HEALTH CARE FINANCING ADMINISTRATION

File
Physician Certification

ADDRESSEE:	FROM: Liz Shannahan
Sarah Bricchi Chris Jennings	OFFICE OF THE ADMINISTRATOR 200 INDEPENDENCE AVE., S.W. ROOM 314G WASHINGTON, DC 20201
PHONE:	PHONE: 202-690-6726 FAX : 202-690-6262

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REMARKS:

For Chris' final review.

9/19/97

HHA PHYSICIAN CERTIFICATION NOTICE -- QUESTION AND ANSWER

Q. Why does this notice need to be published at this time?

A. We believe it is ~~urgent~~ prudent & necessary to publish this notice because there has been confusion regarding the home health physician certification regulations for the last year. We believe the issues at hand should be resolved more formally through the rulemaking process.

This final notice with comment will clarify that HCFA is withdrawing recent letter interpretations relating to indirect compensation arrangements where the physicians are salaried employees of, or have contractual arrangements to provide services for, an entity that also owns an ~~HHA~~ home health agency.

We had issued letters hoping to clarify existing regulations but found that this raised more confusion. In fact, we found that the subject letter interpretations could have unintended consequences affecting integrated delivery systems and current medical practice. The interpretation is especially problematic in rural areas where the hospital or other entity is so large a presence in the community that, in addition to owning the HHA, it also employs the majority of the physicians.

Our next step is to evaluate our recent letter interpretations in conjunction with our development of the Stark II proposed regulation. The Stark II regulation also relates to physician certification issues and affects HHAs. The Stark II regulation is currently under review at OMB and we hope to publish it this Fall, which is when the Balanced Budget Act of 1997 requires us to begin accepting advisory opinions concerning whether a referral for a designated health service (other than clinical laboratory service) violates the physician self-referral provisions. Combining our policy considerations regarding the subject issue in this one regulation (Stark II) and withdrawing our letter interpretations will ensure that consistent policies and definitions will be applied to home health certifications while mitigating the confusion and potential disruption caused by the letter interpretations. The notice announces this intent to the public.

File Home Health
CJ

MEMORANDUM

July 24, 1997

TO: Melanne Verveer

FR: Chris Jennings

RE: Letter to Val Halamandaris

Attached is the letter that the President wrote in response to Val's concerns over the home health care copayment. Apparently, Val is very pleased to have received the letter. I believe that he now feels that we have been responsive to him.

Also, the $5 copayment for home health appears to be dead on the Hill right now.

Please call with any questions.

THE WHITE HOUSE

WASHINGTON

July 17, 1997

Mr. Val J. Halamandaris
President
National Association for Home Care
228 Seventh Street, S.E.
Washington, D.C. 20003

Dear Val:

Thank you for your leadership in raising the important concerns regarding the Senate proposal to require a new copayment for Medicare home health services. As always, I appreciate having the benefit of your thoughtful advice. Ensuring an efficiently administered, high-quality, affordable Medicare home care service is a top priority for my Administration.

Some have argued that imposing a new copayment would help reduce the current problem of overutilization of home health care services. We must take steps to ensure that home health services are used only by those who truly need them. However, because over 85 percent of Medicare beneficiaries have supplemental insurance protections, either through Medigap or Medicaid, this provision would neither substantially reduce utilization of services nor decrease overall spending on health care.

For the 15 percent of beneficiaries without additional coverage protections, however, these costs may be excessive. Medicare beneficiaries who use home health services are often some of our most vulnerable older Americans. This population tends to be sicker, because nearly half have some type of chronic illness. Over 60 percent of Medicare's home health users who lack supplemental insurance protections have incomes below $10,000, and nearly 90 percent have incomes below $20,000. There is no doubt that a five-dollar copay would impose a significant cost burden on this population.

For all of these reasons, I cannot support the Senate-passed proposal and have urged Congress to drop it in the Senate-House conference. Thanks again for your letter. I look forward to working with you on this and other issues of mutual concern.

Sincerely,

Bill Clinton

Chris

HOMECARE®

NATIONAL ASSOCIATION FOR HOME CARE
228 Seventh Street, SE
Washington, DC 20003
202/547-7424, 202/547-3540 fax

MARY SUTHER
CHAIRMAN OF THE BOARD
VAL J. HALAMANDARIS
PRESIDENT

HONORABLE FRANK E. MOSS
SENIOR COUNSEL
STANLEY M. BRAND
GENERAL COUNSEL

July 3, 1997

First Lady Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue, N.W.
OEOB Room 100
Washington, DC 20500

Dear Mrs. Clinton:

Your assistance is needed immediately in order to protect millions of our most vulnerable citizens. Time is of the essence in this matter. It is of such vital importance to us that despite full knowledge of how very busy you are, I have asked for a meeting with you and the President.

I am sure you know that next week the Senate and House conferees will begin to reconcile differences between the Senate and House passed deficit reduction and tax reform bills. Both bills contain Administration initiated proposals which will sharply reduce the Medicare home care benefit. Among these include:

- shifting a major portion of the benefit from Part A of Medicare, which is funded by payroll taxes to Part B, which is funded predominantly by general revenues;
- restricting coverage under Part A to individuals who have a three day prior institutional stay;
- significantly reducing allowable reimbursement to providers, which in many cases will fall below their actual costs for providing care;
- imposing new barriers limiting access to home care; and
- changing the payment system from the current cost based method to prospective payment.

Taken together, these proposals will have a devastating affect on providers and result in millions of Medicare beneficiaries not receiving access to needed home care services which are available under current law. The burden is disproportionate. While home care represents 9.7 percent of Medicare expenditures, we are being asked to carry 17 percent of all the reductions in Medicare.

All of the above are part of the bipartisan agreement which the Administration has hammered out with members of Congress. Since language is congruent on both sides of the Capitol, there is little that we can do about the above proposals.

HOMECARE

However, we can and we must do something about the onerous requirement imposed by the Senate, which, on top of all of the above, would require home care beneficiaries to pay $5.00 per visit out of their pockets beginning with the very first home care visit up to a maximum of $760. President Clinton and the Administration are on record in opposition to copayments: a) because they cost more to collect than they save the program; b) because they become unfunded mandates requiring the states to pick up millions of additional dollars under the Medicaid program; c) because the burden falls heaviest on the poorest and sickest; and d) they constitute a barrier to care resulting in increased expense in the form of hospital admissions or nursing home placement.

We believe it is vitally important for the President and the Administration to do everything possible to delete the Senate copayment provision. Copays are opposed by every single consumer and senior citizen group. The copay proposal was not part of the bipartisan budget agreement and the revenues generated therefrom are not needed to meet the budget reduction target. If the Administration does not intervene aggressively in conference, the copayment proposals, along with all of the other burdens listed above, will become the law of the land.

It would be the most tragic of all ironies to have the Clinton-Gore Administration, which has been the most supportive of hospice and home care issues and has recognized the need to expand the scope of home care to meet the nation's growing long-term care problem, go down in history as playing a part in the dismantling the Medicare home health benefit.

On behalf of the millions of patients, their families, and the thousands of workers in the home care field, I want to thank you in advance for your assistance. You are a great friend, and we very much appreciate all you have done for our country.

With best wishes,

Sincerely,

Val J. Halamandaris
President

VJH:amw
Enclosure

The Honorable Frank E. Moss
519 C Street, NE
Washington, DC 20002
(202) 547-7424

July 3, 1997

First Lady Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mrs. Clinton:

Conferees will soon consider legislation to fundamentally change the nature of the Medicare program. I agree that it is time we examined Medicare; however, I would hate to see us repeat some of the mistakes we made in the past.

I was the author in 1965 of the amendment which included home health care coverage under Medicare. Congressman Claude Pepper introduced the legislation in the House. Our original legislation required seniors to pay some portion of their home care costs out-of-pocket. However, studies by the Senate Committee on Aging and the General Accounting Office persuaded me in 1972 to work with Senators Edmund Muskie (D-ME) and Gaylord Nelson (D-WI) to delete the copayment provision. Our studies clearly indicated that copayments:

* cost Medicare more to collect in administrative costs than they saved the program;
* denied access to care and fell most heavily on those who could least afford it;
* pushed families into poverty and loved ones unnecessarily into institutions, resulting in increased costs to the states and the federal government through the Medicaid program; and
* increased costs to Medicare because people delayed care until they had to be hospitalized.

I am writing to you today because a provision was added in the Senate budget package to require seniors to pay a $5.00 copayment beginning with the very first visit, up to a total of $760. The House version contains no such provision. Copayments were a bad idea in my original bill in 1965 and for the same reason they are a bad idea today. I am writing to urge you to help make sure that we do not repeat the mistakes that we made in the past.

The home care portion of Medicare is small, representing 9.7 percent of the total, and yet home care has been saddled with disproportionate cuts in the Senate package -- fully 17 percent of all of the Medicare reductions. Most of these reductions come at the expense of home care providers, which is bad enough, but the copayment provision is particularly intolerable because it comes at the expense of the most vulnerable seniors.

A strong case can be made for expanding the scope of home care under Medicare to cover long-term care. Approximately ten million individuals who suffer from multiple disabilities are struggling to care for themselves, going without the care that they need, or waiting until an expensive admission to a hospital emergency room is the only answer. Let's do our best to improve Medicare and not make it less responsive to the needs of our seniors.

I am writing to ask that you work with others in the Administration to ensure that the copayment proposal is deleted in conference.

Sincerely,

Ted

Frank E. Moss
U.S. Senator (ret.)

File Home Health care

U.S. Department of Labor

Assistant Secretary for
Pension and Welfare Benefits
Washington, D.C. 20210

JUL 15 1997

Mr. Bruce C. Vladeck
Administrator
Health Care Finance Administration
314G Herbert Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Vladeck:

I am writing to bring to your attention a serious problem regarding the safety of employee benefit plans established and maintained for the benefit of employees of HCFA funded home health agencies (HHAs). On July 31, 1995, members of my staff met with Judith Berek and other HCFA officials, and representatives of the Internal Revenue Service, to discuss several problems which had arisen regarding HCFA funding of employee benefit plans sponsored by HHAs. These employee benefit plans are subject to the coverage of the Employee Retirement Income Security Act (ERISA), a law administered by the agency I head, the Pension and Welfare Benefits Administration (PWBA). While progress has been made on several of the issues discussed at that initial meeting, one major problem remains unresolved.

The problem I refer to is the ability of HHAs to obtain funds from HCFA which are specifically earmarked for employee benefit plan contributions and retain control of those funds for up to twenty and one half months before forwarding them to the affected plans. The practical effect of this practice is to allow the HHAs to "borrow" funds specifically earmarked for their own employees' benefit programs who not only receive no interest on these "loans" but who bear the full risk of any losses. As I will discuss below in more detail, this is not just a hypothetical concern; we know of cases where employees are being seriously hurt by this practice.

Alan Lebowitz, Deputy Assistant Secretary for Program Operations for PWBA wrote to Ms. Berek about this problem on September 18, 1995. In his letter, he expressed PWBA's concern that this practice was specifically approved by HCFA regulations and requested that HCFA give serious consideration to changing those regulations. Ms. Berek responded to his letter on January 17, 1996. While the response agreed that it was within HCFA's authority to lessen the amount of time HHAs could retain HCFA paid employee benefit plan contributions, Ms. Berek expressed concern that doing so could be seen as "discriminatory". Mr. Lebowitz responded to those concerns on June 18, 1996. Since a question has arisen as to whether that letter was actually received, I am attaching a copy of it. In that letter we addressed Ms. Berek's misgivings that reducing the amount of time that HHAs could use HCFA fringe benefit reimbursements for their own purposes could be seen as "discriminatory." The IRS also responded to those concerns, in a letter dated December 5, 1996, by stating that reducing the time period an HHA could retain such contributions "does not raise an issue under the Internal Revenue Code.".

I remain deeply concerned about the threat to employee pension and health benefits caused by HHAs which delay placing HCFA fringe benefit reimbursements into employee benefit trust funds for up to twenty and one half months after payment of the money to them by HCFA. Since our June 18th letter was sent, the misuse of HCFA funds earmarked for employee benefit plans has continued. I am quite disturbed that we have not been able to work together, as agencies of the government should do, to jointly resolve this problem and stop these abuses which involve both our agencies.

We have recently learned of another case in which employees of an HHA are in serious danger of losing the employer pension contributions which their employer is obligated to pay, even though HCFA reimbursed their employer with the understanding and expectation that the employer would use the money for pension contributions. Reavis Health Management Systems, Inc., an HHA located in Round Rock, Texas, which is funded primarily by Medicare, has delayed paying approximately $250,000 of employer contributions due its deferred compensation plan from 1993 on. Because HCFA regulations allow employers to delay paying the HCFA reimbursements into employee benefit trust funds, Reavis has been able to use for its own purposes the money which HCFA intended for pension contributions. Reavis has also failed to process claims or pay premiums of approximately $200,000 in health insurance for its employees for which Medicare has already reimbursed the company. During the time Reavis failed to pay the HCFA reimbursements into its appropriate employee benefit funds, it expanded its business holdings by, among other things, opening two new health-related businesses in the past year. Reavis has now declared its intention to file for bankruptcy, which, if it occurs, will leave the participants and beneficiaries of the employee benefit plans at risk of losing the unpaid but owing contributions.

We have learned that another HHA, Hill Country Health Services located in Killeen, Texas, whose owner is the brother of Reavis' owner, has delayed paying approximately $600,000 of employer contributions due its deferred compensation plan. While we have no reason to believe that Hill Country is planning to declare bankruptcy, we are concerned that the sponsor has expanded its business holdings while it has failed to make timely contributions. In January 1997, Hill Country received Medicare's permission to take an additional two years before depositing over $100,000 due its plan. You should be aware that one reason Hill Country adopted this plan was because it was told by its third party administrator that such use of employee benefit contributions was an "excellent cash flow tool for the agency".

In Ms. Berek's January 17, 1996, letter, she left open the possibility that HCFA would take action to change the Medicare regulations which permitted this practice, but believed that such changes would need to be carefully considered. We pointed out in our June 1996 letter that it is quite common for the federal government to separately fund fringe benefits for contractors who perform work for it. In general, these arrangements are governed by the Service Contract Act of 1965 ("SCA"), which sets standards for minimum compensation of such employees, and also provides for safety and health protection. One provision of the SCA provides for a ninety-day deadline for employers to deposit government-reimbursed pension

and health and welfare contributions (SCA §4.175(d)(1)). This ninety day limit appears to be based on the fact that SCA-covered employers have entered into exclusive contracts with the Federal Government and are receiving employee pension funds from the Federal Government rather than making the pension contributions from their own funds.

