

HOMECARE

NATIONAL ASSOCIATION FOR HOME CARE
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September 26, 1995

Chris Jennings
Office of Domestic Policy
The White House
1600 Pennsylvania Avenue
Room 213, OEOB
Washington, D.C. 20500

Home Health RAH

Dear Chris,

Thanks so much for meeting with us today and for your continued support of home care. We had a very productive meeting with Sharon and John from HCFA. I have a call into you to discuss some important issues that were brought up in that meeting.

As a follow-up on related issues, I thought you might be interested in the attached very important, but small home care issues. We would greatly appreciate your including these provisions in the President's plan. As you'll see, they include making permanent the waiver of liability (which is scheduled to expire this year) and exempting home care and hospices that perform only simple procedures from CLIA.

Thank you again for your interest in home care. Please feel free to contact me if you have any questions or would like additional information on these issues. I look forward to talking with you soon to come to closure on certain issues surrounding the PPS proposal.

Sincerely,

Lucia

Lucia DiVenere
Deputy Director, Government Affairs

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MAKE PERMANENT THE WAIVER OF LIABILITY FOR HOME HEALTH AGENCIES, HOSPICES AND SKILLED NURSING FACILITIES

Issue: The Medicare waiver of liability, which provides a safety-zone for home care, hospice and skilled nursing providers and patients, is scheduled to expire on December 31, 1995. If the waiver expires, HCFA would make all coverage determinations on a case-by-case basis.

Without this buffer, providers would be compelled not to provide services under the Medicare program whenever there is a question of Medicare coverage. The result would be a chilling effect under which elderly and disabled individuals who might otherwise receive Medicare home health, hospice or skilled nursing services would have to pay for their care out-of-pocket or through private insurance.

Case-by-case review would also put an inordinate burden on many beneficiaries who would have to appeal denials and prove that the care in question should be covered.

This change would come at a time when more beneficiaries are in need of home care, hospice and skilled nursing services than ever before.

Proposal: Congress should make permanent the waiver of liability for home health care and hospice agencies and for skilled nursing facilities in this year's reconciliation bill. Without this provision, the availability of Medicare home care, hospice and skilled nursing services may be severely compromised for many individuals in need of this care.

Background: The waiver of liability was created by Congress in 1972 to protect Medicare beneficiaries who are later determined to be ineligible or the services are later determined not to be covered. This cushion for error was created by Congress to encourage providers to render services to Medicare beneficiaries.

In 1972, the Health Care Financing Administration (HCFA) created a presumptive status for providers whereby the providers were presumed to have acted in good faith if they demonstrated a reasonable knowledge of coverage standards in their submission of bills.

WAIVER OF LIABILITY (cont'd)

In the home health setting and for hospices, in order for an agency to be compensated under the waiver presumption, its overall denial of claims rate must be less than 2.5% of the Medicare services provided. For skilled nursing facilities, the denial of claims rate must be less than 5%. Any home health agency, hospice or skilled nursing facility that exceed these limits is not reimbursed under waiver regardless of whether it accepted beneficiaries and acted in good faith. This requirement forces providers to use due diligence in determining eligibility coverage.

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PERMANENTLY EXTEND WAIVER OF LIABILITY

WAIVER OF LIABILITY FOR HOME HEALTH AGENCIES.-- Section 9305(g)(3) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 426(d) of the Medicare Catastrophic Coverage Act of 1988, and amended by section 4027(b)(3) of the Omnibus Budget Reconciliation Act of 1990, is amended by striking "and before December 31, 1995".

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HOME HEALTH AGENCIES AND HOSPICES SHOULD BE EXEMPT FROM CLINICAL LABS IMPROVEMENTS ACT

CLIA was intended to regulate laboratories in order to increase the safety and quality of laboratory tests performed in the U.S. Unfortunately, this law was written so broadly that it imposed new paperwork and fee requirements on thousands of home health agencies and hospices that perform only simple tests -- tests that are available to any home user over the counter from any drug store.

