge planners and aging service providers.<sup>256</sup> Sixty-six percent of discharge planners and 33 percent of aging service providers reported difficulty getting home health services for certain kinds of patients - patients with intensive skilled needs and with a "significant number of visits over a long period of time".

<sup>248</sup> Kaye L., and Davitt, J. (1999) *Current Practices in High-Tech Home Care*. New York: Springer Publishing Co.; Dummit, L. (1998) *Medicare Home Health Benefit: Congressional and HCFA Actions Begin to Address Chronic Oversight Weaknesses*. Washington, DC: GAO/T-HEHS-98-117.

<sup>249</sup> Dummit, supra note 248, p. 10

<sup>250</sup> MedPAC supra note 54

<sup>251</sup> The Lewin Group. (1998). *Implications of the Medicare Home Health Interim Payment System of the 1997 Balanced Budget Act*. Washington, DC: National Association for Home Care.; Komisar, H. and Feder, J., supra note 19.

<sup>252</sup> MedPAC, 1999, supra note 54

<sup>253</sup> Smith, B.M., supra note 55

<sup>254</sup> Smith, B.M., supra note 55; Davitt, J., supra note 48.

<sup>255</sup> Davitt, supra note 48

<sup>256</sup> Scanlon, supra note 58

The reimbursement limits were also felt at the agency level. CMS documented 554 voluntary and 206 involuntary agency closures between October 1997 and June 1998.<sup>257</sup> Agencies that did not close utilized various strategies to try to lower their costs. Surveys of agency directors reported the following strategies to reduce costs: staff layoffs, staff benefit and reimbursement cuts; debt accrual or depletion of endowment or reserve funds; and reduction in staff education and training.<sup>258</sup> In addition, agency directors reported that staff morale was at its lowest and turnover had increased. This was particularly difficult for agencies given the nationwide nursing shortage at this time. Agencies had very limited resources to recruit qualified staff.<sup>259</sup>

One serious flaw in the design of the IPS is that those agencies that had been operating efficiently in 1994 would end up with a lower reimbursement under IPS than an agency that had higher utilization patterns before the BBA.<sup>260</sup> Since the per-beneficiary limit was based on a blended average of agency-specific (75 percent) and regional costs (25 percent), agencies that had lower costs in 1994 would receive lower reimbursements under the IPS. This would not only affect efficient providers but agencies in those regions which had historically lower reimbursements would be penalized as well. Therefore, some of the agencies that were pushed out of business due to these changes may not have been abusing the system, but simply could not go any lower in terms of cost reductions. Any agency that added more costly services after 1994 such as high-tech care components would also have a difficult time continuing that service after the BBA. Agencies that experienced an increase in case-mix acuity after 1994 would also be severely limited by the reimbursement cuts.

Other agency types were likely to be penalized by the IPS. Small agencies serving a large number of high-use/cost patients would be unable to balance lower cost patients under the per-beneficiary limits since they would not be able to increase their total census. Agencies that saw losses of another provider in their service area (especially in rural areas with few alternatives) might be forced to add more high-use patients, again affecting their ability to balance high-use and low-use patients. In a 1999 report GAO stated that agencies that could not control or modify their patient mix were more likely to go out of business.<sup>261</sup>

Interestingly, the growth rate in home health care expenditures had already begun to decline prior to passage of the BBA. This may be due to the fraud and abuse prevention efforts begun in the early to mid-1990s. If that is the case, then much of the fraud may have been eradicated from the system prior to the BBA. Therefore, the additional cuts in reimbursements may have been inflicted upon providers and beneficiaries who were providing and using services appropriately. This raises the question regarding the impact of the additional cuts brought about under the BBA. Did these cuts fall on legitimate users, thus negatively impacting access to home health care and possibly the quality of care that they were receiving? Such across the board cuts absent a case-mix adjuster cannot discriminate legitimate from illegitimate utilization. The only way to do that is through better administration and monitoring of the program, establishing appropriate outcome measures for both utilization and quality of care. This is something that was lacking throughout history. Numerous GAO and OIG reports documented the problems around lack of consistent standards for how to determine what is reasonable and necessary and how to determine inappropriate utilization and/or billings for inappropriate items. "Our work has shown repeatedly that there is a need for greater control and protection from fraud and abuse. However,

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<sup>257</sup> Scanlon, *supra* note 58

<sup>258</sup> Smith, B.M., *supra* note 55; Davitt, J., *supra* note 48.

<sup>259</sup> Davitt, *supra* note 48; Leon, *supra* note 4.

<sup>260</sup> Lewin, *supra* note 251; Scanlon, *supra* note 41; Komisar, H. and Feder, J., *supra* note 19.

<sup>261</sup> Scanlon, *supra* note 60

we must proceed cautiously to ensure that any measures to control the benefit do not harm those beneficiaries who truly need these services. Our focus must be on protecting the benefit as well as controlling expenditures and minimizing the potential for fraud and abuse."<sup>262</sup>

The intention of IPS was to reduce expenditures by an estimated \$16.2 billion over the first five years.<sup>263</sup> The CBO however, revised this projection in 1999 to \$64 billion, a four-fold increase in savings from home health care alone. Some of the decrease was directly due to the design of the IPS. Simply, the use of 1993 cost data to establish the limits would dramatically reduce payments to agencies. However, an added element that contributed to the additional reductions was agency reaction. Many agencies may have overreacted especially at the beginning of the IPS for several reasons. First, the per-beneficiary limits were published after the IPS took effect. The limits for cost-reporting periods beginning on or after October 1, 1997 were published in the *Federal Register* on March 31, 1998, three months later than the BBA required. Therefore, agencies were operating blindly for several months in terms of the new limits. In fact, many agencies found themselves owing CMS or incurring debt because they exceeded the per-beneficiary limits.<sup>264</sup>

## REACTION TO IMPENDING 15 PERCENT CUT

Another factor that may have contributed to agency overreaction was the fear of further cuts. On top of the reductions in reimbursements resulting from the implementation of the IPS, was a pending 15 percent across the board spending reduction with no case mix adjustment. The cut was originally scheduled to be implemented in 1999 regardless of whether the PPS was established by then.<sup>265</sup> The cut would base the PPS rate on that which would have been in effect if the PPS had not been implemented, minus 15 percent. The lack of a case-mix adjuster under this additional cut raises the same concern as the IPS. Such cuts cannot discriminate between appropriate and inappropriate utilization. Therefore, the 15 percent cut does little to directly address Congress' original concern that fraud and abuse were driving the increase in utilization. It also leads to inaccurate utilization data, since such data may eliminate the most needy beneficiaries from the calculations. Again such broad cuts do not target an important element of the program, that is the ability to develop accurate and consistent outcome measures of utilization and quality.

## IMPLEMENTATION OF OASIS

In addition to actual cuts and impending cuts, agencies were being asked to implement added requirements for data collection. The BBA required CMS to develop a case mix adjuster for the PPS. Congress also granted CMS the authority to "require all home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system".<sup>266</sup> CMS began development of such a system after the OBRA of 1987, required them to develop a "standardized, reproducible" instrument to monitor services.<sup>267</sup> It was not until the BBA, though that they required that all agencies use the Outcome and Assessment

<sup>262</sup> Grob testimony, supra note 224, p.3.