Although HCFA payments are not subject to the SCA, the rationale for similar treatment is apparent. As we understand it, when HCFA contracts with HHAs, HCFA is acting in a similar capacity to those government agencies whose contracts are governed by the SCA; the government has an exclusive, guaranteed arrangement with the HHAs, under which the HHAs receive government funds which are specifically intended to pay for employee pension, health and other employee benefits. I am aware of no reason why HHAs should be allowed to hold these funds longer than other employers who contract with agencies of the Federal Government.

PWBA's serious concern with employer delay in depositing contributions led to our amending the Department of Labor's plan asset regulation last year. 61 FR 41220. This amendment significantly shortened the time period during which employers could retain participant contributions to employee benefit plans by requiring employers to forward such contributions as soon as possible, but in no event later than 15 business days after the month in which the contributions were withheld. In amending this regulation, PWBA emphasized that this new rule "enhances the security of employee benefits". 61 FR at 41223. We noted that "[d]elays in the transmittal of these funds into a trust result in lost earnings to the participant", and that the revised regulation "will reduce the likelihood that some participant contributions will be lost in bankruptcy proceedings by being placed in trust sooner, which will put these contributions out of reach of the sponsor's creditors . . ." 61 FR at 41229-30. Given that the Department of Labor, the Internal Revenue Service, and the Service Contract Act all appear to agree that asking employers in certain circumstances to deposit pension contributions in a shorter time frame is a legitimate use of regulatory power to protect employee's pension and health benefits, it does not seem discriminatory to require the same of HHAs.

I firmly believe that workers for HHAs should receive the maximum possible protection and am committed to working with HCFA to achieve this goal. Please feel free to contact me directly at (202)219-8233 or Deputy Assistant Secretary Lebowitz at (202)219-9048.

Sincerely,

Olena Berg

Olena Berg

Enclosure

cc: Mr. Thomas Hoyer
Director of the Office of Chronic Care and Insurance Policy
Health Care Finance Administration
Mail Stop C4-02-16
7500 Security Blvd.
Baltimore, MD 21244-1850

Ms. Linda Ruiz
Director of the Office of Benefit Integrity
Health Care Finance Administration
Mail Stop S3-01-17
7500 Security Blvd.
Baltimore, MD 21244-1850

Ms. Stephanie Crowley
Director of the Bureau of Policy Development
Health Care Finance Administration
Mail Stop S3-01-17
7500 Security Blvd.
Baltimore, MD 21244-1850

U.S. Department of Labor

Pension and Welfare Benefits Administration
Washington, D.C. 20210

JUN 18 1996

Ms. Judith Berek
Assistant to Administrator for Fraud and Abuse
Health Care Finance Administration
Mail Stop C5-16-03
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Ms. Berek:

Thank you for your response to my letter, in which the Department of Labor (DOL) proposed measures to lessen the danger of misuse of the Health Care Finance Administration (HCFA) funds earmarked for employee benefit pension plans. We are in agreement that it is unacceptable to shift costs between related entities unconnected to the delivery of HCFA reimbursable services for the purpose of increasing the organization's profit from Medicare reimbursement. As you said in your letter, a party profiting from such cost-shifting could be guilty of "the commission of Medicare program abuse or fraud."

Based on your letter, we plan to meet soon with representatives of the stock valuation firm of Houlihan, Lokey, Howard and Zukin (Houlihan). As you know, Houlihan has done valuations of employee stock ownership plans (ESOPs) sponsored by Home Health Administrations (HHAs) in which it has attributed value, on a dollar for dollar basis, to the HHA's ability to deliver HCFA reimbursable services for less than the maximum permissible amounts; this valuation is premised on the belief that a purchasing provider could shift costs to the HHA in the amount that the HHA is under the reimbursement limit. We intend to inform them of your and our view that such cost shifting is impermissible unless the shifted costs are necessarily incurred in the provision of the reimbursable service. Thus, by attributing value, on a dollar for dollar basis, to the difference between the maximum permissible charge and the actual cost of the service, Houlihan, we believe, has inflated the value of the employer's stock. As a result, at least one ESOP, which bought employer securities at a price determined by such a valuation, overpaid for the stock it bought. In the Department's view, such an overpayment is a violation of the Employee Retirement Income Security Act of 1974 (ERISA). We intend to make this position known not only to Houlihan, but also to any other appraisal firms which we determine has used similar methodologies, and to fiduciaries of any ESOPS which may have purchased stock at an inflated price due to such valuations.

The second issue we raised in our letter to you concerned the threat to employee pensions that arises from the ability of HHAs to delay placing HCFA pension reimbursements into employee benefit trust funds for as long as 20-1/2 months after payment of the money to the employer by HCFA. You left open the possibility that HCFA might take action to change the Medicare regulations which permitted this practice, but believed that such changes would need to be carefully considered. We agree with the need for careful consideration and would like to direct your attention to additional factors which, in our view, support such a change.

As you know, it is quite common for the Federal Government to separately fund fringe benefits for contractors who perform work for it. In general, these arrangements are governed by the Service Contract Act of 1965 ("SCA"), which sets standards for minimum compensation of such employees, and also provides for safety and health protection. One provision of the SCA provides for a 90-day deadline for employers to deposit government-reimbursed pension and health and welfare contributions (SCA §4.175(d)(1)). This 90-day limit appears to be based on the fact that SCA-covered employers have entered into contracts with the Federal Government and are receiving employee pension funds from the Federal Government rather than making the pension contributions from their own funds.

Although HCFA payments are not subject to the SCA, the rationale for similar treatment is apparent. As we understand it, when HCFA contracts with HHAs, HCFA is functioning similar to those government agencies whose contracts are governed by the SCA; the government has a guaranteed arrangement with the HHAs, under which the HHAs receive government funds as services are rendered which are specifically intended to pay for employee pension contributions. I am aware of no reason why HHAs should be allowed to hold these funds longer than other employers who contract with agencies of the Federal Government.

You expressed a concern that employers who are reimbursed through Medicare might find it "discriminatory" were HCFA to promulgate such a rule, since under the Internal Revenue Code employers who do not contract with the government for employee fringe benefits are allowed, for deduction purposes, 8-1/2 months after the end of the plan year to deposit such contributions. However, we believe the fact that Medicare-reimbursed employers receive specified amounts earmarked for fringe benefits makes them more like those employers who are subject to the SCA than those who pay fringe benefits from their own general assets. Finally, were HCFA to change its rule to conform with SCA practice, there is no reason to think IRS would consider the change "discriminatory", as its anti-discrimination regulations only apply to plans which distinguish between highly-compensated employees and others.

I hope this additional information will be useful to you as you consider whether to change your regulations in a way which would result in greater protection for workers who are participants in HHA-sponsored employee benefit plans.

We remain ready to work with you and your staff or to discuss these issues further. Feel free to contact me at 202-219-9048 or Sherwin Kaplan, Deputy Associate Solicitor for Plan Benefits Security at 202-219-8634.

Sincerely,

ALAN D. LEBOWITZ
Deputy Assistant Secretary
for Program Operations

cc: Mr. Thomas Hoyer
Director of the Office of Chronic Care and Insurance Policy
Health Care Finance Administration
Mail Stop C4-02-16
7500 Security Blvd.
Baltimore, MD 21244-1850

Ms. Linda Ruiz
Director of the Office of Benefit Integrity
Health Care Finance Administration
Mail Stop S3-01-17
7500 Security Blvd.
Baltimore, MD 21244-1850

Ms. Stephanie Crowley
Director of the Bureau of Policy Development
Health Care Finance Administration
Mail Stop S3-01-17
7500 Security Blvd.
Baltimore, MD 21244-1850

Send to: Debbie Chang - 680-8168
Gam Claxton f - 401-7321

File: Home Health

CONCERNS ABOUT MEDICARE HOME HEALTH COPAYMENT 10 pay

PROPOSAL

- Adds a new $5 payment per Part B home health visit for beneficiaries, with an annual limit on the copayments equal to the hospital deductible ($760 in 1997). This provision is intended to reduce unnecessary utilization.

CONCERNS

- **Unlikely to change utilization significantly**. Because over three-fourths of Medicare beneficiaries have Medigap or Medicaid, the provision would neither substantially reduce utilization of services nor decrease overall spending on home care.

- **Severe impact on low-income.** For the 15 percent of beneficiaries without coverage, these costs may be excessive.

  - Over 60 percent of Medicare's home health users without Medigap have incomes below $10,000. Fully 87 percent have incomes below $20,000.

  - Poor home health users without Medigap protection are more likely to have more than 150 visits per year than less.

- **Unfunded mandate to states.** Because Medicaid covers cost sharing for about 6 million Medicare beneficiaries, its spending would increase as a result of this provision. CBO estimates that state costs could rise by $900 million over 5 years.

June 30, 1997

CONCERNS ABOUT RAISING THE MEDICARE ELIGIBILITY AGE

PROPOSAL

- Extend the eligibility age for Medicare from 65 years old to 67 years old. This provision would be phased in one month at time, so that it would be fully implemented in the year 2027. The goal is to extend the life of the Medicare Trust Fund.

CONCERNS

- **Different than Social Security.** Social Security gives people who retire before eligibility a portion of their benefits, so that postponing eligibility age has less of an impact. Medicare gives nothing to early retirees.

- **Would increase the number of uninsured.**

  Many 65 to 67 year olds have low-income. In 1997, an estimated 525,000 Medicare beneficiaries aged 65 to 67 have neither Medicare nor Medigap and income is below $25,000. Another 1.2 million beneficiaries have similar income but purchase Medigap.

  If the Medicare eligibility age were raised to 67, these Medicare beneficiaries will likely be unable to afford insurance. This could increase the number of uninsured Americans by 1.75 million, or 5 percent, according to a preliminary Urban Institute analysis.

  Few affordable alternatives. Today, 60 to 64 year olds rely the most on the individual insurance market. In this market, insurers may consider health and age in setting premiums, making it more expensive than group coverage. For the 65 to 67 year olds, this insurance may be prohibitively expensive.

  Retiree coverage is shrinking. Between 1993 and 1995, the proportion of employers offering coverage for early retirees dropped by 10%. This means that fewer of the 65 to 67 year olds waiting for Medicare eligibility will have employer coverage.

- **No policies to address access problem.** The Senate bill contains no provisions that would assist people waiting longer for Medicare to find affordable health coverage.

June 30, 1997

COMPARISON OF THE ADMINISTRATION OF THE HIGH-INCOME PREMIUM

PROVISION	SENATE BILL ADMINISTERED BY HHS*	SENATE BILL ADMINISTERED BY TREASURY*
Who Administers	Health & Human Services (HHS), Social Security Administration (SSA), & Treasury	Treasury
Savings	$3.9 billion (assumes loss of over 50% of savings in the first 5 years)	$8 to 9 billion (assumes traditional compliance rates)
Administrative Costs	$30 to 50 million per year	$5 to 10 million per year
How Eligible Beneficiaries Are Identified	HHS identifies beneficiaries by: (1) Getting income from the latest reviewed Treasury tax data, which is 2-3 years old (e.g., 1995 for 1998) (2) Sending notices to at least 3 million beneficiaries to ask if this past income is what they will receive in the next year and require them to respond in writing in 30 days **Note: Sharing income data across agencies raises significant privacy concerns**	Beneficiaries report their income, reference a schedule, and add the extra premium to the bottom line of their tax return
How Premiums Are Collected	Assumes that extra premium is subtracted from monthly Social Security check after HHS sends to SSA their estimate of who gets how much taken out of their checks	See above
Reconciling Income	To ensure that the right amount of premium was assessed, Treasury would send the actual income from reviewed tax data to HHS. However, because this would be done retrospectively this would take 2-3 years (e.g., 2001 correction for 1998 mistake)	Since income is not projected but is the actual reported income, no reconciliation is required.

* This policy assumes the Senate policy which phases in 100% of the premium for beneficiaries with incomes between $50,000 and $100,000 for singles, $75,000 and $125,000 for couples. The Administration opposed the Senate's 100% phase out, administration through HHS/SSA, and lack of indexing of the income thresholds.

The Senate's Medicare High Income Premium Policy Concerns

- **Duplicates bureaucracy.** Today, the Treasury Department is the only Federal agency that has the income information needed to collect a high-income premium. HHS or SSA would either have to collect their own income information, like a second tax return, or borrow the Treasury income information. In either case, a large, new bureaucracy, with hundreds of new workers, would be needed to duplicate the Treasury structure. This could cost $30 to $50 million per year — many times more than it would cost if administered through Treasury.

- **Errors likely.** HHS cannot easily identify who should be paying the extra premium. It would base its identification of these people on 3-year old income information received from the Treasury. One in four seniors who are above the income thresholds fall below them three years later, mostly because they have been working but have since retired. Others may have died or have spouses that have died, changing the amount that they owe. Beneficiaries have a 30-day window to mail in any corrections, but this may be too short of a time period and could be difficult to understand or process for some seniors.

- **Collections difficult.** Collecting this extra premium is not as simple as reducing beneficiaries' Social Security checks. Three agencies — HHS, SSA, and Treasury — would have to coordinate information to ensure that the right premium is collected. This not only raises major privacy concerns, but is inefficient. The right amount of the premium won't be known for years, since it takes time for Treasury to review tax returns, HHS to match the actual income with that used to determine the premium, and SSA to collect any over- or under-estimate. Recouping the extra premium years later creates bureaucratic challenges — HHS would need practices like a collections agency — as well as hardship for beneficiaries. Since most beneficiaries' incomes will decline as they age, beneficiaries will be paying no extra premium when they can afford it and more when they can afford it less.

- **Major loss of revenue.** A consequence of this administrative complexity is the loss of the premium revenue from the policy. Cost estimators at CBO and OMB assume that more than half of the potential revenue will be lost due to problems in administration. In contrast, only a small percent will be lost if administered by the Treasury, which already has most of the administrative structures in place.

- **Loss of healthier, wealthier beneficiaries.** Totally phasing out the premium could cause long-run problems for Medicare. Faced with a large, extra premium, the healthiest beneficiaries have a strong incentive to leave Medicare. It is likely that an insurance market will develop that can offer Part B services at a lower price — especially since Medicare spends, on average, 15 percent less for high-income beneficiaries than for all beneficiaries. HHS Actuaries assume that about half a million healthy, wealthier beneficiaries would leave Medicare if the premium rose to 100 percent. The loss of these beneficiaries not only means less premium revenue but could raise the cost of Medicare for those who remain.

The Senate's Medicare High Income Premium Policy
How It Would Work

Senate Policy. The Senate bill increases the Medicare Part B premium for high-income beneficiaries from 25 to 100 percent of Part B costs.

Single beneficiaries:	Begins at $50,000 with full payment at $100,000
Couple:	Begins at $75,000 with full payment at $125,000

	Maximum Extra Premium in 2002
Single beneficiaries:	About $200 per month, $2,400 per year
Couple:	About $400 per month, $4,800 per year

This premium increase would be administered by Health and Human Services (HHS) or Social Security (SSA).