Nearly 90 percent of all Medicare certified home health agencies and hospices perform simple and routine tests that the FDA agrees pose no health or safety risk to patients. Under CLIA, agencies that perform only these tests must apply every two years to HCFA for a waiver from CLIA requirements. This application includes completion of a four page form plus payment of a \$100 fee.

Only about 20 percent of Medicare certified home care agencies and hospices perform tests that are complex and that CLIA was intended to regulate.

Proposal: CLIA should be amended to require that only home health agencies and hospices that perform complex tests must apply to HCFA for certification. Agencies and hospices that do not apply for certification should be assumed to be performing no tests beyond those tests approved by the FDA as simple and routine. The current survey and certification process under which all Medicare certified home care agencies and hospices must prove their compliance with HCFA regulations and requirements would serve as a check on whether agencies who have not applied for and received CLIA certification are performing complex tests.

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August 1995

CLIA LEGISLATIVE LANGUAGE

Option 1. Language to separately address the waiver and moderately complex test issues. Amend current law in the following way:

Add the following language at the beginning of Section 353(b) Certificate Requirement: Except as provided in Paragraph (2),

Amend the language in Paragraph (2) -- Requirements for Certificates of Waiver to read as follows:

(2) Exceptions for Certain Examinations and Procedures -- In General --
- A laboratory which only performs laboratory examinations and procedures described in paragraph (3) shall be exempted from the requirements of this act. The Secretary shall not require any reporting or application for exempt laboratories. [remaining language in paragraph 2 deleted.]

Reorder subparagraphs in Paragraph 3(a) in the following way: Subparagraphs A, B, and C, become (i), (ii), and (iii).

Add at the end of 3(a) a new subsection (b) that reads:

(b) Home health agencies and hospices. When performed by a home health agency or hospice participating in Title 18 of the Social Security Act, the examinations and procedures identified in paragraph (2) shall include moderately complex tests which, as determined by the Secretary, are those which: (i) are performed only on a limited basis, (ii) are performed on-site in conjunction with the clinical assessment of the patient, and (iii) the Secretary has determined to pose no reasonable risk of harm to the patient if performed incorrectly.

Option 2. Language to exempt home health agencies and hospices from CLIA unless they perform tests that pose a risk to patients if performed incorrectly. An alternative way of scaling back CLIA so that it does not overreach into home care agencies and hospices that perform safe tests would be to include language in CLIA such as:

Entities defined under Sections 1861(o) and 1861(dd) (2) are not subject to this Act unless they perform tests deemed by the Secretary to pose a reasonable risk of harm to the patient if performed incorrectly.

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**PROVIDE ACCESS TO MEDICARE HMO ENROLLMENT INFORMATION
TO HOME HEALTH PROVIDERS**

Present Law

Medicare will not reimburse home health agencies for care provided to Medicare HMO enrollees, even though home health agencies are not told when a patient joined an HMO. In these cases, home health agencies are not paid for care they provide in good faith.

Issue

Despite the fact that the Health Care Financing Administration (HCFA) has implemented a nationwide data base known as the Common Working File (CWF) which contains the necessary information to determine the enrollment status of the Medicare beneficiary, there is often significant lag time between when a beneficiary has enrolls in a Medicare HMO and when this information is entered on the CWF database. Moreover, Medicare HMO enrollees often fail to fully understand that HMO enrollment means they cannot go to any agency they choose.

Recommendation

To resolve this issue Congress should:

- * Allow Medicare-certified home health agencies access to beneficiary enrollment information.
- * Establish a "hold harmless" provision, under which providers who in good faith provide care to HMO members and others not enrolled in the fee-for-service Medicare program, would have their claims paid;
- * Require HMOs to inquire about health services their new enrollees are receiving from other providers and to send those providers notification of HMO enrollment.

Rationale

As Congress provides more incentives for Medicare beneficiaries to enroll in Medicare HMOs, the need for timely enrollment status information becomes greater. Despite providers' best efforts at discovering HMO enrollment, information available from patients and families is frequently inaccurate and unreliable, thereby subjecting home health agencies to significant financial losses. In the absence of timely HMO enrollment information, home health agencies should not be denied payment for care provided before they were informed of the patient's HMO enrollment.