<sup>263</sup> CBO, 1997, supra note 236

<sup>264</sup> Davitt, supra note 48

<sup>265</sup> Implementation of the 15 percent cut was delayed by the OCESAA of 1999 (supra note 40) until October 1, 2000. It was further delayed by the BBRA of 1999, supra note 9, until one year after implementation of the PPS which would mean October, 1, 2002.

<sup>266</sup> BBA of 1997, supra note 6

<sup>267</sup> Home health Care Outcome and Assessment Information Set, Kang, Testimony before the Senate Select Committee on Aging, May 24, 1999.

Information Set (OASIS) instrument. The OASIS assessment consists of 79 data elements covering functional abilities, diagnoses, medical history, financial, physical assessment, living arrangements and social supports, and others. Such an assessment must be completed by agencies at admission, discharge, transfer to inpatient facility, and at recertification points. The assessments can only be conducted by professional staff, including nurses and therapists. In addition, the new process requires access to a modem to transmit data electronically. Therefore, not only would more staff time be required for these assessments and recerts, but many agencies would need to invest in new technology in order to remain in the Medicare system. Therefore, at a time of severe cutbacks agencies were being required to devote increasing revenue to comply with program mandates.<sup>268</sup>

In the face of such dramatic change and uncertainty, agencies responded by restricting services to beneficiaries. Although such cuts do not automatically implicate beneficiary access, the methodology raise serious concerns about both access to and quality of home health care during this time. Most importantly, it raises concerns regarding those legitimate high-use or high-cost beneficiaries that may have experienced inappropriate reductions in visits and overall access.

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<sup>268</sup> The BBRA of 1999 (supra note 9) provided an additional \$10 payment per client to help defray costs incurred for conducting the OASIS assessments.

*APPENDIX B:*

**MEDICARE HOME HEALTH IN NUMBERS**

## The average home health user...

### Exhibit B-1. Characteristics of Home Health Users

- **Female (67 percent)**
- **White (84 percent)**
- **Older than the average Medicare beneficiary**
- **Poorer than the average Medicare beneficiary**
- **More likely to live alone**
- **More likely to have 3 or more impairments in activities of daily living (ADLs)**
- **Uses more nursing home and inpatient care than the average Medicare beneficiary**

**Source:** Centers for Medicare and Medicaid Services. A Profile of Medicare Home Health: Chart Book. Washington, DC: Author, August 1999.

### Exhibit B-2.

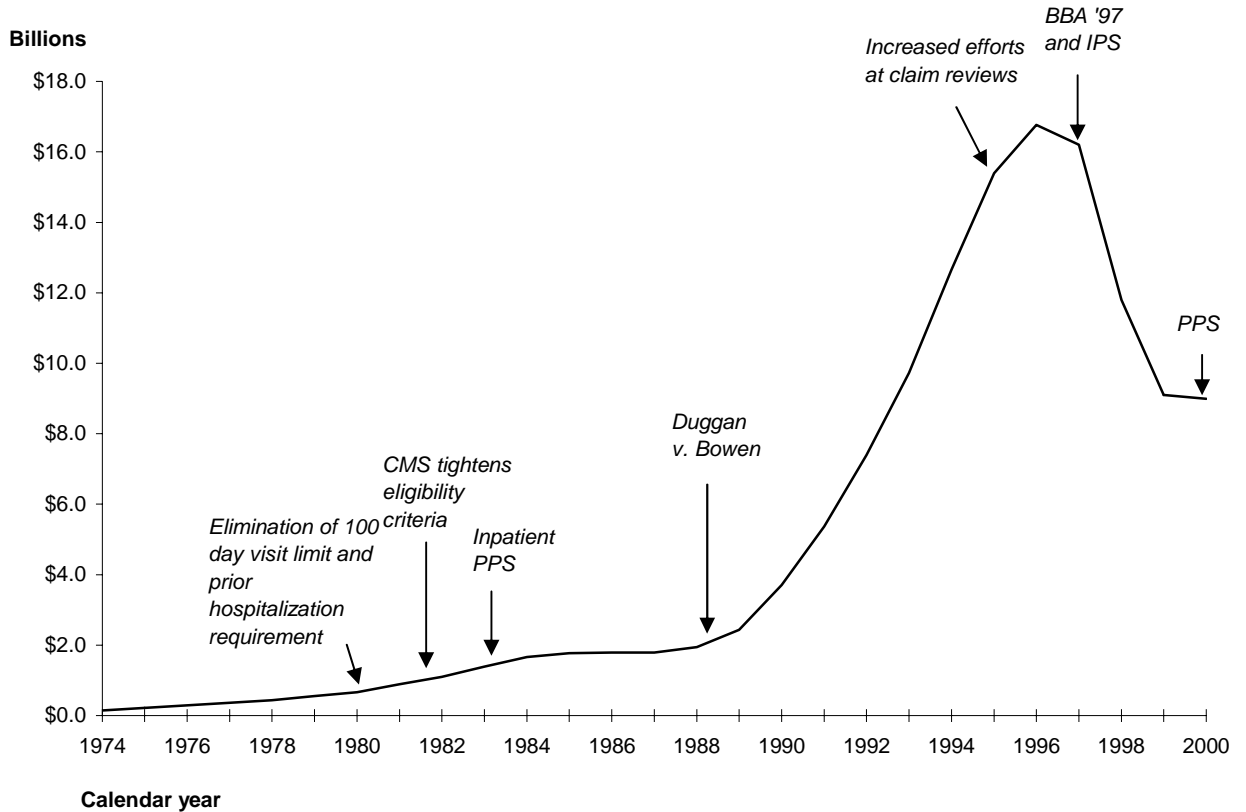
### Common Diagnoses of Home Health Users:

<b>Diagnosis</b>	<b>Percent of Home Health Users in 1997</b>
Diabetes Mellitus	9.1%
Essential Hypertension	6.9%
Heart Failure	6.4%
Osteoarthritis and Allied Disorders	5.8%
Cerebrovascular Disease	5.0%
Chronic Skin Ulcer	4.2%
Chronic Airway Obstruction	4.1%
Other Forms of Chronic Ischemic Heart Disease	3.5%
Cardiac Dysrhythmias	3.2%

**Source:** Centers for Medicare and Medicaid Services. A Profile of Medicare Home Health: Chart Book. Washington, DC: Author, August 1999.