How It Would Work.

- Before the beginning of each year, the Treasury Department will send the latest available, reviewed tax information to HHS. For 1998, this would be 1995 income, for example.
- HHS will then send notices to beneficiaries who appear to be eligible to ask if this income from the older tax returns is accurate for the coming year. Beneficiaries will have 30 days to respond.
- After incorporating any mailed-in changes, HHS will send this income information to SSA, which will deduct any extra premium from Social Security checks (or HHS sets up its own collections and billing process)
- At the end of the year, HHS will use the Treasury tax information to check actual income against income used to assess the premium. For 1998, this actual income information will be available in the summer of 2000.
- HHS will increase or decrease the next year's premiums based on the previous year's error -- plus interest. If the beneficiary had died, the surviving spouse or estate will have to pay the premium owed. For a beneficiaries whose income was understated in 1998, an extra amount will be taken out of their 2001 Social Security check.

TO: Health/Medicare Staff

FROM: Jeff Lemieux, x69010

Income-related Part B premiums, Senate-passed plan and Possible Alternative

Fiscal Years	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	98-02	98-07
	Savings in Billions of Dollars											
Senate-passed plan (HCFA collection using IRS data)	0.0	0.4	0.8	1.1	1.6	2.1	2.6	3.3	3.7	4.0	3.9	19.6
Thresholds in Senate-passed plan, IRS collection	0.3	1.5	1.8	2.4	2.8	3.5	4.0	4.6	5.1	5.8	8.9	31.9

NOTE: Assumes premium levels associated with Senate-passed plan.

File Home Health copay

CONCERNS ABOUT MEDICARE HOME HEALTH COPAYMENT

PROPOSAL

- Adds a new $5 payment per Part B home health visit for beneficiaries, with an annual limit on the copayments equal to the hospital deductible ($760 in 1997). This provision is intended to reduce unnecessary utilization.

CONCERNS

- **Unlikely to change utilization significantly**. Because over three-fourths of Medicare beneficiaries have Medigap or Medicaid, the provision would neither substantially reduce utilization of services nor decrease overall spending on home care.

- **Severe impact on low-income.** For the 15 percent of beneficiaries without coverage, these costs may be excessive.

  - Over 60 percent of Medicare's home health users without Medigap have incomes below $10,000. Fully 87 percent have incomes below $20,000.

  - Poor home health users without Medigap protection are more likely to have more than 150 visits per year than less.

- **Unfunded mandate to states**. Because Medicaid covers cost sharing for about 6 million Medicare beneficiaries, its spending would increase as a result of this provision. CBO estimates that state costs could rise by $900 million over 5 years.

June 30, 1997

File Home Health

IMPACT OF THE SENATE FINANCE HOME HEALTH COPAY

The Finance Committee Chairman's mark would impose a Part B home health copayment of $5 per visit, capped at an amount equal to the annual hospital deductible.

The Administration is concerned that a copayment could limit beneficiary access to the home health benefit. Medicare beneficiaries already spend a significant portion of family income on out-of-pocket health care expenses. A home health copayment would disproportionately affect poorer beneficiaries, who spend an even greater proportion of their income on health care.

Imposing a home health copay is not necessary to balance the budget. Any further consideration of this policy should be part of a bipartisan process to address the long-term financing challenges facing Medicare.

Home Health users are particularly at risk:

Home health users have out-of-pocket expenditures much higher than the overall Medicare population. This is not surprising since these home health users are poorer, less healthy, older, and more likely to live alone.

- Forty-three percent of home health users have incomes below $10,000, while only 30% of all Medicare beneficiaries have incomes this low. On average, beneficiaries in this income range spend 25 percent of their income on out-of-pocket health care costs.

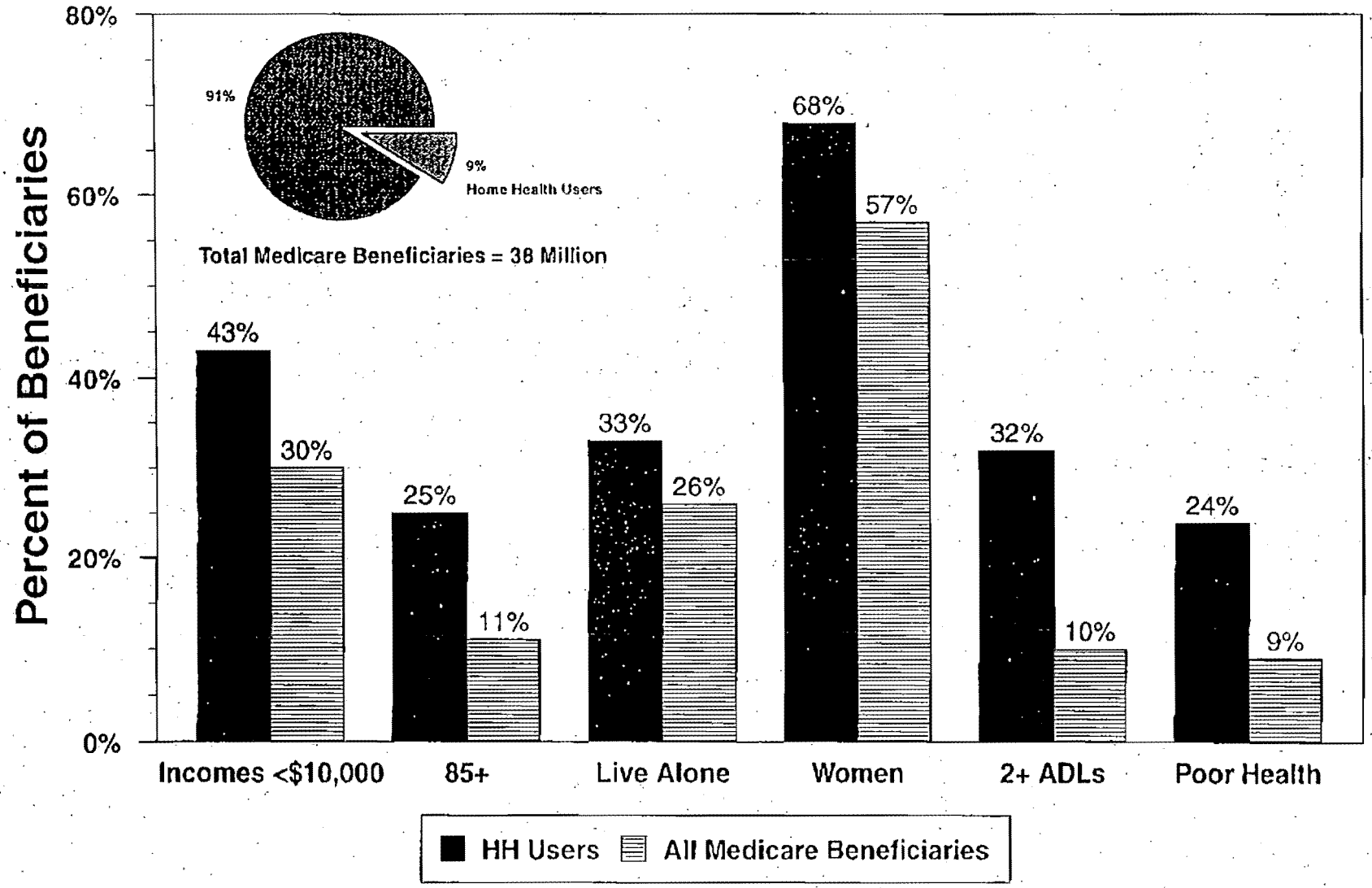
- Home health users are three times as likely as other Medicare beneficiaries to have difficulty performing two or more activities of daily living, and more than twice as likely to report that they are in poor health. Disabled beneficiaries are more likely to have long episodes of home health use, so they would be likely to incur larger copayments.

- One quarter of home health users are over 85 -- this is more than twice the proportion for the whole Medicare population. Over two-thirds are women, and one third live alone. Beneficiaries with these characteristics are less likely than other Medicare beneficiaries to have sources of informal care, and they are more likely to enter a nursing home. Home health may provide them with the care that they need to stay in their homes.

A home health copay would create additional costs for states:

Medicaid pays coinsurance and deductibles for some low-income Medicare beneficiaries (e.g. Qualified Medicare Beneficiaries). Consequently, a copayment on Medicare home health services would increase federal and state Medicaid expenditures. CBO estimates that the additional state and local cost of the home health copay would be $500 million over 5 years.

Characteristics of Medicare Home Health Users



Source: HCFA, Medicare Current Beneficiary Survey

THE HENRY J. KAISER FAMILY FOUNDATION

T HOMECARE RE POLICY PROJECT

NATIONAL ASSOCIATION FOR HOME CARE
228 SEVENTH STREET, SE
WASHINGTON, DC 20003
202/547-7424
Fax: 202/547-9559
E-mail: ldv@nahc.org

Lucia DiVenere
Deputy Director of Government Affairs

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nome Health Expenditures

Prepared by:

Joel Leon, Ph.D
Patricia Neuman, Sc.D
Stephen Parente, Ph.D

Prepared for:

The Henry J. Kaiser Family Foundation

June 1997

Understanding the Growth in Medicare's Home Health Expenditures

Prepared by:

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Prepared for:

The Henry J. Kaiser Family Foundation

June 1997

Joel Leon and Stephen Parente are Senior Research Directors at the Project HOPE Center for Health Affairs in Bethesda, Maryland. Patricia Neuman is a Senior Program Officer at the Henry J. Kaiser Family Foundation. Support for this research was provided by a grant from the Henry J. Kaiser Family Foundation, Grant #95-1587B. The views expressed in this report are those of the authors and do not necessarily reflect those of the Henry J. Kaiser Family Foundation. The Henry J. Kaiser Family Foundation is an independent national health care philanthropy, and not associated with Kaiser Permanente or Kaiser Industries.

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Understanding the Growth in Medicare's Home Health Expenditures

Executive Summary

Medicare's home health benefit has become an integral part of the current effort to slow the growth in Medicare spending, ease the financial pressures on the Medicare hospital insurance trust fund, and balance the federal budget. Funded almost exclusively out of the Medicare Hospital Insurance Trust Fund, the home health benefit is one of the fastest growing components of the Medicare program, experiencing annual average increases of more than 28 percent per beneficiary in the period between 1990 and 1996[1]. During this same period of time, expenditures for home health services have more than doubled as a share of the total Medicare budget, making home health a highly visible target in the current debate over Medicare spending.

This study was undertaken to analyze factors that drive the growth in Medicare spending and to assess the characteristics of elderly and disabled beneficiaries who receive Medicare-covered home health services. The study examines how changes in law, administrative policy and judicial decisions affected utilization of home health services, the supply of home health agencies, and the growth in Medicare home health expenditures. The study also analyzes survey and claims data to assess the characteristics of beneficiaries who receive services and to identify factors that are associated with high levels of home health utilization and expenditures.

Key Findings

Characteristics of Beneficiaries Who Use Home Health Services

The Medicare home health population includes beneficiaries who are among the sickest and most functionally impaired segments of the Medicare population. They are relatively old and poor, predominantly female, and more likely to live alone. In 1994, one quarter (25 percent) were ages 85 or older. More than two thirds (69 percent) had incomes below $15,000. Two thirds (68 percent) were female. One third (33 percent) lived alone.

Additionally, home health users are more likely to perceive their own health as poor and are more likely to have much higher levels of physical impairment than Medicare beneficiaries not using home health services. In 1994, more than half of all home health users (58 percent) perceived their health status to be fair or poor, compared to 26 percent of beneficiaries who did not receive home health services. Nearly three quarters of all home health users (73 percent) had one or more limitations in activities of daily living (ADL) and nearly half (47 percent) had 3 or more ADL limitations, compared to 31 percent and 12 percent respectively among those who did not utilize home health services.

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[1]Komisar H. et al., Medicare Chart Book, The Henry J. Kaiser Family Foundation, 1997.

Medicare beneficiaries who receive home health services are more likely to use the health care system extensively and thus incur overall Medicare costs that are substantially higher than beneficiaries who do not receive home health care. In 1994, on average, Medicare costs for home health users were more than 5-times greater than Medicare costs for beneficiaries who did not receive home health care ($15,321 and $2,723 respectively in 1994).

Three Distinct Groups of Beneficiaries Who Receive Home Health Care

Medicare's home health population includes three distinct patient groups: (1) patients requiring post-acute care; (2) persistently ill patients with serious and complex medical conditions; (3) chronically-ill patients with long-term care needs.

In 1994, one third (34 percent) of all home health users were provided care immediately after they were discharged from the hospital. These beneficiaries typically have one hospital stay of average duration over the course of a year. This "post-acute" group most closely resembles the acutely ill population for whom the benefit was originally conceived and generally served through the late 1980s. In 1994, this group accounted for 22.5 percent of home health expenditures, received 47 visits on average, with average Medicare home health expenditures of $2,957 per beneficiary in 1994.

Another third (33 percent) of the Medicare home health population included beneficiaries who were seriously ill, with higher levels of hospital and home health service use. About half of this group also used skilled nursing facility services within the same year. Beneficiaries in this "medically complex" group were more likely than other home health users to have severe functional impairments, were more likely to perceive their health as fair or poor, and were more likely to have had extensive inpatient hospital care. In 1994, beneficiaries with "medically-complex" needs accounted for nearly 42.5 percent of all home health expenditures, received an average of 91 home health visits, with average Medicare home health expenditures of $5,736 per beneficiary.

The remaining third (33 percent) of the Medicare home health population in 1994 relied on Medicare's home health benefits to help meet their long-term care needs. These beneficiaries had high levels of functional impairments, but appeared to be medically-stable. They had neither hospital nor skilled nursing facility (SNF) care and fewer than the average number of physician visits within the year. When compared to other home health users, beneficiaries in the "long-term care" group were more likely to fall within the lowest income levels and to live alone. In 1994, the long-term care group accounted for 35 percent of home health expenditures, received about 81 visits, with average Medicare home health expenditures of $4,671 per beneficiary.

High Utilizers: Rising Costs for Beneficiaries Who Receive 200 or More Visits

This study also examines the characteristics of Medicare beneficiaries who received more than 200 visits within a year because they account for a small but growing share of the Medicare home health population and a disproportionate share of Medicare home health

expenditures. In 1991, only 4 percent of all home health users received 200 or more visits and accounted for 19 percent of total home health expenditures. By 1994, 10 percent of Medicare's home health population received 200 or more visits, and accounted for 43 percent of total Medicare home health expenditures.

Persons who receive 200 or more home health visits are more likely to have medically-complex needs and require extensive hospital care and multiple episodes of home health care within a year. These "high utilizers" are more likely than other home health recipients to have severe functional impairments. They are more likely to be African American, more likely to be from the South, and more likely than other home health users to receive their care from a for-profit home health agency. In 1994, on average, they received 323 home health visits with average Medicare home health expenditures of $18,435 per beneficiary.