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PROVIDE ACCESS TO HMO ENROLLMENT INFORMATION

Section 1876 of the Social Security Act (42 U.S.C. § 1395mm) is amended by adding at the end the following new subsection:

(k) The Secretary shall provide all providers of services with access to a nationwide data base containing enrollment information on Medicare beneficiaries. The Secretary shall develop the data base in such a manner as to be accessible to providers, at a minimum, through electronic means with adequate and appropriate protections regarding patient confidentiality to assure that only Medicare participating providers of services have access to the information.

Section 1876(c)(3)(B) (42 U.S.C. 1395mm(c)(3)(B)) of the Social Security Act is amended by inserting after "in regulations" the following:

, such enrollment shall not be effective until the enrollment information is included in the enrollment data base as required by subsection (k).

Section 1879 of the Social Security Act (42 U.S.C. § 1395pp) is amended by adding at the end the following new subsection:

(i) Notwithstanding any other provisions of this title, individuals enrolled in organizations eligible to receive payments under Section 1876 and providers of services who did not know or have reason to know that services for which a claim has been filed are excluded from coverage as a result of the individual's enrollment in an organization eligible to receive payment under Section 1876 shall be entitled to have payment made for such items or services as though the exclusion for coverage did not apply. In each such case, the Secretary shall notify both such individual and such provider of the conditions under which payment for such items and services was made and by reason of such notice the individual and provider shall be deemed to have knowledge that payment cannot be made for such items or services in case of comparable situations arising thereafter. The Secretary is authorized to develop a method by which payment under this subparagraph made to the provider on behalf of an individual shall be taken into account in determining the rate of payment to organizations eligible to receive payments under Section 1876.

Specific Home Health Fraud and Abuse Recommendations

In addition to the fraud and abuse proposals set forth by the Coalition of Health Associations United Against Fraud and Abuse, NAHC has specific recommendations that apply to the home health industry.

- A. Limit Agencies' Ability to Subcontract Care.** Medicare certified home health agencies should be allowed to utilize only a limited amount of subcontracted care for the dominate health care service, such as nursing, which they provide.
- B. Mandate Freedom of Choice Information.** Hospitals, physicians, and other health care providers, should be required to give patients full information about the availability of Medicare certified home health agencies serving the areas in which the patients reside, and should be prohibited from steering patients to certain agencies.
- C. Provide Detailed and Appropriate Explanation of Benefits to Home Health Patients.** Informing patients of bills submitted by home health agencies for their care will allow beneficiaries to join in the enforcement effort.
- D. Home Health Agencies should be Prohibited from Assisting Physicians in Care Billing.** Home health agencies should be prohibited from providing record keeping and bill preparation services to physicians for their role in home care.
- E. Require Home Health Care Administrators to Meet Certification and Accreditation Standards.** The last several years have seen a unbridled growth in the number of Medicare certified home health agencies. Home care agency administrators should be required to meet high and rigorous standards for all aspects of running an agency, including issues that affect quality of care.

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LIMIT MEDICARE REGULATIONS TO MEDICARE REIMBURSED CARE ONLY

Strike Section 1891(a)(4) of the Social Security Act (42 U.S. Code Section 1395bbb(a)(4)) and insert the following new paragraph: (4) the agency includes an individual's plan of care as part of the clinical records. The plan of care shall be established and reviewed (A) by a physician, or, (B) where the individual does not receive skilled nursing care or other skilled home health services and the nurse assessment of the individual determines that a physician's plan of care is not necessary, by a nurse or other home care professional authorized to establish such a plan of care under the laws of the state in which such care is furnished.

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LIMIT MEDICARE REGULATIONS ONLY TO MEDICARE REIMBURSED CARE

Present Law

Medicare certified home health agencies have to comply with Medicare regulations for all of their patients, even non-Medicare private paying individuals. Included in these regulations is the requirement that a written plan of care be established and periodically reviewed by a physician and that agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.

The plan of care must include the patient's mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral and any other factors.