**Since 1997, use of the home health benefit has been dramatically curtailed. Medicare spending on home health care has fallen sharply...**

**Exhibit B-3. Historic Trends in Medicare Home Health Expenditures**



**...a large number of home health agencies have ceased serving Medicare beneficiaries...**

**Exhibit B-4. Number of Home Health Agencies, 1967-2001**

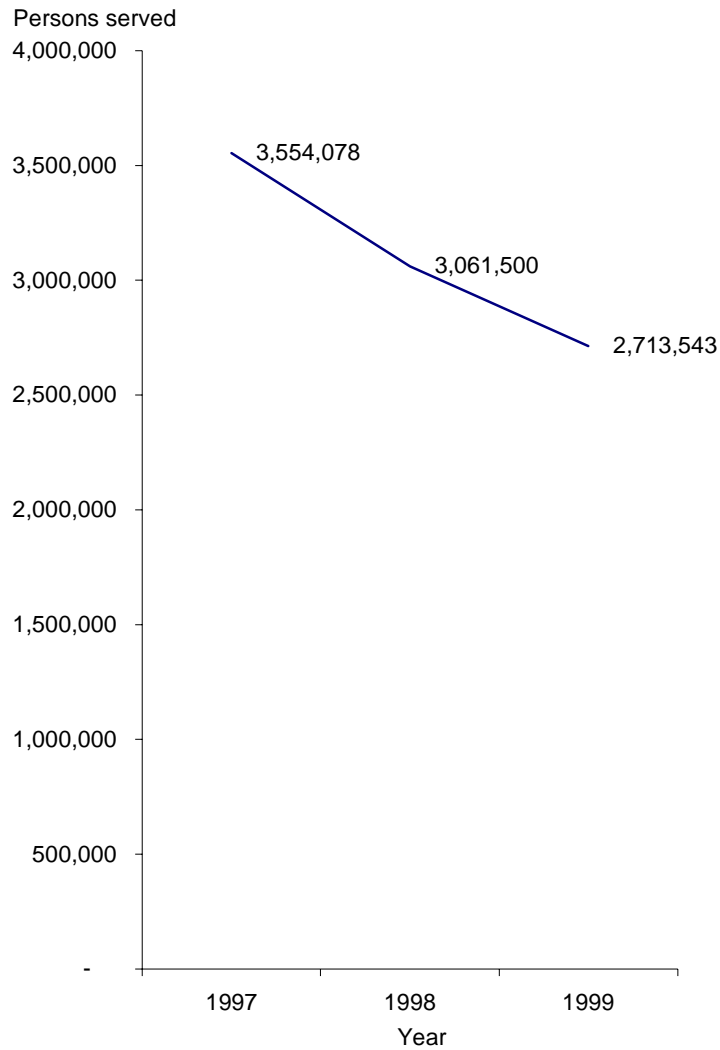
Year	Medicare certified agencies
1967	1,753
1975	2,242
1980	2,924
1985	5,679
1990	5,730
1997	10,807
1998	9,330
2000	7,160
2001	6,881

**Sources:** CMS Office of Information Services, February 2002; 1999 CMS Statistics; CMS 1998 Data Compendium

Data for years 1975-1990 are as of July 1. Data for years 1997-2001 are as of December.

**...and the number of Medicare beneficiaries receiving home health services has declined sharply.**

**Exhibit B-5. Decline in Medicare Beneficiaries Using Home Health**



**Source:** Centers for Medicare and Medicaid Services (CMS) Customer Information System (HCIS)  
Latest available statistics cover 1999.

## The fall in the number of beneficiaries served extends to every state.

### Exhibit B-6.

#### Decline in Number of Patients Served from 1997 to 1999, by State

State	1997 Total Patients	1999 Total Patients	Percent change 1997-1999
Alabama	81,234	51,554	-37%
Alaska	2,505	1,915	-24%
Arizona	34,855	24,539	-30%
Arkansas	45,294	31,065	-31%
California	253,089	203,514	-20%
Colorado	33,468	25,080	-25%
Connecticut	61,133	45,738	-25%
Delaware	9,932	8,915	-10%
District of Columbia	7,600	5,443	-28%
Florida	273,063	204,622	-25%
Georgia	95,278	66,187	-31%
Hawaii	4,997	4,213	-16%
Idaho	15,036	10,699	-29%
Illinois	156,699	120,662	-23%
Indiana	76,694	52,700	-31%
Iowa	38,490	27,717	-28%
Kansas	32,380	20,495	-37%
Kentucky	68,459	51,530	-25%
Louisiana	82,773	55,969	-32%
Maine	24,904	21,028	-16%
Maryland	50,511	44,789	-11%
Massachusetts	117,464	88,293	-25%
Michigan	137,575	119,194	-13%
Minnesota	37,865	27,906	-26%
Mississippi	62,030	44,584	-28%
Missouri	93,082	66,708	-28%
Montana	11,475	8,910	-22%
Nebraska	20,027	15,695	-22%
Nevada	13,129	10,381	-21%
New Hampshire	18,538	13,571	-27%
New Jersey	102,294	88,731	-13%
New Mexico	17,978	13,762	-23%
New York	211,311	187,734	-11%
North Carolina	113,582	91,248	-20%
North Dakota	8,992	7,286	-19%
Ohio	148,332	106,446	-28%
Oklahoma	61,385	42,595	-31%
Oregon	28,454	23,955	-16%
Pennsylvania	208,977	165,540	-21%
Puerto Rico	38,735	31,794	-18%
Rhode Island	20,997	13,108	-38%
South Carolina	51,611	43,111	-16%
South Dakota	9,221	6,698	-27%
Tennessee	106,242	72,859	-31%
Texas	259,144	169,684	-35%

**Exhibit B-6. (continued)**  
**Decline in Number of Patients Served from 1997 to 1999, by State**

<b>State</b>	<b>1997 Total Patients</b>	<b>1999 Total Patients</b>	<b>Percent change 1997-1999</b>
Utah	18,464	15,751	-15%
Vermont	13,291	11,012	-17%
Virgin Islands	271	169	-38%
Virginia	80,722	68,095	-16%
Washington	43,979	36,149	-18%
West Virginia	30,237	22,116	-27%
Wisconsin	50,378	39,394	-22%
Wyoming	5,366	3,786	-29%
<b>United States</b>	<b>3,554,078</b>	<b>2,713,543</b>	<b>-24%</b>

**Source:** Centers for Medicare and Medicaid Services (CMS) Customer Information System (HCIS)

## Visits and expenditures per home health user have also fallen sharply.

### Exhibit B-7.

#### Medicare Home Health Utilization Statistics, By Quarter, 1996-1999

Quarter	Users per 1,000 beneficiaries	Visits per user			Aide	Payments per user
		All types	Skilled Nursing	Other skilled*		
Prior to BBA						
1996-Q1	52.7	35.7	14.8	3.6	17.3	\$2,201
1996-Q2	53.6	36.7	15.1	3.7	17.9	\$2,274
1996-Q3	53.3	37.1	15.2	3.7	18.2	\$2,310
1996-Q4	53.5	36.9	15.2	3.7	18.0	\$2,316
1997-Q1	55.1	36.1	14.8	3.8	17.5	\$2,266
1997-Q2	54.7	36.8	15.0	3.9	17.9	\$2,323
1997-Q3	53.0	36.9	14.9	3.9	18.0	\$2,338
IPS phase-in						
1997-Q4	50.5	36.0	14.9	3.9	17.2	\$2,310
1998-Q1	48.0	31.3	13.7	3.7	13.8	\$2,042
1998-Q2	43.0	30.1	13.8	3.9	12.4	\$1,993
1998-Q3	38.9	28.3	13.2	3.9	11.2	\$1,864
IPS fully implemented						
1998-Q4	37.1	26.6	12.6	4.0	10.0	\$1,750
1999-Q1	37.1	25.3	12.2	4.1	9.0	\$1,691
1999-Q2	35.9	25.2	12.1	4.3	8.8	\$1,713
1999-Q3	33.3	25.3	12.4	4.3	8.6	\$1,751
1999-Q4	32.7	24.9	12.0	4.4	8.5	\$1,749

**Source:** McCall et al. analysis of Center for Medicare and Medicaid Services (CMS) 1 Percent Denominator and Home Health Standard Analytic Files (McCall et al., "Medicare Home Health Before And After The BBA," Health Affairs 20(3): 189-198)