For-Profit Agency Use Leads to Higher Expenditures

Finally, we found that care provided by for-profit home health agencies increases the average annual cost of Medicare home health services. In 1994, the average home health cost per beneficiary ($4,442 in 1994) was $1,064 higher for those receiving care from for-profit home health agencies. This additional amount was the net increase in Medicare home health costs for patients served by proprietary agencies, after controlling for the characteristics of beneficiaries that should be linked to their *need* for home health services. In 1994, the higher per patient cost of beneficiaries who received services from a for-profit agency added more than $1 billion to overall Medicare home health expenditures that cannot be explained by other factors.

Implications of Results

As policymakers look toward the home health benefit as a source of potential Medicare savings, this study provides new information to explain factors that drive home health expenditures and describes the characteristics of Medicare beneficiaries who use home health services. These findings provide new evidence to assess the implications of potential policy changes in the structure of Medicare's home health benefit.

Clearly, Medicare home health coverage is no longer simply the short-term post-acute benefit that it was originally intended to be. Only a third of all beneficiaries who receive home health services received their care immediately following a hospital discharge. The remaining two thirds either rely on Medicare's home health benefit for relatively extensive support related to their more complex and ongoing medical problems, or they use Medicare's home health benefit to help meet their long-term care needs. This study supports the growing body of evidence confirming the emerging role of Medicare's home health benefit as a safety net for elderly beneficiaries with long-term care needs and further differentiates the acutely ill patients needing short-term acute post hospital care from those who are seriously ill and requiring on-going home health services.

Efforts to pare back the Medicare home health benefit to short-term post acute-care would clearly impact some of the most vulnerable segments of the Medicare population who either have complex medical problems or significant long-term care needs. While such a move

would return the benefit to its original intent, it could also leave significant gaps in coverage for Medicare's oldest and most frail beneficiaries.

Likewise, imposing copayments on beneficiaries would disproportionately impact the near poor who do not qualify for Medicaid but are unable to afford a private supplemental Medigap policy. Such low-income beneficiaries may refuse home health services in the face of potentially unaffordable co-insurance requirements, with uncertain effects on patient outcomes.

Moreover, the imposition of copayments would be unlikely to deter utilization among the majority of home health users. For the poorest Medicare beneficiaries who are also eligible for Medicaid, a new coinsurance would be unlikely to discourage utilization since the costs would be passed on to Medicaid. For the majority of beneficiaries who have private insurance that finances Medicare's coinsurance, a new coinsurance on home health services would be unlikely to impact utilization. It would, however, result in higher Medigap premiums when health insurers pass the additional cost of the coinsurance on to beneficiaries.

Finally, we found substantially higher costs associated with the delivery of home health care by for-profit agencies -- $1 billion in 1994. This higher cost attributable to for-profit agencies cannot be explained by the health or functional status of the people they serve. Beneficiaries who turn to for-profit agencies for their care are likely to receive more visits than they would if served by a non-profit or government agency. Additional government oversight and monitoring of care delivered by for-profit agencies offers promise as a potential source of Medicare savings.

Understanding the Growth in Medicare's Home Health Expenditures

Overview

Medicare's home health benefit has become a key component in the current effort to slow the growth in Medicare spending, ease the financial pressures on the Medicare Hospital Insurance Trust Fund, and balance the federal budget. Funded almost exclusively out of the Medicare Hospital Insurance Trust Fund, the home health benefit is one of the fastest growing components of the Medicare program, experiencing annual average increases of more than 28 percent per beneficiary between 1991 and 1996.[2] During this same time period, expenditures for home health services have more than doubled as a share of the total Medicare budget, making home health a more visible target in the current debate over Medicare spending.

This study was undertaken to analyze factors that drive the growth in Medicare spending and to assess the characteristics of elderly and disabled beneficiaries who receive Medicare-covered home health services. The study examines how changes in law, regulation, administrative policy and judicial decisions have affected patterns of care, the supply of home health agencies, and the growth in home health expenditures over time. The study also analyzes survey and claims data to assess the characteristics of beneficiaries who receive services and to identify factors that are associated with high levels of home health utilization and expenditures.

Background

Medicare's home health benefit was originally conceived as a short-term, post-acute service designed to help beneficiaries recover following an inpatient hospital stay. Home health services were covered primarily under Part A with no-cost-sharing requirements. Beneficiaries who had inpatient hospital stays of a minimum of three days were eligible for up to 100 home health visits per spell of illness. Beneficiaries were also entitled to home health benefits under

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[2] Komisar H. et al., The Medicare Chart Book, The Henry J. Kaiser Family Foundation, 1997.

Medicare Part B without a prior hospitalization requirement, however the Part B benefit could only be used after Part A benefits were exhausted. Part B home health services were subject to a coinsurance.

To be eligible for benefits, an individual had to be under the care of a physician, confined to a home, in need of skilled nursing or skilled physical or speech therapy and expected to show improvement as a direct result of services rendered. Services were covered only if needed and provided on a part-time or intermittent basis. Home health coverage criteria explicitly excluded custodial, non-remedial care for patients who were unlikely to improve as a direct result of their treatment (i.e., long-term health care for the chronically ill). Home health agencies were paid then, as they are today, on a cost-reimbursement basis, subject to limits.

Through the 1970's, the home health industry was largely dominated by public, voluntary, nonprofit agencies including traditional community nursing programs run by state, county, and local health departments and by the larger Visiting Nurse Associations. In 1972, Congress repealed the Medicare cost-sharing requirements for home health visits under Part B as part of a broader bill that expanded Medicare coverage to non-elderly individuals who were permanently disabled or had end stage renal disease. Despite this change, expenditures for home health grew relatively slowly during this period of time.

Beginning in the early 1980's, home health expenditures started to climb as basic changes to the Medicare home health benefit were enacted. Figure 1 presents a brief chronology of the key legislative, administrative and judicial events that underlie the program changes that have lead to the tremendous growth in home health utilization and spending since 1980.

The Omnibus Budget Reconciliation Act of 1980 (OBRA) repealed the 3-day prior hospitalization requirement and eliminated the 100-day limit on the number of covered home health visits. The elimination of the 3-day hospital stay broadened the potential range of persons eligible for home health services and the removal of the 100-visit limit created an opportunity for higher levels of home health service use. The 1980 law also permitted

proprietary agencies to become Medicare-certified and provide Medicare-covered home health services.

In 1983, the Congress enacted the Medicare Prospective Payment System (PPS) for inpatient services to control the growth in hospital spending. The new payment system created incentives for hospitals to discharge Medicare patients earlier in their recovery period and to substitute home health and other post-acute services for care provided in a hospital setting. As an apparent result of the new payment systems, hospitals began discharging patients with greater need for complex medical care at home, rather than keeping them in the hospital for longer periods of time.[3]

Figure 1: Chronology of Key Events Affecting Medicare's Home Health Benefit, 1980-1990

YEAR	LEGISLATIVE, ADMINISTRATIVE, AND JUDICIAL REFORMS
1980	The Omnibus Budget Reconciliation Act (OBRA) abolished the three-day prior hospitalization requirement, eliminated the 100-visit limit, and removed the $100 deductible for home care services. In addition, OBRA permitted for-profit home health agencies to become Medicare-certified providers.
1983	Enactment of Medicare Prospective Payment System for inpatient hospital care that reduced the average length of inpatient hospital stays.
1984	The Administration imposed restrictions on home health coverage through instructions to fiscal intermediaries. The new guidelines clarified that home health services would be covered only if the individual required "part-time and intermittent" care and was homebound.
1988	*Duggan v. Bowen* court ruling required the Health Care Financing Administration to modify and clarify home health coverage rules.
1989	In reaction to *Duggan v. Bowen*, the Health Care Financing Administration modified its interpretation of "part-time and intermittent care" to "part-time or intermittent", clarified its definition of homebound and relaxed its clinical criteria governing home health eligibility.

Beginning in the early 1980's, the Health Care Financing Administration (HCFA) began to restrict access to Medicare-covered home health services through a series of administrative instructions to fiscal intermediaries. In 1984, HCFA prodded intermediaries to intensify their

[3]United States General Accounting Office, Information Requirements for Evaluating the Impacts of Medicare's Prospective Payment on Post-Hospital Long Term Care Services: Preliminary Report, (GAO/PEMD-85-8), Washington, D.C.:, February, 1985.

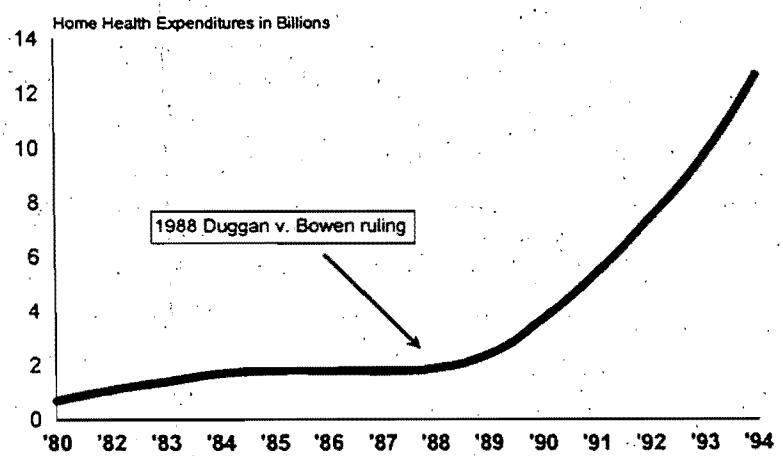
review of home health claims, in response to allegations that Medicare was reimbursing agencies for uncovered services with the liberalization of coverage permitted by OBRA 80. As a result of this effort, there was a significant increase in the number of retrospective denials of payments to home health agencies for home health care that had been provided. Actual denials and the potential threat of denials are believed to have constrained utilization and program expenditures.[4]

In response to HCFA's more restrictive interpretation of home health coverage throughout the 1980s, a class-action suit, *Duggan v. Bowen*, was filed in 1988, challenging HCFA's interpretation of the Medicare home health provision. As a result of this case, HCFA revised the *Medicare Home Health Agency Manual* and the *Medicare Intermediary Manual* to permit coverage of home health services if the beneficiary required "part-time or intermittent care". The new rules also clarified the definition of homebound and relaxed HCFA's clinical criteria governing home health coverage.

The changes made to Medicare regulation and policy resulted in a huge surge in home health service utilization and spending. Figure 2 shows the rapid rise in home health expenditures that followed the 1988 Duggan v. Bowen ruling and the subsequent 1989 revisions to the operation manuals issued to agencies and fiscal intermediaries.

Figure 2

Medicare Home Health Expenditures, 1980-1994



Source: Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1996.

[4]United States General Accounting Office, Medicare: Increased Denials of Home Health Claims During 1986 and 1987, (GAO/HRD-90-14BR), Washington, D.C.:, January, 1990.

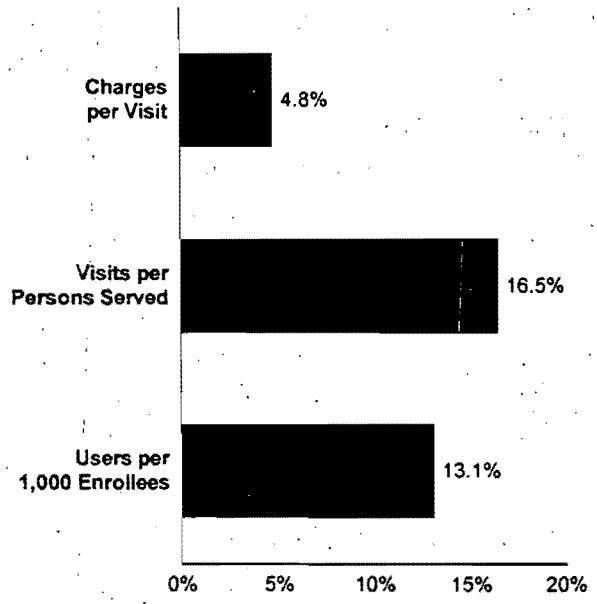
Key Trends

Trends in Utilization and Expenditures

The Medicare home health benefit has been and continues to be one of the fastest growing components of the Medicare program. From 1980 –1990, the average annual growth rate for Medicare home health expenditures was 19.8 percent and increased to 36 percent in the period between 1990 and 1994. Between 1990 and 1994, Medicare spending for home health services grew from $3.7 billion to $12.7 billion, increasing from 4.8 percent to 8.6 percent of total program spending.[5]

Figure 3

Sources of Growth in Medicare Payments for Home Health Care, 1990-1994



Source: Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1996.

Medicare spending for home health services increased during this period of time because of two key factors: (1) the rise in both the absolute number and in the proportion of Medicare beneficiaries receiving home health services; and (2) the increase in the number of home health visits per home health user (Figure 3). While cost per service unit helped to drive up expenditures for most other Medicare services, it contributed less significantly to the growth in Medicare home health spending (Table 1).

- **Persons served:** Between 1990 and 1994, the number of Medicare beneficiaries who received home health services increased from 57 to 86 per 1,000 enrollees, with

[5]Health Care Financing Administration Review, *Medicare and Medicaid Statistical Supplement, 1996.*

an average annual growth rate of 13.1 percent. The growth in the number of home health users accounts for 38 percent of the increase during this 4-year period in the specified time period.

- **Visits per user:** The average number of visits provided to beneficiaries who receive home health care increased from 36 visits in 1990 to 66 visits in 1994, with an average annual growth rate of 16.5 percent. The growth in the number of visits per person accounts for nearly half (45.2 percent) of the increase in expenditures over this time period.

- **Charges per visit:** Between 1990 and 1994, the average cost per home health visit increased from $69 to $83, with an average annual growth rate of 4.8 percent. The increased cost in service units over this period accounted for approximately 16.8 percent of the increase in home health expenditures.

Between 1990 and 1994, the average payment per person served increased from $1,892 to $3,987, a 20.6 percent average annual rate of growth, reflecting increases in the number of home health visits per user more directly.