Issue

This means that a 30-year-old auto accident victim who wants bath services from a home health agency aide while he recuperates would need a physician's verbal approval before care could begin, followed by a signed detailed plan of care. Or, that normal new mother and baby cannot have home visits for assessment and teaching routine post-partum and newborn care without a physician's order and detailed plan of care.

Regulations requiring that care be physician certified for non-Medicare paying patients is an unnecessary regulatory burden. In most instances, such an extensive care plan and physician certification for non-Medicare paying patients is not needed, especially if the patient is only seeking non-skilled or health promotion services. Moreover, nurses are qualified and authorized under state licensure laws and practice acts to order and supervise the provision of unskilled services and to carry out health promotion and teaching activities without the orders of a physician.

LIMIT MEDICARE REGULATIONS (cont'd)

Recommendation

Limit the requirement that Medicare certified home health agencies have all care plans certified by a physician to apply to Medicare patients only.

Rationale

Under current law, an individual who contracts with a Medicare certified agency, even for purely custodial care or health promotion, must have this care prescribed by a physician before it can be provided. This regulatory requirement is unnecessary, burdensome and contributes to increased health care costs. State laws and professional practice acts do not require physician orders for personal care and health promotion activities. The licensed nurse is recognized as the person who performs health teaching and supervises nonskilled aide services. The regulations requiring physician certification also place Medicare certified home health agencies, when treating non-Medicare paying patients, at an unfair disadvantage with other home care organizations that do not have to meet these requirements.

file Home Health

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F I N A L

9-25-95

Comments on the Chairman's Mark for the
Senate Finance Committee's Budget Reconciliation Package

Home Health Services' Payments

Issue 1: Interim per visit payment rates (provision #1 in Senate package, beginning on p.33)

The proposal establishes per visit rates at the average cost adjusted for regional cost differences.

Industry Proposal: The per visit rate would be set at the average but agencies could be reimbursed up to the cost limit if costs could be documented. Quarterly reports would be required to prevent overpayment situations.

Rationale: Agencies may have higher visit costs but still provide care within the episode caps. They would have cash flow problems until the end of the year settlement on the aggregate episode cap. A prospective payment system should support providers that can achieve the goal of containing overall episode costs. Allowing payment up to the cost limit with monitoring to prevent overpayments protects both agencies and the Medicare program.

Issue 2: Calculating the per episode limit (#3)

The proposal calls for calculating the per episode limit for a base year using the 1994 home cost report data.

Industry Proposal: The first year's per episode cap should be based on 1995 cost and utilization data. If 1995 data is not available at the time of calculation, the most recent available data should be trended forward to reflect 1995 experience. After the first year the episode cap should be updated to reflect home health market basket increases.

Issue 4: Limits on sharing savings (#6)

The proposal limits the shared savings to 5% or less of an agency's aggregate Medicare payments in a year.

Industry Proposal: The home health agency retains 50% of the total savings. However, in light of more onerous provisions in the Senate proposal, the HHA should retain all the savings.

Rationale: Since the 50% share of savings was not scored as any savings to the Medicare program and the Senate proposal contains more onerous provisions, the HHA should retain all the savings. Limiting the savings sharing provision removes the incentive to keep costs below the episode caps. It would be financially advantageous for a home health agency to provide care up to the level where the sharing of savings ends.

Issue 5: No new episode until after a 60 day gap (#8)

The proposal does not recognize a new episode of care until after the patient has not had home health services for a period of 60 days.

Industry Proposal: The gap in services period should be 45 days.

Rationale: Medicare beneficiaries who use home health services are those with significantly more health care needs than the general Medicare population. For example, in 1992 70% of home health users were hospitalized during the year as compared to 13 % for non-home health users. A 45 day waiting period is sufficient to prevent artificial new episodes for care that should have been provided during the previous episode, while allowing for new illnesses and exacerbations expected in this population.

Issue 6: Adjustments based on market basket minus 2% and episode cap rebased every 2 years (#9)

The proposal calls for annual updates to the per visit and episode limits by the home health market basket minus two percentage points and rebasing the episode cap every two years.

Industry Proposal: Per visit payment rates and episode caps would be updated annually based on the home health market basket. The per visit rates would be recalculated annually for the first three years.