\*Includes physical therapy, occupational therapy, speech language pathology, and medical social services

## Spending per home health user has fallen in every state.

### Exhibit B-8.

#### Decline in Average Payment per Patient from 1997 to 1999, by State

State	1997 Avg Pmt/Pat	1999 Avg Pmt/Pat	Percent change 1997-1999
Alabama	\$5,969	\$3,557	-40%
Alaska	\$5,055	\$2,878	-43%
Arizona	\$4,146	\$2,057	-50%
Arkansas	\$3,826	\$2,557	-33%
California	\$4,408	\$2,898	-34%
Colorado	\$4,739	\$2,708	-43%
Connecticut	\$4,607	\$2,988	-35%
Delaware	\$3,298	\$2,523	-23%
District of Columbia	\$3,596	\$3,063	-15%
Florida	\$5,105	\$3,102	-39%
Georgia	\$5,515	\$3,432	-38%
Hawaii	\$3,282	\$2,274	-31%
Idaho	\$4,091	\$2,115	-48%
Illinois	\$3,457	\$2,390	-31%
Indiana	\$4,206	\$2,454	-42%
Iowa	\$2,526	\$1,462	-42%
Kansas	\$4,060	\$1,973	-51%
Kentucky	\$4,125	\$2,931	-29%
Louisiana	\$9,261	\$5,574	-40%
Maine	\$3,699	\$2,444	-34%
Maryland	\$2,986	\$2,361	-21%
Massachusetts	\$5,168	\$3,184	-38%
Michigan	\$3,903	\$2,747	-30%
Minnesota	\$3,106	\$1,724	-44%
Mississippi	\$6,168	\$4,407	-29%
Missouri	\$3,456	\$2,214	-36%
Montana	\$3,434	\$2,114	-38%
Nebraska	\$2,905	\$1,841	-37%
Nevada	\$4,776	\$3,004	-37%
New Hampshire	\$3,440	\$2,394	-30%
New Jersey	\$3,119	\$2,435	-22%
New Mexico	\$4,564	\$2,384	-48%
New York	\$3,831	\$2,705	-29%
North Carolina	\$3,544	\$2,652	-25%
North Dakota	\$2,596	\$1,604	-38%
Ohio	\$3,157	\$2,287	-28%
Oklahoma	\$8,605	\$4,143	-52%
Oregon	\$2,971	\$1,963	-34%
Pennsylvania	\$3,383	\$2,349	-31%
Puerto Rico	\$1,715	\$1,502	-12%
Rhode Island	\$4,634	\$2,864	-38%
South Carolina	\$3,965	\$2,911	-27%
South Dakota	\$2,701	\$1,517	-44%
Tennessee	\$6,427	\$4,216	-34%
Texas	\$9,083	\$4,097	-55%

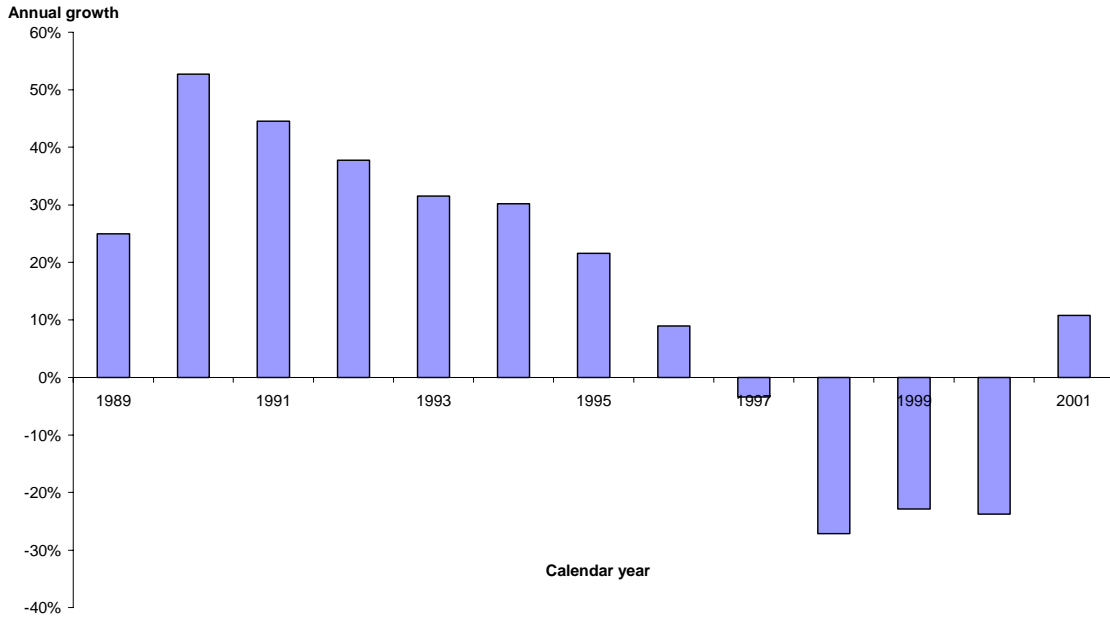
**Exhibit B-8. (continued)****Decline in Average Payment per Patient from 1997 to 1999, by State**

<b>State</b>	<b>1997 Avg Pmt/Pat</b>	<b>1999 Avg Pmt/Pat</b>	<b>Percent change 1997-1999</b>
Utah	\$6,911	\$3,604	-48%
Vermont	\$2,954	\$2,239	-24%
Virgin Islands	\$4,750	\$1,648	-65%
Virginia	\$3,771	\$2,695	-29%
Washington	\$2,772	\$2,110	-24%
West Virginia	\$3,410	\$2,149	-37%
Wisconsin	\$2,843	\$2,001	-30%
Wyoming	\$4,077	\$2,310	-43%
<b>United States</b>	<b>\$4,705</b>	<b>\$2,892</b>	<b>-39%</b>

**Source:** Centers for Medicare and Medicaid Services (CMS) Customer Information System (HCIS) 1997 and 1999 HHA National State Summary

**The cuts in spending were mandated at a time (1997) when the growth rate of Medicare home health expenditures was approaching zero.**

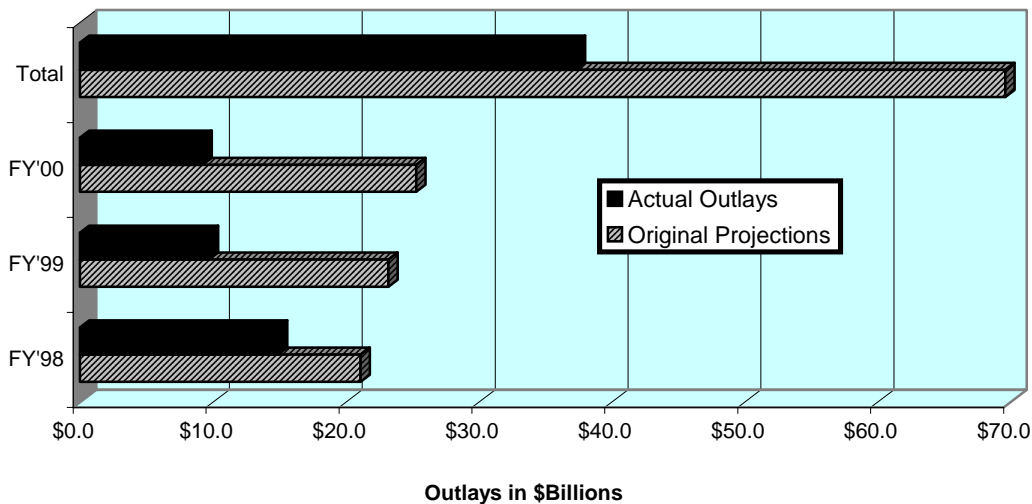
**Exhibit B-9. Growth Rate of Home Health Expenditures 1969 - 2001**



**Source:** 1974 to 1996 data is from Health Care Financing Review 1999 Statistical Supplement. 1997 to 2000 data is from the Center for Medicare and Medicaid Services (CMS) Office of the Actuary, National Statistics Group. Year 2000 data is a CMS Office of the Actuary estimate. Year 2001 data is a Congressional Budget Office forecast.