The Growth in the Number of Medicare Certified Home Health Agencies

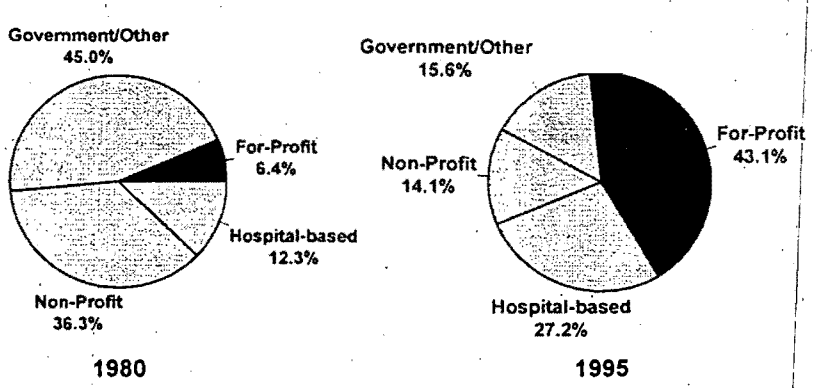
Between 1980 and 1995, the number of Medicare-certified home health agencies more than quadrupled, from 2,949 agencies in 1980 to 9,120 agencies in 1995.[6] The most dramatic growth during this period occurred in the number of proprietary (for-profit) home health agencies -- an apparent result of the OBRA 80 change in law that facilitated Medicare certification of for-profit providers. Between 1980 and 1985, for example, the number of for-profit agencies increased from 186 to 1,943 nationwide. Between 1985 and 1995, the number of for-profit agencies more than doubled to 3,951.

In 1980, for profit agencies represented only 6 percent of all Medicare-certified home health agencies, but by 1995, 43 percent of all home health agencies were proprietary (Table 2). During this same period of time, both government-owned agencies and non-profit home health agencies declined as a share of the total. Between 1980 and 1995, the share of government-owned agencies declined from 43 percent to 13 percent and the share of non-profit agencies declined from 36 percent to only 14 percent. Clearly today, free-standing, proprietary agencies

[6]National Association for Home Care, May 1997.

Figure 4

Distribution of Medicare-Certified Home Health Agencies, 1980-1995



Note: Government/other refers to either public agencies operated by a state, county, city, or local unit of government, or freestanding agencies that do not fit one of the major categories of agencies.
Source: National Association for Home Care, May 1997.

represent the largest share of all home health agencies serving the Medicare population (Figure 4).

The growth in the total number of home health agencies generally, and for-profit agencies more specifically, appears to have contributed directly to the increases in utilization of Medicare-covered home health services.

Projected Growth in Home Health Expenditures

Future growth in Medicare home health expenditures is expected to continue, but the rate of continued growth is the subject of some speculation. CBO projects that for the period between 1996 and 2007, home health expenditures will not continue to grow as a share of program spending as it has in the past, remaining relatively constant at about 9 percent of total Medicare spending.[7]

However, it is conceivable that home health services will not level off as CBO assumes and that historically high rates of growth will continue into the future. If, for example, home health expenditures increase on average by 12 percent between now and 2007, rather than 9 percent as projected by CB0, then home health expenditures would grow from 9 percent of total program spending to more than 12 percent by 2007. Under this alternative projection, Medicare home health spending would exceed $60 billion in 2007 -- which is about $17 billion more than CBO estimated.

[7] Congressional Budget Office, The Economic and Budget Outlook: Fiscal Years 1998-2007, Appendix H: Medicare Projection, January 1997.

Even if the CBO projections turn out to be correct, home health expenditures will still grow at an average annual rate of more than 11 percent per beneficiary between the years 1996 and 2002, which is more than twice the per beneficiary growth rate projected by CBO for hospital and physician services during this same period of time.[8] Home health services are therefore likely to remain a focus of Medicare policy discussions in the years to come.

[8]Komisar H et al, Medicare Chart Book, Henry J. Kaiser Family Foundation, 1997.

Methods and Data Sources

The present study uses person-level information from the four years of the Medicare Current Beneficiary Survey (1991-1994) and their related Medicare claim files[9]. Univariate and bivariate analyses are used to profile the beneficiaries who use home health services and to quantify the level of services they use. Multivariate estimation techniques were used to examine factors that determine the quantity of services used and the relationship of these factors to Medicare's home health expenditures.

For the analysis of beneficiaries by the quantity of home health services they received, beneficiaries were classified into one of four groups: 1-29 visits; 30-99 visits, 100-199 visits and 200 or more visits. This categorization permits an examination of utilization and expenditure trends and a description of beneficiaries who receive a relatively large number of visits (200 or more) within a given year.

Medicare beneficiaries were also grouped according to their use of other health care services (inpatient hospital and skilled nursing facility) to derive a better understanding of their medical status and home health needs. These health utilization groups help to identify distinct patterns of service utilization that were found to remain relatively constant year after year. Nine distinct service utilization groups were identified which were ultimately collapsed back into three groups for the analysis in this paper.

Group One (referred to as the post-acute group) includes beneficiaries who were typically hospitalized once within the year and received home health services within 15 days of discharge from the hospital. Group two (the "medically-complex" group) includes beneficiaries who used significantly higher levels of inpatient hospital care in conjunction with their home health care. About half of the beneficiaries in this group were also admitted to a skilled nursing facility (SNF) within the year. Group three (the "long-term care" group) includes medically-

[9]The database used in this analysis excludes Medicare beneficiaries enrolled in Medicare risk plans for whom home health and other claims data are not available.

stable beneficiaries who received home health care, but were neither hospitalized nor admitted to a skilled nursing facility within the year.

A more detailed discussion of these groups, which we refer to as home health episode groups or HHEGs, is included in the Appendix. We believe that these groups may be a useful tool for gaining a more thorough understanding of home health beneficiaries' needs and variations in their home health utilization and expenditures. The HHEGs may also be helpful in constructing a meaningful prospective payment system.

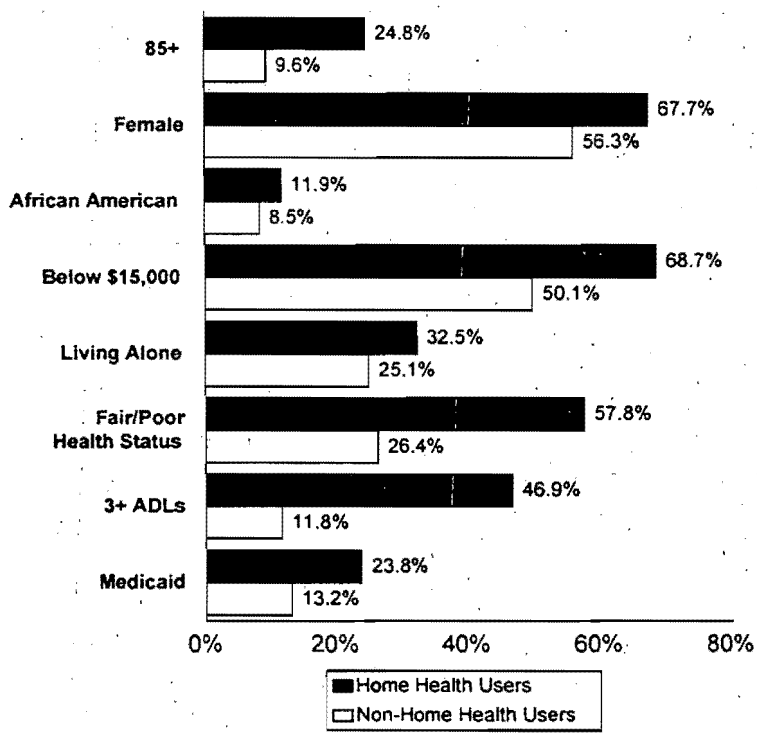
Findings

Profile of Medicare Home Health Users

While Medicare 's home health program was originally intended as a short-term post-acute benefit, it has more recently become a significant source of care for seriously ill beneficiaries with highly complex medical needs and for older and disabled beneficiaries with long-term care needs.

Figure 5

Percent of Medicare Home Health Users and Non-Users with Selected Characteristics, 1994



The Medicare home health population includes beneficiaries who are among the sickest and most functionally impaired segments of the Medicare population. They are relatively older and poorer, predominantly female, and more likely to live alone compared to other beneficiaries (Table 3). In 1994, one quarter of all home health users were age 85 or older; more than two thirds (69 percent) had incomes below $15,000; two thirds (68 percent) were female; and one third (33 percent) lived alone (Figure 5).

More than half of all home health users (58 percent) perceived their health status to be fair or poor, compared to 26 percent of beneficiaries who did not receive home health services.

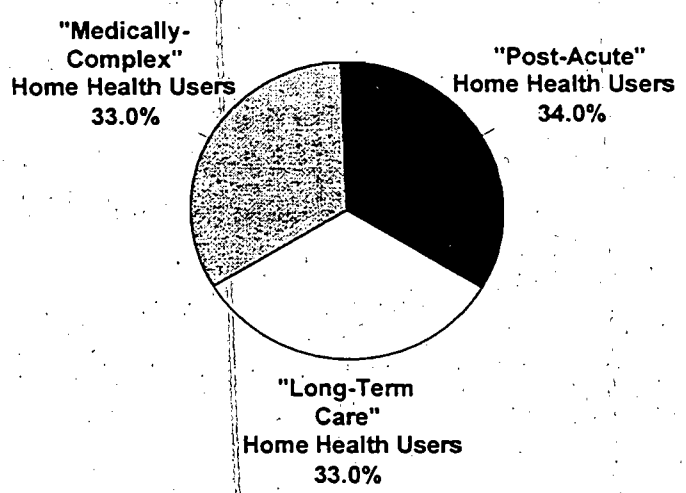
Three quarters of all home health users (73 percent) had one or more limitations in activities of daily living (ADL) and nearly half (47 percent) had 3 or more ADL limitations, compared to 31 percent and 11.8 percent respectively among those who did not receive home health services. Medicare beneficiaries who receive home health services were more likely to use the health care system extensively and incurred Medicare costs that were, on average, more than 5-times greater than Medicare costs for beneficiaries who did not receive home health care ($15,321 and $2,723 respectively in 1994). The average home health beneficiary in 1994 received 73 visits annually with a mean reimbursement of $4,442.

Three Distinct Groups of Beneficiaries Use Home Health Care

Medicare's home health population consists of the three distinct patient user groups (Figure 6):

Figure 6

Medicare Beneficiaries Who Receive Home Health Care, 1994

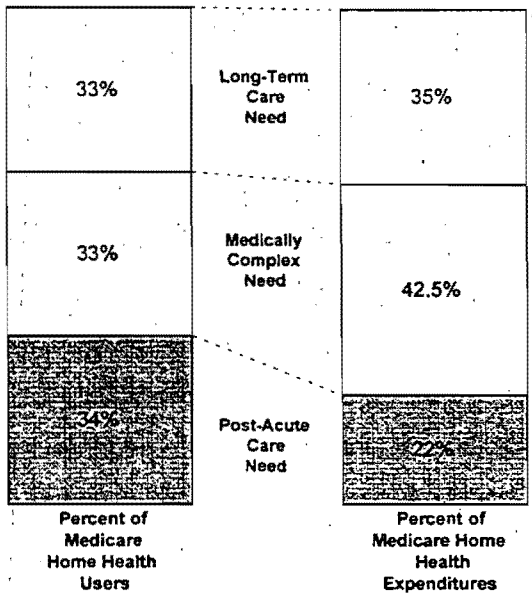


Post-Acute Home Health Users: The first third of the home health population "post-acute" group consists of beneficiaries who were hospitalized during the year and in most cases received home health services immediately after discharge from the hospital. This group most closely resembles the profile of home health users for whom the benefit was originally conceived and tended to serve up until the late 1980's (Tables 4a and 4b).

In 1994, more than half (53 percent) of beneficiaries in the "post-acute" group perceived their health status to be fair or poor. Two thirds (67 percent) reported 1 or more ADL impairments. Beneficiaries in this group used more

Figure 7

Distribution of Medicare Home Health Users and Expenditures, 1994



physician visits than beneficiaries in the "medically-complex" or "long-term care" group, while using substantially less hospital care than beneficiaries in the "medically complex" group. Also, in 1994, beneficiaries in the post-acute group tended to be younger and had higher incomes than other Medicare beneficiaries who receive home health services.

In 1994, this post-acute group accounted for one third (34 percent) of the total Medicare home health population but only a fifth (22.5 percent) of all 1994 home health expenditures (Figure 7). The average "post-acute" home health beneficiary received 47 visits, with nearly two thirds (64 percent) receiving less than 30 visits per year, 25 percent receiving between 30-99 visits, 6 percent receiving between 100-199 visits and about 5 percent receiving 200 visits or more. The average Medicare home health expenditure for beneficiaries in this group was $2,957 in 1994.

Medically-Complex Home Health Users: Another third (33 percent) of Medicare's home health population in 1994 were seriously ill patients with complex medical problems. These beneficiaries, compared to all other home health users, received substantially more hospital care and, in the case of about half of this group, were also admitted to a skilled nursing facility within the same year.

Beneficiaries in the "medically complex" group were also more likely than other home health users to be in poor health and have significant functional impairments. Two thirds of all beneficiaries in this group (67 percent) perceived their health status to be fair or poor and 83

percent had 1 or more ADL impairments. "Medically-complex" home health users are more likely than others to receive their care from a non-profit home health agency.

In 1994, this "medically-complex" group accounted for 42.5 percent of all home health expenditures with average Medicare home health expenditures of $5,736 per beneficiary. The typical beneficiary in this group received 91 home health visits in 1994, with a third receiving less than 30 visits, another third receiving between 30-99 visits, 17 percent receiving 100-199 visits and 15 percent receiving 200 or more visits in 1994.

Within the "medically complex" user group, there were differences in home health utilization and expenditures that depended upon whether or not the beneficiary received care in a SNF. Beneficiaries who were also admitted to a SNF during the year received substantially fewer home health visits than beneficiaries *without* SNF care (70 vs 114 home health visits, respectively). As a consequence, average home health expenditures for beneficiaries *with* SNF care were substantially lower ($4,410) than for beneficiaries who *did not* receive SNF care ($7,151), suggesting a substitution effect.

Long-Term Care Users: In 1994, the remaining third (33 percent) relied on Medicare's home health benefits to help meet their long-term care needs. These beneficiaries had higher levels of functional impairments, but appeared medically-stable. They had neither hospital nor skilled nursing facility (SNF) care and fewer than the average number of physician visits within the year. When compared to other home health users, beneficiaries in this group were more likely to fall within the lowest income levels (20 percent had incomes below $5,000) and live alone (39 percent). The increasing role of Medicare's home health benefit as a source of long-term care for chronically ill beneficiaries confirms the findings of earlier studies.[10, 11, 12]

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[10]Bishop, Christina and Kathleen Skwara, "Recent Growth of Medicare Home Health," Health Affairs, 12 (Fall 1996):95-110.

[11]Welch, G.H., Wennberg, D.E., and W.B. Welch, "The Use of Medicare Home Health Care Services," The New England Journal of Medicine, 335:5 (August 1, 1996):324-329.

[12]Kenney, G. and M. Moon, "Reining in the Growth in Home Health Services Under Medicare," The Commonwealth Fund, May 1997.

In 1994, the "long-term care" group of home health users accounted for 35 percent of total home health expenditures with average Medicare home health expenditures of $4,671 per beneficiary. Beneficiaries in the "long-term care" group received on average 81 visits in 1994, which is about 10 visits fewer than beneficiaries in the "medically complex" group received. However, beneficiaries in the "long-term care" group received, on average, substantially higher numbers of home health aide visits than beneficiaries in the medically-complex group, but fewer skilled nursing visits.