Rationale: The proposed PPS system is a transitional program designed to create a linkage to a pure per episode system.

Rationale: Basing the per episode limits on 1994 data would represent a cut back in current home health benefits and could adversely impact the health status of home health patients. A reduction in the episode cap requires home health agencies to reduce services to beneficiaries.

Issue 3: Basing episode limits on the mean cost of 120 days of care while requiring agencies to provide up to 165 days of care (#6)

NAHC and Industry Position: Services provided between day 121-165 should not apply toward the aggregate episode cap. During the first year of the PPS system, a case mix and payment methodology for extended care cases should be developed to adequately reimburse for and control expenditures to this category of patients. Until that is developed extended care cases should be subject to initial and ongoing medical review when care extends beyond 120 days.

Rationale: The current pattern of home care services includes approximately 30% of all episodes extending beyond 120 days and 43% or more of all visits occurring after 120 days. If the episode cap is set at 100% of the mean cost of care for 120 days, this proposal is in effect requiring home health agencies to provide services for 45 days without any reimbursement that reflects this care. The likely response is that home health agencies will not accept or limit patients into care if there is a predictable need for services beyond 120 days. These patients will either experience extended hospital stays or enter more costly nursing home settings. Additionally, home care providers will be placed at significant financial risk for serving these types of patients.

Implementing an untested system with this potential to jeopardize the care provided to Medicare beneficiaries who need home care services may prove to be disastrous to the overall goal of containing Medicare expenditures. Home health is generally the least expensive alternative for ongoing health care services, but if it is not available there will be an increase in the use of hospitals and nursing facilities.

Alternatives to consider:

1. Base the episode cap on the mean cost of 165 days of care
2. Set the episode cap above the mean (e.g., 110%) to offset the losses
3. If any amount of time is applied to the 120 day episode cap then the savings sharing provision under paragraph 6 should be modified to allow the provider to retain all of the savings to help fund care during that time.

Reimbursement for home health services must keep pace with the costs of providing those services during the transition phase to avoid jeopardizing the financial solvency of Medicare-certified agencies and the access to home care. The current home health market basket does not take into account all the factors that contribute to the cost of providing services, so subtracting 2 percentage points will exacerbate the problem. Episode caps should not be rebased every two years unless there is also an analysis of the impact of further reductions on patient outcomes and cost to other sectors of the Medicare program.

Issue 7: Distribution of short stay patients (#11)

The proposal requires monitoring the proportion of short stay patients and making payment adjustments if agencies have an increase in short stay patients.

Recommendation: The proportion of long stay patients should also be monitored and payment adjustments made to reflect the increased cost of providing care to the long stay patients.

Rationale: The Senate PPS proposal requires short stay monitoring presumably to avoid unwarranted financial windfalls to agencies that experience a disproportionate volume of these patients. It is also likely that some agencies' case mix would include a disproportionate number of long stay patients without adequate reimbursement.

Issue 8: Exceptions payments cannot exceed 1995 levels (updated) (14)

Industry Proposal: HHAs would be allowed to seek exceptions as are currently allowed.

Rationale: This is an untested system that may create significant unforeseen problems. There should be a mechanism to prevent untoward effects on agencies that through no fault of their own are unable to provide care at the prescribed reimbursement level. The current standards are sufficiently restrictive to ensure only truly bona fide exceptions would be granted.

Issue 9: The waiver of liability shall not be extended (#15)

Industry Position: Retain waiver of liability until implementation of PPS and thereafter retain only for the extended care cases.

Rationale: Waiver of liability is necessary to ensure that patients are not refused care because providers may be unsure the

care will be covered under Medicare. It also saves administrative dollars by avoiding case by case adjudications.

Issue 10: Recertification at 30, 60, 120, and 165 days (#16)

The proposal requires the intermediary to recertify care at the intervals specified above.

Industry Proposal: The industry proposal does not include recertification by intermediaries.

Rationale: Once the patient has been determined to meet the coverage criteria there is no reason for recertification unless the patient requires care beyond 120 days. This would simply add administrative cost to the program.