**The cuts have been far deeper than projected.**

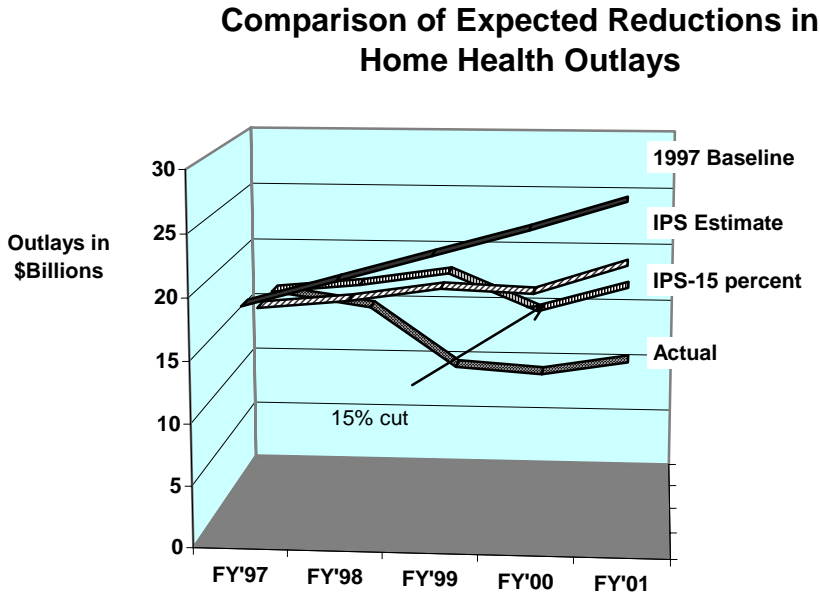
**Exhibit B-10. Comparison of Home Health Outlays: Original Projections vs. Actual Outlays (FY '98 – FY '00)**



Source: CBO Baseline Projects for Medicare, FY 97 through FY'00.

**The savings that the additional October 1, 2002 cut was designed to achieve, have already been reached.**

**Exhibit B-11.  
Comparison of Expected Reductions  
In Home Health Outlays (FY '97 – FY '01)**



Source: CBO Baseline Projects for Medicare, FY 97 through FY'00.

## Historical utilization figures.

### Exhibit B-12.

#### Medicare Home Health Utilization, 1974-1999

Calendar year	Persons served		Visits		Expenditures		
	Total (thousands)	Per 1,000 enrollees	Total (millions)	Per person served	Total (billions)	Per person served	Per visit
1974	393	16	8.07	21	\$0.1	\$359	\$17
1976	589	23	13.34	23	\$0.3	\$493	\$22
1978	780	28	17.35	22	\$0.4	\$558	\$25
1980	957	34	22.43	23	\$0.7	\$691	\$30
1982	1,172	40	30.79	26	\$1.1	\$943	\$36
1983	1,351	45	36.84	27	\$1.4	\$1,035	\$38
1984	1,516	50	40.34	27	\$1.7	\$1,099	\$41
1985	1,589	51	39.74	25	\$1.8	\$1,116	\$45
1986	1,600	50	38.36	24	\$1.8	\$1,122	\$47
1987	1,565	48	36.09	23	\$1.8	\$1,145	\$50
1988	1,602	49	37.71	24	\$1.9	\$1,215	\$52
1989	1,725	51	47.26	27	\$2.4	\$1,410	\$51
1990	1,967	57	70.27	36	\$3.7	\$1,888	\$53
1991	2,243	64	99.83	45	\$5.4	\$2,394	\$54
1992	2,506	70	132.22	53	\$7.4	\$2,951	\$56
1993	2,874	79	164.23	57	\$9.7	\$3,384	\$59
1994	3,179	93	208.62	66	\$12.7	\$3,982	\$61
1995	3,469	102	249.39	72	\$15.4	\$4,436	\$62
1996	3,600	107	264.80	74	\$16.8	\$4,658	\$63
1997	3,558	108	258.17	73	\$16.2	\$4,554	\$63
<b>Fiscal year</b>							
1997	3,296	101	259.8	79	\$16.2	\$4,969	\$63
1998	2,953	92	183.5	62	\$11.8	\$4,052	\$65
1999	2,518	80	116.3	46	\$9.1	\$3,110	\$67

**Sources:** 1974 to 1996 expenditure figures are from Health Care Financing Review 1999 Statistical Supplement. Calendar year 1997 expenditure figures are from the Center for Medicare and Medicaid Services (CMS) Office of the Actuary, National Statistics Group. Visits and persons served from calendar years 1974 through 1997 are from Health Care Financing Review 1999 Statistical Supplement. Fiscal year 1997 to 1999 data are from McCall et al., "Medicare Home Health Before And After The BBA," Health Affairs 20(3): 189-198

## Change in the number of agencies by state.

### Exhibit B-13.

#### Home Health Agency Closures and Openings by State, 1997 to 1999

State	Number of Medicare-certified HHAs		Changes, Oct. 1 1997 to Jan. 1, 1999	
	Oct. 1, 1997	Jan. 1, 1999	Closures	Openings
Alabama	183	181	2	0
Alaska	27	18	9	0
Arizona	131	112	22	3
Arkansas	205	195	11	1
California	848	703	165	20
Colorado	200	161	42	3
Connecticut	116	101	17	2
Delaware	21	18	3	0
District of Columbia	21	22	1	2
Florida	398	365	47	14
Georgia	97	103	0	6
Hawaii	28	21	7	0
Idaho	77	62	16	1
Illinois	393	362	35	4
Indiana	292	248	49	5
Iowa	211	195	19	3
Kansas	221	187	34	0
Kentucky	111	116	2	7
Louisiana	519	407	112	0
Maine	52	46	9	3
Maryland	81	78	3	0
Massachusetts	199	183	18	2
Michigan	230	223	11	4
Minnesota	266	262	9	5
Mississippi	70	69	1	0
Missouri	273	221	56	4
Montana	62	60	4	2
Nebraska	83	76	8	1
Nevada	54	41	14	1
New Hampshire	46	43	3	0
New Jersey	57	55	3	1
New Mexico	118	95	23	0
New York	227	223	5	1
North Carolina	162	174	6	18
North Dakota	35	35	1	1
Ohio	465	426	43	4
Oklahoma	388	299	90	1
Oregon	91	74	18	1
Pennsylvania	381	370	22	11
Rhode Island	30	29	5	4
South Carolina	82	77	5	0
South Dakota	57	53	5	1