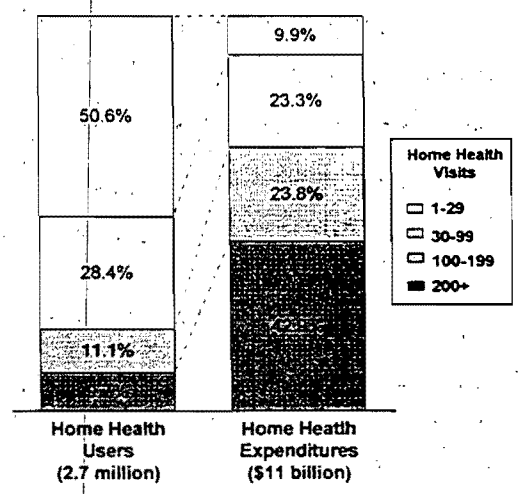
Since 1991 the share of all home health users in each of the above categories has remained remarkably constant.

Beneficiaries Who Receive 200 or More Home Health Visits

We examined the characteristics of beneficiaries who received 200 or more visits and compared their characteristics to beneficiaries who received fewer services, because these "high utilizers" account for a small but growing share of the home health population and a disproportionate share of Medicare's home health expenditures. In 1991, only 4 percent of all home health users received 200 or more visits, and accounted for 19 percent of total Medicare home health expenditures. By 1994, 10 percent of all home health users received 200 or more visits, and accounted for 43 percent of total home health expenditures (Figure 8).

Figure 8

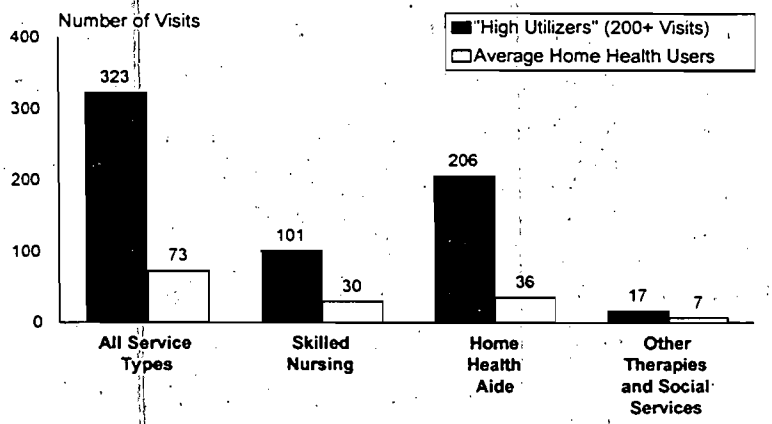
Distribution of Home Health Beneficiaries and Expenditures by Number of Visits Received, 1994



Beneficiaries with 200 or more visits in 1994 received on average 323 visits which is more than 4-times the number of home health visits received by the average beneficiary (73 visits in 1994). Beneficiaries in this "200-plus high use group received 101 skilled nursing visits (more than 3-times the average) and 17 physical therapy visits (more than twice the average).

Figure 9

Number and Type of Home Health Visits Received: Comparison of High Utilizers and Average Home Health Users, 1994



However, the most significant difference was in the use of home health aides. Beneficiaries with 200 or more visits per year received an average of 206 home health aide visits within the year, compared to 36 visits for the average home health beneficiary (Figure 9).

The average Medicare payment for home health services provided to beneficiaries with 200 or more visits in 1994 was $18,435, which is more than 4-times greater than the mean reimbursement for all home health recipients ($4,442 in 1994).

When compared to the average 1994 home health users on a bivariate level, beneficiaries who received 200 or more visits were in poorer health and had significantly higher levels of ADL impairments (Tables 5a and 5b). They more frequently experienced multiple hospitalizations within the course of the year followed by long episodes of home health service use. They were more likely to have lower incomes, to be African-American and female. They were also more likely to be covered under Medicaid and less likely to be covered under Medigap insurance (Figure 10).

Beneficiaries with 200 or more home health visits in 1994 were more likely to have received their care from a for-profit home health agency[13]. Home health agencies that were hospital-based agencies were not found to be more likely to provide care to people who received 200 or more visits. Hospital-based agencies provided home health services to nearly one third

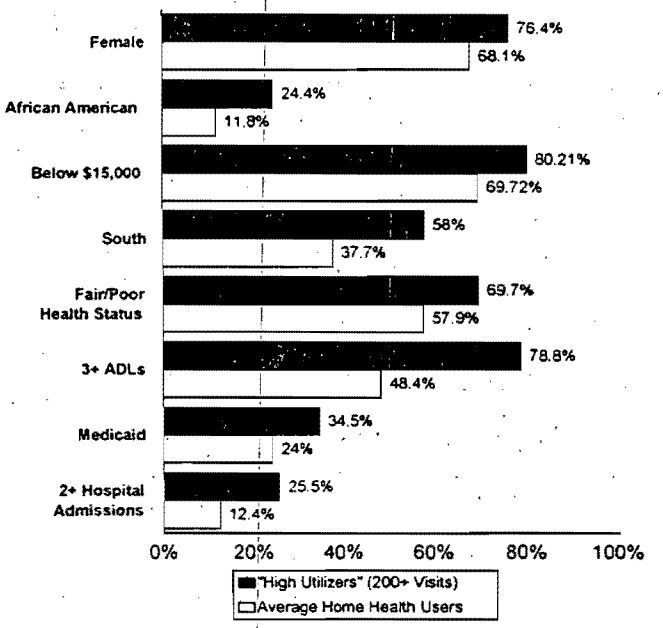
[13]These findings are confirmed by Health Care Financing Administration program statistics that show for 1994, the average number of visits was 66 per person served, while the average number of visits per persons served by proprietary agencies was nearly 92.

of all home health recipients (31.8 percent) in 1994, but less than a quarter (22.2 percent) of those with 200 or more visits.

Nearly half (47 percent) of all beneficiaries who received 200 or more home health visits were in the "medically-complex" group. Another 38 percent were in the "long-term care group". Only a small share, 15 percent, were in the post-acute category.

Figure 10

Percent of Medicare Home Health Users with Selected Characteristics
(Comparison of "High Utilizers" and Average Home Health Users, 1994)



Determinants of Receiving 200 or More Home Health Visits

A multivariate model was used to identify factors that explain the number of home health services received within a year while controlling for the simultaneous effects of other variables associated with home health use. This modeling technique estimates the probability that a particular characteristic increases the person's likelihood of being in the high or low home health use group. Table 6 shows the marginal probabilities of being in the high use group (200 or more visits) and the low use group (1-29 visits) for statistically significant characteristics.

Determinants of Low Use (1-29 visits): Home health recipients who received fewer than 30 visits a year were less likely than other home health users to perceive their health status as fair or poor. They were less likely than other home health users to have functional impairments (require assistance with bathing). Also, beneficiaries in this group were less likely than other home health users to have medically-complex needs. They were less likely to be among users with 2 or more hospital admissions and home health episodes and less likely to begin receiving home health services after an extended gap following hospital discharge (where services start 16-45 days following discharge), a pattern appearing to be associated with medically complex

cases. Beneficiaries in this low use group were less likely to be male, African-American, 85 years of age or older, or to live in the South. They were also less likely to receive services from proprietary home health agencies rather than government-owned or non-profit home health agencies. When other factors were controlled, hospital-based agencies showed no effect.

Determinants of High Use (200 or more visits): Beneficiaries who received 200 or more visits annually were more likely to have functional impairments (require assistance with bathing). They were substantially more likely than other home health users to receive home health services in conjunction with multiple hospitalizations, more likely to receive services beginning several weeks after discharge from the hospital, and less likely to receive home health services immediately following discharge from the hospital. Beneficiaries who were African-American and beneficiaries living in the South were more likely than others to receive 200 or more visits. The finding of higher home health utilization among beneficiaries in the South is consistent with other studies.[14]

In the multivariate model, the presence of supplemental health insurance (Medicaid or Medigap) was not associated with higher levels of home health utilization. Because there are no coinsurance requirements for home health services that could create financial barriers to care, it is not surprising that supplemental insurance has no effect on utilization of services.

We found that beneficiaries who received care from a for-profit home health agency were more likely to receive 200 or more Medicare-covered home health visits, even after controlling for the effects of health status, functional status and demographic variables. We did not find a statistically significant relationship between intensity of home health service utilization and whether or not the agency was free-standing or hospital-based.

Determinants of Higher Home Health Expenditures

We developed a multivariate model to identify statistically significant factors that explain Medicare home health expenditures while controlling for the simultaneous effects of other variables. The model identifies the following conditions or patient characteristics: patients who

[14]Schore, Jennifer. Regional Variation in Medicare Home Health, Mathematica Policy Research Inc., 1996.

require assistance with bathing; patients who experience multiple hospitalizations; patients who are of African-American decent; patients who receive routine home health immediately following hospital discharge; and patients who receive care from proprietary agencies. Table 7 presents the actual dollar amount each statistically significant factor added to (or subtracts from) Medicare's average annual per person home health cost in 1994. The Table also presents the aggregate amount contributed by each variable to total home health expenditures in 1994.

The Impact of For-Profit Home Health Agencies on Medicare Expenditures

The fact that the care was provided by a for-profit home health agency, rather than a government or not-for profit agency, increased the average annual cost of Medicare home health expenditures ($4,442 in 1994) by $1,064 per beneficiary. This additional amount is the net increase in Medicare home health costs for services provided by proprietary agencies, after controlling for the effects of health and functional status, age, gender, race, income, living arrangements, race, geographic location, and use of hospital and skilled nursing home services. In 1994, this higher per patient cost of beneficiaries served by proprietary agencies added more than $1 billion to overall Medicare home health expenditures.

The finding of a positive and statistically significant relationship between for-profit agency status and increased home health utilization and expenditures confirms a similar recent finding by the GAO.[15,16] This study also quantifies the effects of for-profit agency status on overall home health expenditures, while controlling for the effects of other variables. By controlling for the effect of other factors, our study suggests that the growth in utilization is the result of agency ownership, rather than whether the agency is hospital-based. In our multivariate model, hospital-based agencies were not found to be more likely than free-standing agencies to generate higher levels of services and expenditures.

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[15]United States General Accounting Office, Medicare Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16), March 1996.

[16]Kenney and Moon (1997) also reported higher utilization of services by patients served by proprietary agencies.

Other Factors Associated with Home Health Expenditures

Not surprisingly, beneficiaries who have poor functional status and beneficiaries with complex medical needs were more likely than other home health users to receive the greatest number of home health benefits and account for higher levels of Medicare home health expenditures. Medicare's home health expenditures were $2,898 higher for home health users who required assistance with bathing than for those who could bathe independently. Medicare home health expenditures were $2,647 higher for home health users who were medically unstable, evidenced by multiple hospitalizations during the year, than for other home health users. Beneficiaries who received home health services immediately after discharge from the hospital, the "post-acute" users, incurred home health expenditures that were $1,534 below the average.

Less intuitive, however, is the finding of higher than average home health expenditures among African American beneficiaries. African Americans incurred expenses that were on average $1,245 greater than the mean, even after controlling for health, functional status, income, region, and other factors. There is some speculation that African Americans are less likely than others to live in areas where nursing homes are available and therefore more likely to rely on noninstitutional home health services. There may also be cultural aversions to institutional care resulting in stronger preferences for home and community-based services.

Future Research

This research focuses only on Medicare expenditures for home health care. Extending the analysis to examine total expenditures for all Medicare-covered services would provide a measure of the typical home health user's impact on the total Medicare system. We found that total Medicare costs for home health users were more than 5-times greater than Medicare costs for beneficiaries who did not receive home health care ($15,321 compared to $2,723 respectively). Certainly some of this additional cost is the direct result of the costs of home health services themselves. What is yet to be determined is whether certain patterns of home care use - such as care delivered by hospital-based systems and for-profit agencies - affect use of other Medicare services and overall Medicare expenditures. Identifying the impact of home

health agency attributes on total Medicare outlays will be an important next step in understanding changes in the home health care market for public policy formulation.

Implications of Findings

As policy makers look toward the home health benefit as a source of potential Medicare savings, this study provides new information that explains the factors that drive home health expenditures and describes the characteristics of Medicare beneficiaries who use home health services. The findings provide new evidence to assess the implications of potential policy changes in the structure of Medicare's home health benefit.

Clearly, Medicare home health coverage is no longer simply the short-term post-acute benefit as it was originally intended. Only a third of all beneficiaries who receive home health services received their care immediately following a hospital discharge. The remaining two thirds of home health users rely on Medicare's home health benefit to assist with their recovery from more complex and ongoing medical problems or use home health services to help meet their long-term care needs. Our findings support the growing body of evidence confirming the evolving role of Medicare's home health benefit as a safety net for elderly beneficiaries with long-term care needs. Our findings also go further by differentiating the acutely ill patients into those needing short-term acute post-hospital care and those who are seriously ill and require on-going home health services.

Efforts to pare back the Medicare home health benefit to short-term post acute-care would clearly impact some of the most vulnerable segments of the Medicare population who either have complex medical problems or significant long-term care needs. While such a move would conform the benefit to its original intent, it could also leave significant gaps in coverage for Medicare's oldest and most frail beneficiaries.

Likewise, imposing copayments on beneficiaries who receive more than 100 visits to discourage utilization (21 percent of all home health users) would disproportionately impact the near poor who do not qualify for Medicaid but are unable to afford private supplemental Medigap

insurance. If copayments are imposed, protections for Medicare's poor and near-poor will need to be strengthened. A new copayment would be unlikely to affect utilization levels among beneficiaries with supplemental insurance to cover Medicare's coinsurance, but could result in higher monthly Medigap premiums as insurers pass through their higher costs to enrollees.

For beneficiaries who are eligible for Medicare and Medicaid, efforts to scale back the quantity of services directly or through copayments would impact state expenditures for long-term care services. A significant share of beneficiaries who receive high levels of home health care are also entitled to Medicaid. If Medicare home health benefits were significantly constrained, these dual eligible beneficiaries would turn to Medicaid for coverage which would have financial implications for States.

Finally, our finding of substantially higher Medicare costs associated with the delivery of home health services by for-profit home health agencies begs for additional government oversight. The finding of $1 billion in Medicare payments to proprietary home health agencies in 1994 -- that cannot be explained by the health status, functional status, living status or other beneficiary characteristics -- offers promise as a potential source of Medicare savings. Clearer guidelines are needed to define the circumstances under which Medicare will pay for higher numbers of home health visits per beneficiary.

Table 1. Medicare Home Health Utilization and Expenditure Trends, 1990-1994

Year	Persons per 1,000 Enrollees	Visits per Person Served	Charges per Visit	Payments per person Served	Home Health as a % of all Medicare Program Payments
1990	57	36	69	$1,892	3.7
1991	64	45	71	$2,397	4.8
1992	70	53	75	$2,955	6.1
1993	79	57	81	$3,389	7.5
1994	86	66	83	$3,987	8.6
Year to Year Increases					
1990 to 91	12.3%	25.0%	2.9%	26.7%	29.7%
1991 to 92	9.4%	17.8%	5.6%	23.3%	27.1%
1992 to 93	12.9%	7.5%	8.0%	14.7%	23.0%
1993 to 94	8.9%	15.8%	2.5%	17.6%	14.7%
Average Annual Growth Rate	**13.1%**	**16.5%**	**4.8%**	**20.6%**	**23.6%**

Source: Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1996

Table 2. Number and Percent Distribution of Home Health Agencies, 1980–1995

	1980		**1985**		**1990**		**1995**	
Agency Type	number	%	number	%	number	%	number	%
For- Profit	186	6.4%	1,943	32.5%	1,884	33.0%	3,951	43.0%
Non-Profit	1,062	36.3%	1,405	23.5%	1,231	21.6%	1,282	14.1%
Government	1,260	43.1%	1,205	20.1%	985	17.3%	1,182	13.0%
Other	57	1.9%	153	2.6%	109	1.9%	235	2.6%
Hospital-Based	359	12.3%	1,277	21.3%	1,486	26.1%	2,470	27.1%
Total	2,924	100%	5,983	100%	5,695	100%	9,120	100%

Note: numbers may not add to 100% due to rounding.
Source: National Association for Home Care, May 1997.

Table 3. Characteristics of Medicare Home Health Users and Non-Users, 1994

Characteristics	Medicare Beneficiaries Who Receive Home Health Services (cases=1462) (wgt n=2,711,625)	Medicare Beneficiaries Who Did Not Receive Home Health Services (cases=14,657) (wgt n=31,967,079)	Total (cases=16,119) (wgt n=34,675,512)
Age			
< 65	6.7 %***	11.2 %	10.8 %
65 to 74	29.0 ***	49.0	47.4
75 to 84	39.4 ***	30.3	31.0
85+	24.8 ***	9.6	10.7
Female	67.7 ***	56.3	57.2
Race			
White	81.1 %	83.8 %	83.6 %
Black	11.9 **	8.46	8.7
Hispanic	5.5	5.92	5.9
Other	1.5	1.79	1.8
Income			
$5,000 or less	14.3 %	9.5 %	9.9 %
$5,001 to $15,000	54.4 ***	40.6	41.7
$15,001 to $25,000	17.0 ***	22.2	21.8
$25,001 or greater	14.4 ***	27.7	26.7
Medicaid eligible	23.8 %	13.2 %	14.0 %
Private Medigap policy	70.1 %	76.1 %	75.6 %
Household composition			
Living alone	32.5 %***	25.1 %	25.7 %
Spouse only	30.0 ***	44.1	43.0
Others in home	37.5 ***	30.8	31.4
Region			
Northeast	25.6 %**	21.1 %	21.5 %
Midwest	22.5	24.7	24.6
South	38.4	35.2	35.4
West	13.5 ***	19.0	18.6
Urban Location			
Those in SMAs	72.3 %	74.1 %	74.0 %
Fair/Poor Health Status	57.8 %***	26.4 %	28.8 %
Chronic Conditions			
At least one	83.9 %	68.1 %	69.3 %
Functional status (ADLS)			
No ADLS	27.1 %***	69.0 %	65.7 %
1-2 ADLS	26.0 ***	19.2	19.7
3-4 ADLS	20.5 ***	6.2	7.3
5-6 ADLS	26.4 ***	5.6	7.3
Difficulty bathing	53.6 %***	14.5 %	17.5 %

p<.05, **p<.01, ***p<.001 Home health users compared to other beneficiaries.

Source: Medicare Current Beneficiary Survey, 1994

Table 4a. Characteristics of Medicare Beneficiaries Who Receive Home Health Services by User Group, 1994

Characteristics	"Post-Acute" Home Health Users (cases=426) (wgt n=838,032)	"Medically-Complex" Home Health Users (cases=444) (wgt n=815,741)	"Long-Term" Care Home Health Users (cases=472) (wgt n=823,595)	Total[T] (cases=1342) (wgt n=2,477,368)
Age				
< 65	7.1 %	5.3 %	8.0 %	6.8 %
65 to 74	32.6	26.4	23.8	27.6
75 to 84	40.7	40.9	38.7	40.1
85+	19.6 ***	27.4	29.6	25.5
Female	66.7 %	47.7 %**	68.5 %	68.1 %
Race				
White	82.1 %	82.6 %	78.5 %	81.1 %
Black	10.8	11.3	13.2	11.8
Hispanic	5.0	5.0	6.7	5.6
Other	2.1	1.1	1.7 [a]	1.6
Income				
$5,000 or less	11.4 %	11.5 %	19.6 %	14.3 %
$5,001 to $15,000	49.8 *	60.0	56.7	55.5
$15,001 to $25,000	20.6	17.7	12.3 *	16.8
$25,001 or greater	18.2	10.7	11.5	13.5
Medicaid eligible	18.9 %	26.2 %	27.0 %	24.0 %
Private Medigap policy	74.8 %	72.0 %	63.2 %**	70.0 %
Household composition				
Living alone	29.8 %	28.8 %	39.0 %**	32.7 %
Spouse only	36.7	27.3	25.4	29.8
Others in home	33.6	43.9	35.7	37.6
Region				
Northeast	26.5 %	28.1 %	21.6 %	25.4 %
Midwest	24.1	23.1	21.0	22.8
South	36.4	34.0	42.9	37.7
West	13.0	14.8	14.5	14.1
Urban Location				
Those in SMAs	73.1 %	74.2 %	71.0 %	72.8 %
Fair/Poor Health Status	53.1 %	66.6 %	54.3 %	57.9 %
Chronic Conditions				
At least one	81.5 %	86.8 %	84.5 %	84.2 %
Functional status (ADL Impairments)				
Mean number ADLs	2.2	3.1 **	2.5	2.6
Mean for those with at least one	3.3	3.7	3.5	3.5
No ADLS	32.8	16.9	26.2	25.4
1-2 ADLS	27.1	23.8	27.7	26.3
3-4 ADLS	19.6	23.8	19.9	21.1
5-6 ADLS	20.5 *	35.5	26.2	27.3
Difficulty bathing	46.9 %	66.7 %	53.3 %	55.5 %

*p<.05, **p<.01, ***p<.001 compared to row totals

[T] Yearly total number of cases for the Home Health Episode Group tables are smaller than the yearly totals for the 'Use Intensity Tables' (Tables 5a &5b) because of definitional requirements of the HHA ONLY, the IP no HHA post IP, and the 1-IP/HHA episode 15 days post IP groups.

Source: Current Medicare Beneficiary Survey, 1994; and Medicare Claims Data

Table 4b. Service Utilization and Expenditures of Medicare Beneficiaries Who Receive Home Health Services by User Group, 1994

Health Service Use Patterns and Expenditures	"Post-Acute" Home Health Users (cases=426) (wgt n=838,032)	"Medically-Complex" Home Health Users (cases=444) (wgt n=815,741)	"Long-Term" Care Home Health Users (cases=472) (wgt n=823,595)	Total[T] (cases=1342) (wgt n=2,477,368)
Mean reimbursement for home health visits[1]	$2,957 **	$5,736 *	$4,671	$4,442
Total reimbursement for 1994 (in millions)	$2,478	$4,679	$3,847	$11,004
Mean number of home health visits[1]	47.0 ***	91.0	80.5	72.6
Number of skilled nursing visits[1]	19.0 ***	41.0 *	29.6	29.8
Mean reimbursement	$1,918 ***	$4,212	$2,984	$3,028
Visits to patients with 1 or more skilled visits [2]	20.0 ***	42.0	32.1	31.7
Mean reimbursement	$2,050 ***	$4,340	$3,230	$3,218
Number of home health aides visits[1]	21.0 **	41.0	45.4	35.7
Mean reimbursement	$1,343 **	$2,518	$2,802	$2,215
Visits to patients with 1 or more nurse aide visits [2]	45.0 **	67.0	98.6	69.9
Mean reimbursement	$2,910 **	$4,043	$6,082	$4,340
Visits to patients with 1 or more skilled nurse visits [2]	26.0 ***	47.0	40.5	39.0
Mean reimbursement	$2,637 ***	$4,737	$4,114	$3,956
Number of phys. therapy, soc. services, occ. therapy[1]	7.0	9.0	5.4	7.1
Mean reimbursement	$753	$993	$577	$773
Physical therapy, social services, occ. therapy[2]	14.0	15.0	12.5	14.0
Mean reimbursement	$1,520	$1,626	$1,328	$1,517
Supplies (Mean reimbursement)	$101	$232	$199	$177
Ownership of agencies (percent distribution)				
Voluntary non-profit	52.1	58.9	50.9	55.0
Proprietary	36.4	33.1	41.2	36.9
Government	8.4	8.0	7.9	8.1
Hospital-based agencies	34.5	33.7	27.8	32.0
Hospital utilization				
Total number of inpatient days	8.4 ***	23.4 *	n.a.	17.4
Average length of stay	8.8	9.4	n.a.	8.7
Inpatient days tied to episode of home health	9.0 ***	15.8	n.a.	12.4
Average length of stay/episodes	2.1 **	9.3	n.a.	9.1
Mean number of doctor visits	9.7	8.8	7.4	8.6
Home health intensity levels (percent distribution)				
1 - 29 visits	64.4 %	33.0 %	49.0	48.9 %
30 - 99 visits	25.0	35.9	26.1	29.0
100 - 199 visits	5.9 *	16.5	13.1	11.8
200 or more visits	4.7 *	14.6	11.9	10.3

[1] for those with at least one HHA visit

[2] for those with at least one type of this visit

p<.001 compared to row totals

[T] Yearly total number of cases for the Home Health Episode Group tables are smaller than the yearly totals for the 'Use Intensity Tables' (Tables 5a & 5b) because of definitional requirements of the HHA ONLY, the IP no HHA post IP, and the 1-IP/HHA episode 15 days post IP groups.

Note: Percentages may not add to 100 due to rounding

Source: Current Medicare Beneficiary Survey, 1994; and Medicare Claims Data

Table 5a. Characteristics of Medicare Beneficiaries Who Use Home Health Services by Number of Visits Received, 1994

Characteristics	1-29 visits (cases=711) (weighted n=1,372,977)	30-99 visits (cases=423) (weighted n=772,647)	100-199 visits (cases=170) (weighted n=302,003)	200+ visits (cases=158) (weighted n=263,998)	Total (cases=1462) (weighted n=2,711,625)
Age					
< 65	7.8 %	5.6 %	5.0 %	7.8 %	6.8 %
65 to 74	30.6	24.2	27.6	23.0	27.6
75 to 84	39.0	43.3	36.0	41.3	40.1
85+	22.7	27.0	31.5	27.9	25.5
Female	65.0 %	70.0 %	69.2 %	76.4 %*	68.1 %
Race					
White	86.2 %	77.9 %	81.5 %	64.8 %	81.1 %
Black	7.4	14.2	12.8	24.4	11.8
Hispanic	4.9	6.1	4.1	8.8	5.6
Other	1.5	1.7	1.6	1.9	1.6
Income					
$5,000 or less	14.0 %	13.9 %	12.3 %	19.0 %	14.3 %
$5,001 to $15,000	52.9	56.2	59.1	61.2	55.5
$15,001 to $25,000	16.9	17.2	18.3	13.5	16.8
$25,001 or greater	16.3	12.8	10.3	6.3 [a]	13.5
Medicaid eligible	20.7 %	23.0 %	31.3 %	34.5 %*	24.0 %
Private Medigap policy	70.3 %	72.7 %	73.3 %	57.5 %*	70.0 %
Household composition					
Living alone	34.0 %	34.1 %	26.4 %	29.9 %	32.7 %
Spouse only	33.4	27.7	30.1	18.4 **	29.8
Others in home	32.7	38.2	43.4	51.7 **	37.6
Region					
Northeast	29.4 %	24.4 %	20.4 %	15.8 %*	25.4 %
Midwest	23.5	23.9	23.5	15.5	22.8
South	29.9	40.8	44.2	58.0 ***	37.7
West	17.2	11.0	11.9	10.7	14.1
Urban Location					
Those in SMAs	74.1 %	73.5 %	68.8 %	68.8 %	72.8 %
Fair/Poor Health Status	51.4 %*	58.6 %	73.0 %**	69.7 %**	57.9 %
Chronic Conditions					
At least one	81.6 %	85.5 %	89.9 %*	86.8 %	84.2 %
Functional status (ADLS)					
Mean number ADLs	2.0 ***	2.8 ***	3.4 ***	4.0 ***	2.6
Mean for those with at least one	3.2 **	3.5	3.9 *	4.2 ***	3.5
No ADLS	36.6 ***	18.7 **	13.2 ***	4.8 [a]	25.4
1-2 ADLS	27.1	28.5	26.0	16.3 *	26.3
3-4 ADLS	18.0	26.0	16.9	26.8	21.1
5-6 ADLS	18.3	26.9	44.0 ***	52.0 ***	27.3
Difficulty bathing	39.7 %*	61.2 %	77.8 %**	89.3 %***	55.5 %

*p<.05, **p<.01, ***p<.001 compared to row totals

Note: Percents may not add to 100 due to rounding

Source: Current Medicare Beneficiary Survey, 1994; and Medicare Claims Data

Table 5b. Service Utilization and Expenditures of Medicare Beneficiaries Who Use Home Health Services by Number of Visits Received, 1994