## Exhibit B-13. (continued)

**Home Health Agency Closures and Openings by State, 1997 to 1999**

<b>State</b>	<b>Number of Medicare-</b>		<b>Changes, Oct. 1 1997</b>	
	<b>Oct. 1, 1997</b>	<b>Jan. 1, 1999</b>	<b>Closures</b>	<b>Openings</b>
Tennessee	232	206	26	0
Texas	1,948	1,580	392	24
Utah	89	72	19	2
Vermont	13	13	0	0
Virginia	233	226	15	8
Washington	68	66	3	1
West Virginia	92	91	4	3
Wisconsin	176	164	13	1
Wyoming	65	56	9	0
<b>United States</b>	<b>10,524</b>	<b>9,263</b>	<b>1,436</b>	<b>175</b>

**Source:** General Accounting Office (GAO) analysis of CMS OSCAR data for 1997 and 1999

*APPENDIX C:*  
**A PPS PRIMER**

## THE BASIC STRUCTURE OF HOME HEALTH PPS

To understand PPS as a payment system,<sup>269</sup> it is necessary to understand some basic components: (1) the episode of care; and (2) the approach used to classify home health beneficiaries into designated patient categories, referred to as Home Health Resource Groups or HHRGs. Linking the two elements is (3) the national standardized 60-day episode payment rate, referred to in this report as the ‘NSPR-60.’

### *Episodes of Care*

Evidence from the National Home Health Prospective Payment Demonstrations<sup>270</sup> showed that a defined period of service duration rather than a defined number of service visits created incentives for cost-efficiency without obvious reductions in quality. Analyses showed that a 60-day period captured the complete service duration for the majority of patients.<sup>271</sup>

Under PPS, the initial 60-day episode begins with the first billable visit and ends 60 days later. Any consecutive episode begins on the 61<sup>st</sup> day and then extends an additional 60-day period.<sup>272</sup> Payments are based on episodes and there is no limit on the number of episodes as long as the beneficiary remains eligible for services and a physician certifies that the continuing care is medically necessary.

### *Home Health Resource Groups and OASIS*

The payment rate for each episode is predetermined based on the classification of beneficiaries into case-mix groupings derived from their predicted resource use (HHRGs).<sup>273</sup> The patient categories are derived from the use of a 79-item standardized assessment tool referred to as OASIS.<sup>274</sup> It covers information about patients' current health and functional status, health service use, living arrangements, and the availability of social supports.<sup>275</sup> Use of OASIS as the standard assessment tool became a “Condition of Participation” for Medicare home health agencies in 1999.<sup>276</sup>

### *OASIS as a Basis for Classifying Home Health Beneficiaries*

Algorithms called ‘case-mix groupers’ categorize patients using 23 OASIS items distributed across three domains: (1) clinical severity, (2) functional status, and (3) service utilization characteristics. The clinical dimension is influenced by whether the patient has any neurological, orthopedic, or diabetic primary diagnoses and whether certain conditions are present including surgical wounds, vision and sensory problems, pain, incontinence, cognitive deficits or behavioral problems. The functional dimension considers if the patient has difficulties performing various routine daily activities such as dressing, bathing, transferring from surfaces such as chairs and beds, and toileting. The service utilization dimension is informed by whether

<sup>269</sup> And not as a system leading to quality improvement in the delivery of home health services (Outcome-Based Quality Improvement).

<sup>270</sup> Cheh, V. (2001) “The Final Evaluation Report on the National Home Health Prospective Payment Demonstration: Agencies Reduce Visits While Preserving Quality” Mathematica Policy Research, Inc.

<sup>271</sup> *Federal Register* 3748-3763 (January 25, 1999)

<sup>272</sup> Grimaldi, supra note 78

<sup>273</sup> Supra note 271

<sup>274</sup> OASIS is an acronym for Outcome and Assessment Information Set.

<sup>275</sup> Testimony of Jeff Kang, M.D., M.P.H., Director, Office of Clinical Standards and Quality, Health Care Financing Administration, On the Home Health Care Outcome And Assessment Information Set (OASIS) Before The Senate Select Committee on Aging, May 24, 1999.

<sup>276</sup> Conditions of Participation are the requirements that a home health agency must meet to participate in Medicare.

the patient in the last 14 days has been discharged from a skilled nursing facility (SNF) or an inpatient rehabilitation program and whether 10 or more skilled therapy visits are expected during the 60-day episode of care as documented in the plan of care. There are four clinical severity levels (0-3),<sup>277</sup> five functional levels (0-4), and four service utilization levels (0-3) resulting in 80 HHRGs. A patient is assigned into one of the 80 categories by combining the severity levels from the three dimensions where: C represents clinical; F represents functional; and S represents service utilization. Thus COF1S2 designates a beneficiary with low levels of medical needs (C0), with moderate functional impairment (F1), and higher needs for rehabilitation services (S2).<sup>278</sup>

### ***The National Standardized 60-Day Episode Payment Rate***

The single most important driver of episode reimbursement levels, as well as total program expenditures, is the ‘NSPR-60.’ The basic elements that underlie this all-important rate are either directly mandated or implied by legislation. The BBA required the Secretary to establish a home health PPS that pays for all covered services including medical supplies based on a prospective amount that is “computed on a reasonable cost basis” and “standardized to eliminate the effects of case-mix and wage levels among home health agencies.”<sup>279</sup> Legislation also mandates that the total expenditures for the prospective payment system at its inception (FY01) must be budget neutral to “what would be expended under the interim payment system [IPS].”<sup>280</sup>

In complying, CMS created the initial *NSPR-60* by first calculating the national average 60-day episode payment level and then making adjustments to comply with additional mandated requirements. The unadjusted national 60-day rate is based on the national average cost of visits for each type of home health visit (skilled nursing, physical therapy, etc.) and the following components that are tied directly to a 60-day episode of care:

- (1) The national mean discipline-specific utilization rates;
- (2) Costs associated with routine and non-routine medical supplies and Part B therapy services now bundled into the episode payment; and
- (3) Costs associated with the collection and processing of OASIS assessments.

The unadjusted rate was derived by multiplying the national average per visit cost by the national mean number of each type of home health visit used in a 60-day period<sup>281</sup> and adding the average expected costs for medical supplies, Part B therapies, and conducting and processing the OASIS assessments.

This national average amount was then standardized based upon legislatively mandated adjustments: (1) a standardization factor to adjust for case-mix and wage variations, (2) a budget neutrality factor,<sup>282</sup> and (3) a factor that adjusts for CMS outlays for expected outlier payments.<sup>283</sup> The latter two adjusters are used to insure that the 60-day episode rate meets the budget neutrality targets, so that in aggregate, the total expenditures for the estimated number of full episodes under PPS do not exceed the budget neutral targets.

<sup>277</sup> Higher numbers indicate greater severity.

<sup>278</sup> Example given in Grimaldi, supra note 78

<sup>279</sup> Section 1895(b)(3)(A)(i) of the Act.

<sup>280</sup> *Federal Register* 41130 (July 3, 2000)

<sup>281</sup> Excluding home health patients who receive less than 4 visits during a 60-day episode.

<sup>282</sup> In the calculation of the national standardized 60-day episode payment rate, the budget neutrality factor is of supreme importance and is discussed elsewhere.

<sup>283</sup> *Federal Register* 41135 - 41170 (July 3, 2000)

In the initial year of PPS (FY01), that target is based on the level of aggregate expenditures that would have occurred under IPS. In establishing the *NSPR-60* for the initial PPS period, starting October 1, 2000, CMS had to comply with the legislative mandates specifying that the cost data ‘is computed on a reasonable cost basis’ and ‘based on most currently available audited home health cost reports.’<sup>284</sup> To comply, CMS used cost reports for home health agencies covering FY97. Base-year costs were updated for inflation through using the home health market basket index. There was no similar mandate regarding the use of utilization data. CMS used Medicare home health claims data covering calendar year 1998, the first year of IPS, organized into 60-day episodes.<sup>285</sup>

The budget neutrality targets were modified under legislation<sup>286</sup> so there are two *NSPR-60s*, covering FY01:<sup>287</sup> \$2,115.30 for episodes between October 1, 2000 and April 1, 2001 and \$2,161.84 for episodes between April 1, 2001 and October 1, 2001.<sup>288</sup> FY ‘02 the rate is \$2,274.17.<sup>289</sup>

### ***The Basis for Payment Levels***

Under PPS, episode payment levels are adjusted by case-mix as represented by the HHRG and by local wage levels. Each HHRG has a derived numeric value<sup>290</sup> that indicates how much the cost for a particular HHRG differs from the overall *NSPR-60*. The 60-day payment level for each HHRG is calculated by multiplying the *NSPR-60* by the value associated with each HHRG. The agency payment is adjusted for the wage levels in a local area where the patient is served by adjusting labor-related portion of the payment (77.668 percent of the total).<sup>291, 292</sup> The following example illustrates the 60-day episode payment for the beneficiary categorized by the HHRG designation COF1S2 where the beneficiary was living in Denver Colorado and the 60-day episode of care began after September 1, 2002.<sup>293</sup>

## **THE NATIONAL STANDARDIZED 60-DAY EPISODE PAYMENT RATE**

The single most important driver of episode reimbursement levels, as well as total program expenditures, is the ‘*NSPR-60*.’ The basic elements that underlie the calculation of this all-important rate are either directly mandated or implied by legislation. The BBA required the Secretary to establish a home health PPS that pays for all covered services including medical supplies based on a prospective amount that is ‘‘computed on a reasonable cost basis’’ and ‘‘standardized to eliminate the effects of case-mix and wage levels among home health agencies.’’<sup>294</sup> Legislation also mandates that the total expenditures for the prospective payment system at its inception (FY01) must be budget neutral to ‘‘what would be expended under the interim payment system [IPS].’’<sup>295</sup>

<sup>284</sup> *Ibid.*, p. 41130.

<sup>285</sup> *Ibid.*, pp. 41134 and 41171.

<sup>286</sup> Section 502 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 restored the full home health market basket update for home health services for FY01

<sup>287</sup> CMS Transmittal Notice A-01-06, January 16, 2001.

<sup>288</sup> Section 502 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 restored the full home health market basket update for home health services for FY 01, CMS Transmittal Notice A-01-06, January 16, 2001.

<sup>289</sup> MedPAC Report to the Congress: Medicare Payment Policy, March 2002, p. 94.

<sup>290</sup> Called its *relative cost weight* and represents the expected level of resource use required by the patient

<sup>291</sup> *Federal Register* 41183 (July 3, 2000)

<sup>292</sup> Because labor-related rates are not available for home health, payments in FY01 are adjusted by Medicare’s hospital wage index for the geographic area where the beneficiary receives care.

<sup>293</sup> Grimaldi, *supra* note 78

<sup>294</sup> Section 1895(b)(3)(A)(i) of the Act.

<sup>295</sup> *Federal Register* 41130 (July 3, 2000)

<b>EXHIBIT Appendix C-1. Calculation of Payment Level for an Episode of Care for a Beneficiary in Denver Designated at HHGR C0F1S2, FY '02<sup>1</sup></b>		
National standardized payment rate	\$2,274.17	
HHRG - Weight Adjustment	<u>x 1.5796</u>	
Case-mix adjusted payment rate	\$3,592.28	
Labor-related component	<u>x 0.77668</u>	
Labor-related portion	\$2,790.05	
Wage index adjustment	<u>x 1.019</u>	
Wage adjusted labor portion of payment	\$2,843.06	\$2,843.06
Calculation of nonlabor portion		
Case-mix adjusted payment rate	\$3,592.28	
Nonlabor-related component	<u>x 0.22332</u>	
Nonlabor adjusted portion of payment	\$802.23	<u>\$802.23</u>
Payment level for episode		\$3,645.29
<sup>1</sup> For a 60-day episode beginning after September 1, 2002		
<b>Source:</b> Grimaldi, P. (2000), "Medicare's New Home Health Prospective Payment System Explained," Healthcare Financial Management, p. 50.		

In complying, CMS created the *NSPR-60*, by first calculating the national average 60-day episode payment level and then making adjustments to comply with additional mandated requirements. The unadjusted national 60-day rate is based on the national average cost of visits for each type of home health visit (skilled nursing, physical therapy, etc.) and the following components that are tied directly to a 60-day episode of care:

- (1) The national mean discipline-specific utilization rates;
- (2) Costs associated with routine and non-routine medical supplies and Part B therapy services now bundled into the episode payment; and
- (3) Costs associated with the collection and processing of OASIS assessments.

The unadjusted rate is derived by multiplying the national average per visit cost by the national mean number of each type of home health visit used in a 60-day period<sup>296</sup> and adding the average expected costs for medical supplies, Part B therapies, and for conducting and processing the OASIS assessments.

This national average amount is then standardized based upon legislatively mandated adjustments: (1) a standardization factor to adjust for case-mix and wage variations, (2) a budget neutrality factor,<sup>297</sup> and (3) a factor that adjusts for CMS outlays for expected outlier payments.<sup>298</sup> Other adjustments might be necessary after the initial years of PPS as more experience is gathered under PPS.<sup>299</sup> The standardization factor that adjusts for case-mix and wage variations is used to neutralize the effects of case-mix and wage-rate variations that exist in claims data. This adjustment is necessary because ample historical evidence shows considerable

<sup>296</sup> Excluding home health patients who receive less than 4 visits during a 60-day episode.

<sup>297</sup> In the calculation of the national standardized 60-day episode payment rate, the budget neutrality factor is of supreme importance and is discussed elsewhere.