Health Service Use Patterns and Expenditures	1-29 visits (cases=711) (weighted n=1,372,977)	30-99 visits (cases=423) (weighted n=772,647)	100-199 visits (cases=170) (weighted n=302,003)	200+ visits (cases=158) (weighted n=263,998)	All (cases=1462) (weighted n=2,711,625)
Mean reimbursement for home health visits[1]	$904 ***	$3,579 ***	$8,977 ***	$18,435 ***	$4,442
Total reimbursement for 1994 (in millions)	$1,096	$2,568	$2,619	$4,721	$11,004
Mean number of home health visits[1]	13.3 ***	54.8 ***	142.7 ***	323.0 ***	72.6
Number of skilled nursing visits[1]	8.6 ***	29.3	57.1 ***	100.7 ***	29.8
Mean reimbursement	$856 ***	$2,926	$5,869 ***	$10,358 ***	$3,028
Visits to patients with >1 skilled visits [2]	9.6 ***	29.8	57.1 ***	100.7 ***	31.7
Mean reimbursement	$962 ***	$2,978	$5,869 ***	$10,358 ***	$3,218
Number of Home health aides visits[1]	1.7 ***	17.0 ***	73.3 ***	205.7 ***	35.7
Mean reimbursement	$102 ***	$1,062 ***	$4,520 ***	$12,820 ***	$2,215
Visits to patients with 1 or more nurse aide visits [2]	7.2 ***	25.8 ***	84.4 *	211.2 ***	69.9
Mean reimbursement	$427 ***	$1,611 ***	$5,200 *	$13,166 ***	$4,340
Visits to patients with 1 or more skilled nurse visits [2]	7.3 ***	25.0 ***	49.1 **	91.8 ***	39.0
Mean reimbursement	$727 ***	$2,489 ***	$5,003 **	$9,409 ***	$3,956
Number of phys. therapy, social services, occ. therapy[1]	3.0 ***	8.5	12.4 **	16.6 **	7.1
Mean reimbursement	$318 ***	$879	$1,428 **	$1,891 ***	$773
Physical therapy, social services, occ. therapy[2]	7.2 ***	13.7	20.6 **	31.8 ***	14.0
Mean reimbursement	$756 ***	$1,417	$2,380 **	$3,618 ***	$1,517
Supplies Mean reimbursement	$31 ***	$115 *	$299 **	$899 ***	$177
Ownership of agencies (percent distribution)					
Voluntary non-profit	60.2 %	53.5 %	49.3 %	40.9 %*	55.0
Proprietary	29.5	40.9	41.6	55.5 **	36.9
Government	10.3	5.5	9.1	3.6 [a]	8.1
Hospital-based agencies	35.1 %	31.7 %	28.6 %	22.2 %*	32.0
Hospital utilization					
Total number of inpatient days	13.6 ***	20.6	22.1	21.7 **	17.4
Average length of stay	8.3	9.4	8.3	9.6	8.7
Inpatient days tied to episode of home health	9.8 ***	13.9	15.3	16.8 **	12.4
Average length of stay/episodes	8.9	9.5	8.5	10.0	9.1
Mean number of doctor visits	8.9	8.8	8.4	7.2 *	8.6
Home Health Episode Groups (HHEGs)					
#1 Home Health Only (no inpatient or SNF use)	33.3	30.0	36.9	38.2	33.2
#2 Inpatient use (IP), no HHA episodes after inpatient stays	6.6	4.7	0.5 [a]	0.0 [a]	4.6
#3 One IP/HHA episode-HHA within 15 days of discharge	38.0 **	24.6	16.4 ***	15.3 ***	29.2
#4 One IP/HHA episode-HHA 15-45 days of discharge	2.1 *	4.5	4.7 [a]	6.8	3.6
#5 Two IP/HHA episodes-HHA within 15 days of discharge	3.7 ***	10.8	16.8 **	12.5	8.2
#6 Two + IP/HHA episodes-HHA after discharge mix	0.8 [a]	4.6	9.4	13.0 **	4.2
#7 HHA and SNF, no IP/HHA episodes of HHA	3.7	3.2	4.8 [a]	2.1 [a]	3.5
#8 SNF between IP/HHA episodes	2.3	6.8	2.4 [a]	2.5 [a]	3.6
#9 SNF use not between IP/HHA episodes	9.7	11.0	8.2	9.6	9.9

[1] for those with at least one HHA visit

[2] for those with at least one type of this visit

*p<.05, **p<.01, ***p<.001 compared to row totals

Note: Percentages may not add to 100 due to rounding

Source: Current Medicare Beneficiary Survey, 1994; and Medicare Claims Data

Table 6. Probability of Being in the High Use or Low Use Groups by Beneficiary Characteristics

Beneficiary Characteristic	Estimated Percentage Increase/Decrease (Estimated Marginal Probability)	
	Low Use Group (1-29 Annual Visits)	High Use Groups (200+ Annual Visits)
Age 85 years or older	-4.7 %*	--
Patient is male	-6.2 %*	--
Resides in South	-12.5%**	6.0***
Lives in MSA	7.0%***	--
African American	-16.5***	5.0***
Perceives Health as Fair/Poor	-5.2**	--
Requires bathing assistance	-31.2%***	16.9%***
Has cancer or arthritis	4.5%*	--
No home health episodes following hospital discharge	15.2***	-19.4%**
One home health episode within 15 days of hospital discharge	--	-5.4%**
One home health episode within 16-45 days following discharge	-21.0%***	3.4**
Two or more home health episodes following hospital discharge	-56.7%***	10.2%***
Receives Services from Proprietary Agency	-10.2***	4.5*
Patient Covered by Medigap	-5.5%*	--

Source: Medicare Current Beneficiary Survey, Medicare Claims and Provider of Services Files, 1992-1994
Asterisks indicate significance: * p=.05; ** p=.01; *** p=.001

Table 7: Beneficiary Characteristics with Significant Impact on Medicare Home Health Expenditures, 1994

Patient Characteristic	Per Person Addition (Reduction) [1]	Total Effect on Home Health Expenditures 1994
Requires Assistance with Bathing	$2,896***	$4,360.7 million
Seriously Ill with Multiple Hospitalizations	$2,647***	$1,141.2 million
Racial Status of African-American	$1,245**	$397.3 million
Receives Services from Proprietary Agencies	$1,064***	$1,064.6 million
Home Health after Routine Hospital	($1,534)***	($1,406.0 million)

Source: Medicare Current Beneficiary Survey, Medicare Claims and Provider of Services Files, 1992 and 1994.
[1] Values are beta coefficients of dummy (0,1) variables from weighted multiple regression equations.
Asterisks indicate significance: * p=.05; ** p=.01; *** p=.001;

APPENDIX

Explanation of Home Health Episode Groups (HHEGs)

Overview

Home health users present very distinct patterns in their use of home health, hospital, and skilled nursing home services that remain relatively constant year after year. From their patterns we have also created service utilization groups. Groups are defined by their pattern of home health services use over the course of a year in conjunction with their use of hospital and skilled nursing home services. Some home health users appear to never use hospital or skilled nursing home services; others only use home health services for a limited period of time following a single episode of hospitalization; other use home health service almost continuously interspersed by repeated use of hospital and/or skilled nursing home services. We refer to these groups as home health episode groups (HHEGS). They appear to clarify the complex relationships between levels of home health service use and the users medical status where more direct, finely delineated measures of medical status are unavailable. After identifying these patterns, we found the episode groups to be very useful in both describing the user population and in explaining the quantity of services used and overall levels of home health expenditures.

We generated a set of nine exclusive categories to represent the health service utilization patterns of home health users. The HHEGs distinguish the different types of home health users receiving the benefit. Using the HHEGs, we are able to identify beneficiaries who are likely to be receiving home care as part of post-acute care recovery from a hospital admission. The HHEGs also identify the population using only home health care services, with no connection to inpatient care.

Collapsing the Home Health Episode Groups

The nine finely delineated home health episode groups were collapsed into more limited numbers of groups for analytic purposes. Specifically, the nine groups were collapsed into three groups representing a "post-acute care group," a seriously ill group, and a group with long-term home health needs. Additionally, the seriously ill group can be differentiated into two sub-groups: those who used skilled nursing home services and those who did not.

The "post-acute group" is composed of the two health episode groups who used limited amounts of both home health and inpatient hospital services, groups two and three. Group two used both services but the use of home health services did not occur within 45 days following the discharge of an inpatient event. Group three, on the other hand, had only one episode of home health care use following hospital discharge where home health services began within 15 days of the discharge. Both groups show roughly the same pattern of limited number of home health visits and inpatient hospital days. For example, in 1994, groups two and three respectively received 28 and 50 home health visits on average compared to 73 visits for all users and received 9.5 and 8.2 inpatient hospital days compared to the overall average of 16 days. Overall, the post-acute group used an average of 47 visits.

The seriously ill group without skilled nursing home services is composed of persons falling into group four - those who only had one episode of home health use following a hospital stay where the home health services began between 15 and 45 days following the discharge- and groups five and six- those with two or more episodes of home health use following hospital discharge. These three groups show high levels of home health use and inpatient days. For example, in 1994, groups four, five, and six, respectively, received 110, 102, and 141 home health visits on average compared to 73 visits for all users and received 13, 28, and 26 inpatient hospital days compared to the overall average of 16 days.

The seriously ill group using skilled nursing home services is composed of persons falling into groups seven, eight, and nine. Groups seven used skilled nursing home services in addition to home health and inpatient services, but the use of home health services did not occur

within 45 days following hospital discharge. Groups eight and nine used home health, skilled nursing home, and inpatient services where home health use occurred in episodes in conjunction with hospital stays. These three groups also show high levels of inpatient days, but compared to the other seriously ill group, skilled nursing home services appear to serve as a substitute for the extremely high use in home health visits by the other seriously ill group. For certain analyses the two seriously ill groups are collapsed into one group representing seriously ill home health patients with complex medical problems. Even collapsed into one seriously ill group, this group used more home health and inpatient services. For example, in 1994, on the average this single seriously ill group received 91 home health visits compared to 73 visits for all home health users and 23 hospital days compared to 17 days more generally. The entire seriously ill population used an average of 91 home health visits.

The long-term care home health group is composed of the single HHEG that includes Medicare home health services to the exclusion of hospital and skilled nursing home care. Compared to al the other groups of home health users, this long-term group uses substantially higher levels of home health aide services and also presents lower levels of use of physician visits. For example, in 1994, among those who received home health aide visits, on the average they received 99 visits compared to 70 visits more generally. The total long-term care group used an average of 81 home health visits.

Summary Descriptions of the Home Health Episode Groups (HHEGS)

Home Health Episode Group (HHEG)	Description	Rationale	Examples
(1) Home health only group (HH- Only)	Beneficiaries who used home health services during the calendar year but did not use any Medicare covered inpatient (IP) or SNF services during the year.[1]	Home health users most likely to be viewed as the medically stable, chronically-ill long-term care population. Proportionately, these patients require more supportive home health aide services.	Beneficiaries with arthritis that severely limits ADL capacities and persons with various forms of dementia that limit cognitive functioning.
(2) IP no IP/HH episodes[2]	Beneficiaries who used both home health and IP services during the calendar year but where the use of home health did not occur within 45 days following the inpatient event.[1] No use of the SNF benefit.	A somewhat less chronically-ill, long-term care population, with less medically stable health conditions who have occasional acute care events, but where home health use is not connected to the use of acute care services. Patients present more chronic health conditions and fewer dementias.	Beneficiaries with diabetes mellitus with periodic electrolyte disturbances requiring hospital treatment.
(3) 1-IP/HH episode 15 days post IP[2]	Beneficiaries who during the calendar year had ***only one*** episode of home health use following hospital discharge where home health services begin within 15 days following the discharge from the inpatient stay.[1] These patients may have had other inpatient stays during the year, but home health was not connected to these inpatient stays. No use of the SNF benefit.	Home health users most likely to resemble the home health beneficiaries as conceived under the original home health benefit: acutely ill medical patients requiring home health services following a hospital stay.	MI patients after coronary angioplasty or coronary artery bypass surgery.

(4) 1-IP/HH episode 15-45 days post IP[2]	Beneficiaries who during the calendar year had ***only one*** episode of home health use following a hospital discharge where home health services began between 15 and 45 days following the discharge.[1] These patients may have had other inpatient stays during the year, but home health is not connected to these inpatient stays. No use of the SNF benefit.	These discharged hospital patients began using home health services because of unexpected or serious secondary medical problems that developed after the inpatient stay. Patients display high levels of acuity and also resemble the home health beneficiaries as conceived under the original home health benefit: acutely ill medical patients requiring home health following a hospital stay. Generally these patients require more home health skilled nursing care.	Post surgical patients who develop secondary infections.
(5)2-IP/HH episodes both 15 days post IP[2]	Beneficiaries who during the calendar year had ***two or more*** episodes of home health use following hospital discharge where home health services begin within 15 days following each hospital discharge. These patients may have other inpatient stays during the year, but home health is not connected to these inpatient stays. No use of the SNF benefit.	Patients best characterized as acutely ill who return to the hospital for repeated medical treatments or surgical procedures. These patients use very high levels of home health skilled nursing services.	Patients with various malignancies requiring recurrent chemotherapy, radiation, hormonal therapy or surgical procedures and dementia patients with various combinations of these medical conditions.
(6) 2-IP/HH episodes post IP mixed patterns of HHA use[2]	Beneficiaries who during the calendar year had ***two or more*** episodes of home health use following hospital discharge where home health services begin within 45 days following each hospital discharge. These patients may have other inpatient stays during the year, but home health is not connected to these inpatient stays. No use of the SNF benefit.	Patients best characterized as in the late stages of chronic diseases who repeatedly return to the hospital for medical treatments or surgical procedures, whose health conditions appear to be extremely unstable. These patients also use very high levels of home health skilled nursing services.	Patients require immediate treatment because of organ failures or severe impairment in function. Patients present various malignancies, respiratory, cardiovascular and other diseases, and those who are wheelchair bound as a result of various physical disorders.

(7) HH & SNF but no IP/HH episodes[2]	Beneficiaries who used home health, SNF and IP services during the calendar year but where the use of home health did not occur within 45 days following any inpatient event.[1]	Patients best characterized as in the later stages of chronic diseases where their medical status, while deteriorating and limiting, appear stable. Because of failure to arrest disease processes, beneficiaries present disability, pain, and/or restricted ADL function, and impaired cognition.	Patients would include those with severe joint deformity resulting from arthritis, and those with impaired cognitive functioning from various forms of dementia such as Alzheimer's disease.
(8)IP/SNF/HH episode(s)	Beneficiaries who used home health, SNF and IP services during the calendar year, where there was 1 or more episodes of home health use within 45 days following hospital discharge and where there was one or more SNF stays within the 45 day period.	Patients best characterized as in the later stages of chronic diseases where their deteriorating and limiting medical status is complicated by acute health care events. Patients present disability, pain, and/or restricted ADL function, and impaired cognition.	Patients with severe ADL limitations, dementing illnesses such as Alzheimer's disease combined with episodes of acute illness.
(9) SNF use not between IP/HH episodes[2]	Beneficiaries who used home health, SNF and IP services during the calendar year, where there was 1 or more episodes of home health use within 45 days following hospital discharge, but where SNF use never occurred between any IP/HH episode.	Similar to patients in previous HHEG but where their medical status is far less stable and fewer individuals appear afflicted with diseases resulting in dementias.	Patients with severe ADL limitations and requiring immediate treatment because of organ failures or severe impairment in medical functioning. Patients present various combinations of chronic diseases, malignancies, respiratory, cardiovascular and other diseases.

[1] The beneficiaries who only used home health during January and/or February were excluded to insure no IP or SNF stays occurred within 45 days prior to the use of home health services.
[2] IP/HH Episode is defined as one or more home health visits within 45 days of discharge of an inpatient hospital stay (IP).