<sup>298</sup> *Federal Register* 41135 - 41170 (July 3, 2000)

<sup>299</sup> *Ibid.*

**EXHIBIT Appendix C-2.  
Calculation of the National Standardized  
60-Day Episode Payment Rate (NSPR-60)**

Type of Home Health Visit	Mean Visits per Episode <sup>1</sup>	Meanc Cost per Visit	Total Cost per Episode <sup>1</sup>
Home health aide	\$13.40	\$41.75	\$559.45
Medical social services	\$0.32	\$153.59	\$49.15
Occupational therapy	\$0.53	\$104.76	\$55.52
Physical therapy	\$3.05	\$104.05	\$317.35
Skilled nursing	\$14.08	\$94.96	\$1,337.04
Speeh pathology	\$0.18	\$113.26	\$20.39
<i>Subtotal</i>	\$31.56		\$2,338.90
<b>Additional Cost Items</b>			
Costs Related to Consolidated Billing C			
<i>Routine and nonroutine medical supplies</i>			\$49.62
<i>Part B therapy visits</i>			\$6.08
OASIS costs			
<i>One time start-up</i>			\$5.50
<i>Ongoing</i>			\$4.32
<b>National average 60-day episode payment (unstandardized)</b>			\$2,416.01
<b>Standardization adjustments</b>			
Divided by the standardization factor for case-mix and wage level variations <b>(factor=0.96184)</b>			\$2,511.86
Multiplied by budget neutrality factor <b>(factor=0.88423)</b>			\$2,221.06
Divided by the outlier payment adjustment <b>(factor =1.05)</b>			\$2,115.30
<b>National Standardized 60-Day Episode Payment Rate (NSPR-60) - October 1, 2000 - March 31, 2001</b>			<b><u>\$2,115.30</u></b>
<b>Multiplied by Market basket Adjustment (1.022)</b>			X 1.022
<b>National Standardized 60-Day Episode Payment Rate (NSPR-60) - April 1, 2001 - September 30, 2001</b>			<b><u>\$2,161.84</u></b>

<sup>1</sup> For home health patients with more than 4 visits during 60-day episodes

**Sources:** Grimaldi, P. (2000), "Medicare's New Home Health Prospective Payment System Explained," Healthcare Financial Management, p. 49, and 50 and CMS Transmittal Notice A-01-06, January 16, 2001.

regional variations both service use levels and wage levels.<sup>300</sup> Once neutralized for such variation, the HHRG weights then specifically account for case-mix and the HHRG rate is then specifically adjusted for local wage rates. If this standardization adjustment were not made, the resulting 60-day episode payment would not properly represent a nationally uniform level. The latter two adjusters are used to insure that the 60-day episode rate meets the budget neutrality targets, so that in aggregate, the total expenditures for the estimated number of full episodes under PPS do not exceed the budget neutral targets. In the initial year of PPS (FY01), that target is based on the level of aggregate expenditures that would have occurred under IPS. In establishing the *NSPR-60* for the initial PPS period, starting October 1, 2000, CMS had to comply with the legislative mandates specifying that the cost data ‘is computed on a reasonable cost basis’ and ‘based on most currently available audited home health cost reports.’<sup>301</sup> To comply, CMS used cost reports for home health agencies covering FY97. Base-year costs were updated for inflation through FY01 using the home health market basket index. There was no similar mandate regarding the use of utilization data. CMS used Medicare home health claims data covering calendar year 1998, the first year of IPS, collected into 60-day episodes.<sup>302</sup>

As previously indicated, the budget neutrality targets were modified under Section 502 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 which restored the full home health market basket update for home health services for FY01, thus for FY01 there are two *NSPR-60s*, covering the first and second halves of FY01.<sup>303</sup> The following example updates one presented by Grimaldi<sup>304</sup> describing the calculation of *NSPR-60s* for FY01.

## CALCULATION OF OUTLIER PAYMENTS

Medicare also adjusts payments for patients who generate unusually large treatment costs during a 60-day episode. Referred to as ‘outlier payments,’ they apply to patients with standard 60-day episodes, PEPs, and for those with SCIC. Such payments are made when patient costs exceed a preset threshold that, for a given patient, is the sum of 113 percent of the *NSPR-60* adjusted for local wage variation plus the original HHRG amount. The actual outlier payment adjustment is 80 percent of the difference between the threshold amount and the costs incurred in serving the patient, derived by multiplying the number of the discipline-specific visits by the per-visit rates under LUPA adjusted for local wage rates. Payment to the agency for the patient is the sum of the adjustment plus the original HHRG amount. The following example shows how the outlier payment would be calculated for the previously describe home health patient, living in Denver Colorado for care receive after April 1, 2001.

Because of the use of the large preset threshold, the outlier payment adjuster would discourage agencies from taking on patients likely to exceed typical payment levels. Outlier payments also pose significant problems for agencies regarding cash flow and revenue recognitions because of the extraordinarily high threshold level used by CMS and because the actual adjustments, made automatically in the processing of the claim, do not come close to the actual costs.<sup>305</sup>

<sup>300</sup> Masuer, E, and Miller, N (1994) “A Profile of Home Health Users in 1992,” Health Care Financing Review, Vol. 16, No. 1, pp. 17-33; Schore, J. (1994) “Patient, Agency, and Area Characteristics Associated with Regional Variation in the Use of Medicare Home Health Services,” Princeton, NJ: Mathematica Policy Research, Inc., September, 1994; Leon, supra note 4.

<sup>301</sup> *Federal Register* 41130 (July 3, 2000)

<sup>302</sup> *Federal Register* 41134 and 41171 (July 3, 2000)

<sup>303</sup> CMS Transmittal Notice A-01-06, January 16, 2001.

<sup>304</sup> Grimaldi, supra note 78

<sup>305</sup> Grimaldi, supra note 78, p. 53.

<b>Exhibit C-3</b>			
<b>Calculation of Outlier Episode Payment HHRG=C0F1S2, Denver, CO April 30, 2001</b>			
<b>Estimated Cost of Episode</b>	<b>Number of Visits</b>	<b>LUPA Per-Visit Rate</b>	<b>Total Payment</b>
Skilled Nursing	27	\$97.90	\$2,643.30
Physical Therapy	19	\$107.04	\$2,033.76
Home Health Aide	31	\$44.32	\$1,373.92
Total estimated standardized cost			\$6,050.98
Calculate Labor Component			\$6,050.98
Multiply by labor-related percentage			x 0.77668
			\$4,699.68
Multiply by wage index			x 1.019
Labor-related cost			\$4,788.97
Calculate Nonlabor Component			\$6,050.98
Multiply by nonlabor-related percentage			x 0.22332
Non-labor-related cost			\$1,351.30
Total estimated cost			\$6,140.27
<b>Cost Outlier Threshold</b>			
National standardized payment rate			\$2,161.84
Multiply by fixed-dollar loss factor			x 1.13
Fixed-dollar loss factor			\$2,442.88
Multiply by labor-related percentage			x 0.77668
			\$1,897.34
Multiply by wage index			x 1.019
Labor-related cost			\$1,933.38
Calculate Nonlabor Component			\$2,442.88
Multiply by nonlabor-related percentage			x 0.22332
Nonlabor-related cost			\$545.54
Wage-adjusted fixed-dollar loss			\$2,478.93
National standardized payment rate			\$2,161.84
Relative cost weight (C0F1S2)			1.5796
Add case-mix and wage-adjusted payment rate			\$3,414.84
Outlier threshold for (C0F1S2)			\$5,893.77
Subtract cost outlier threshold from estimated cost			\$246.50
<b>Outlier Payment</b>			
Estimated cost above the threshold			\$246.50
Multiply by loss-sharing ratio			x .80
Outlier payment adjustment			\$197.20
Add case-mix and wage-adjusted payment rate			\$3,414.84
Total payment with adjustment			\$3,612.04
<b>Difference between actual costs and reimbursement - Outlier loss to Agency</b>			<b>(\$2,528.23)</b>
<b>Source:</b> Grimaldi, P. (2000), "Medicare's New Home Health Prospective Payment System Explained," <i>Healthcare Financial Management</i> , p. 53			