Issue 11: Provisions not contained in the Senate proposal

Industry Proposal: The industry proposal included provisions for due process, conversion to a pure per episode system, and a separate fee schedule for non-routine supplies and security services as outlined in the Unified Proposal for Prospective Payment System for Home Health Services.

Rationale: Changing financial incentives to provide less service calls for changing quality control measures. Providing a mechanism for patients to challenge coverage decisions made by home care providers is essential. The PPS system described should only be considered an interim system until a pure per episode payment system with an adequate case mix classification system can be developed. Non-routine supplies and security costs will not be accounted for in the case mix classification to adjust episode reimbursement and therefore, should be reimbursed separately.

MITCHELL BILL – HOME HEALTH CO-PAYMENT OPTIONS
Option 1: No Co-Payment Until 1/1/99 When 20% Co-Payment Would Begin

(by fiscal year, in billions of dollars)

Source: CBO Preliminary Analysis of Sen. Mitchell's Health Proposal, August 9, 1994, Tables 1 and 2 and HCFA Estimates, August 23, 1994.

PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999	1995-2000	1995-2004
Part A													
Inpatient PPS Updates	0.0	0.0	-0.3	-1.6	-3.4	-5.6	-8.0	-10.7	-13.8	-17.4	-5.3	-10.9	-60.8
Reduce Payments for Hospital Capital	0.0	-0.8	-1.0	-1.2	-1.6	-2.1	-2.2	-2.4	-2.7	-2.9	-4.6	-6.7	-16.9
DSH Reductions	0.0	0.0	-1.7	-2.1	-2.3	-2.5	-2.8	-3.1	-3.4	-3.7	-6.1	-8.6	-21.6
Extend OBRA93 SNF Update Freeze	0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.6	-0.8	-1.8
Prohibit PPS Exemptions for New LTC Hosp	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4	-0.3	-0.5	-1.7
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0.0	0.0	0.0	0.0	0.3	0.3	0.3
Sole Community Hospitals	a	a	a	a	a	a	a	a	a	a	0.0	0.0	0.0
Part A Interactions	0.0	0.0	0.1	0.2	0.4	0.6	0.7	0.9	1.1	1.3	0.7	1.3	5.3
Essential Access Community Hospitals													
Medical Assistant Facility Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.5	0.6	1.0
Rural Primary Care Hospitals (RPCH) Payments	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.5	0.7	1.5
Sub-total, Part A	0.2	-0.6	-2.8	-4.7	-7.0	-9.7	-12.4	-15.5	-19.1	-23.1	-14.9	-24.6	-94.7
Part B Reductions													
Reduce Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1	-3.1	-3.9	-7.9
Use Real GDP in MVPS for Physician Services	0.0	0.0	-0.3	-0.8	-1.6	-2.5	-3.3	-4.2	-5.3	-6.6	-2.7	-5.2	-24.6
Correct MVPS Upward Bias	0.0	0.0	0.0	0.0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5	-0.2	-0.8	-14.2
Eliminate Formula Driven Overpayments	-0.8	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1	-7.2	-10.4	-36.3
Prohibition on Balance Billing	0.0	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.7	0.9	2.1
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9	-6.1	-7.9	-17.7
Payments to Eye/Ear Specialty Hospitals	a	a	a	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Competitive Bidding for Part B Services	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.4	-0.5	-1.2
Competitive Bidding for Clinical Lab Services	a	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6	-1.1	-1.5	-3.5
Durable Medical Equipment Price Reduction	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-1.0
Payments for MD Assistants/Nurse Pract	0.0	0.0	0.1	0.2	0.3	0.3	0.4	0.5	0.6	0.7	0.6	0.9	3.1
Reduce Payments to High-Cost Medical Staffs	0.0	0.0	0.0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0	-1.3	-2.1	-5.8
Permanent Extension of 25% Part B Premium	0.0	0.6	0.9	1.4	0.6	-1.0	-2.8	-5.0	-7.7	-9.8	3.5	2.5	-22.8
Sub-total, Part B	-1.9	-2.3	-2.8	-3.9	-6.7	-10.8	-15.3	-21.5	-28.6	-36.0	-17.6	-28.4	-129.8

Home Health Care File

ID:

H05 26 '94

10:38 No.002 P.02

MITCHELL BILL - HOME HEALTH CO-PAYMENT OPTIONS
Option 1: No Co-Payment Until 1/1/99 When 20% Co-Payment Would Begin

(by fiscal year, in billions of dollars)

Source: CBO Preliminary Analysis of Sen. Mitchell's Health Proposal, August 9, 1994, Tables 1 and 2 and HCFA Estimates, August 23, 1994.

PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999	1995-2000	1995-2004
Parts A and B													
Home Health Copayments	0.0	0.0	0.0	0.0	-3.0	-5.3	-5.8	-6.2	-6.8	-7.3	-3.0	-8.3	-34.4
Reduce Routine Cost Limits for HHAs	0.0	0.0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0	-1.6	-2.3	-6.0
Extend OBRA93 Medicare Secondary Payer	0.0	0.0	0.0	0.0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3	-1.2	-3.0	-11.4
Expand Centers of Excellence	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	a	a	0.0	0.0	-0.4	-0.5	-0.5
Extend ESRD Secondary Payer to 24 Months	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.5	-0.6	-1.2
Sub-total, Part A and B	-0.1	-0.2	-0.5	-0.8	-5.1	-8.0	-8.6	-9.2	-10.2	-10.8	-6.7	-14.7	-53.5
Proposed Additions (8/24/94)													
1995 Physician Update	-0.3	-0.6	-0.6	-0.7	-0.7	-0.8	-0.9	-0.9	-1.0	-1.1	-2.9	-3.7	-7.6
HMO Payment Improvement	0.0	-0.1	-0.2	-0.3	-0.4	-0.4	-0.4	-0.5	-0.5	-0.6	-1.0	-1.4	-3.6
Disabled MSP 100 to 20	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.2	-0.4	-0.4	0.0	0.0	-1.0
Part B Deductible @ \$150	0.0	0.0	0.0	0.0	-0.7	-1.3	-1.3	-1.3	-1.4	-1.4	-0.7	-2.0	-7.4
Part B Interaction	0.1	0.2	0.2	0.2	0.4	0.6	0.6	0.6	0.7	0.7	1.1	1.7	4.3
Sub-total, Proposed Additions	-0.2	-0.5	-0.6	-0.8	-1.4	-1.9	-2.0	-2.3	-2.6	-2.8	-3.5	-5.4	-15.1
Offsetting Receipt Changes													
Income-Related Part B Premium (\$90K/\$100K)	0.0	0.0	-2.0	-2.0	-2.8	-3.5	-4.4	-5.5	-6.9	-8.7	-6.8	-10.3	-35.8
Extend HI Tax to All State/Local Employees	0.0	-1.6	-1.8	-1.5	-1.5	-1.4	-1.4	-1.3	-1.2	-1.2	-6.4	-7.8	-12.9
TOTAL: Part A+B+A and B+Additions+Receipts	-2.0	-5.2	-10.5	-13.7	-24.5	-35.3	-44.1	-55.3	-68.6	-82.6	-55.9	-91.2	-341.8
EXHIBIT													
Mitchell Co-Payment	-0.7	-3.4	-4.2	-4.6	-5.0	-5.4	-5.9	-6.4	-7.0	-7.6	-17.9	-23.3	-50.2
Option 1 Co-Payment	0.0	0.0	0.0	0.0	-3.0	-5.3	-5.8	-6.2	-6.8	-7.3	-3.0	-8.3	-34.4
Difference	-0.7	-3.4	-4.2	-4.6	-2.0	-0.1	-0.1	-0.2	-0.2	-0.3	-14.9	-15.0	-15.8
Total, Proposed Additions	-0.2	-0.5	-0.6	-0.8	-1.4	-1.9	-2.0	-2.3	-2.6	-2.8	-3.5	-5.4	-15.1
NET	-0.5	-2.9	-3.6	-3.8	-0.6	1.8	1.9	2.1	2.4	2.5	-11.4	-9.6	-0.7

MITCHELL BILL – HOME HEALTH CO-PAYMENT OPTIONS
Option 3: 10% Co-Payment Beginning 1/1/96, 20% Co-Payment Beginning 1/1/00
 (by fiscal year, in billions of dollars)

Source: CBO Preliminary Analysis of Sen. Mitchell's Health Proposal, August 9, 1994, Tables 1 and 2 and HCFA Estimates, August 23, 1994.

PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999	1995-2000	1995-2004
Part A													
Inpatient PPS Updates	0.0	0.0	-0.3	-1.6	-3.4	-5.6	-8.0	-10.7	-13.8	-17.4	-5.3	-10.9	-60.8
Reduce Payments for Hospital Capital	0.0	-0.8	-1.0	-1.2	-1.6	-2.1	-2.2	-2.4	-2.7	-2.9	-4.6	-6.7	-16.9
DSH Reductions	0.0	0.0	-1.7	-2.1	-2.3	-2.5	-2.8	-3.1	-3.4	-3.7	-6.1	-8.6	-21.6
Extend OBRA93 SNF Update Freeze	0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.6	-0.8	-1.8
Prohibit PPS Exemptions for New LTC Hosp	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4	-0.3	-0.5	-1.7
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0.0	0.0	0.0	0.0	0.3	0.3	0.3
Sole Community Hospitals	a	a	a	a	a	a	a	a	a	a	0.0	0.0	0.0
Part A Interactions	0.0	0.0	0.1	0.2	0.4	0.6	0.7	0.9	1.1	1.3	0.7	1.3	5.3
Essential Access Community Hospitals													
Medical Assistant Facility Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.5	0.6	1.0
Rural Primary Care Hospitals (RPCH) Paymts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.5	0.7	1.5
Sub-total, Part A	0.2	-0.6	-2.8	-4.7	-7.0	-9.7	-12.4	-15.5	-19.1	-23.1	-14.9	-24.6	-94.7
Part B Reductions													
Reduce Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1	-3.1	-3.9	-7.9
Use Real GDP in MVPS for Physician Services	0.0	0.0	-0.3	-0.8	-1.6	-2.5	-3.3	-4.2	-5.3	-6.6	-2.7	-5.2	-24.6
Correct MVPS Upward Bias	0.0	0.0	0.0	0.0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5	-0.2	-0.8	-14.2
Eliminate Formula Driven Overpayments	-0.8	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1	-7.2	-10.4	-36.3
Prohibition on Balance Billing	0.0	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.7	0.9	2.1
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9	-6.1	-7.9	-17.7
Payments to Eye/Ear Specialty Hospitals	a	a	a	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Competitive Bidding for Part B Services	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.4	-0.5	-1.2
Competitive Bidding for Clinical Lab Services	a	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6	-1.1	-1.5	-3.5
Durable Medical Equipment Price Reduction	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-1.0
Payments for MD Assistants/Nurse Pract	0.0	0.0	0.1	0.2	0.3	0.3	0.4	0.5	0.6	0.7	0.6	0.9	3.1
Reduce Payments to High-Cost Medical Staffs	0.0	0.0	0.0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0	-1.3	-2.1	-5.8
Permanent Extension of 25% Part B Premium	0.0	0.6	0.9	1.4	0.6	-1.0	-2.8	-5.0	-7.7	-9.8	3.5	2.5	-22.8
Sub-total, Part B	-1.9	-2.3	-2.8	-3.9	-6.7	-10.8	-15.3	-21.5	-28.6	-36.0	-17.6	-28.4	-129.8

MITCHELL BILL – HOME HEALTH CO-PAYMENT OPTIONS
Option 3: 10% Co-Payment Beginning 1/1/96, 20% Co-Payment Beginning 1/1/00
 (by fiscal year, in billions of dollars)

Source: CBO Preliminary Analysis of Sen. Mitchell's Health Proposal, August 9, 1994, Tables 1 and 2 and HCFA Estimates, August 23, 1994.

PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999	1995-2000	1995-2004
Parts A and B													
Home Health Copayments	0.0	-1.2	-2.1	-2.3	-2.4	-5.3	-5.8	-6.2	-6.8	-7.3	-8.0	-13.3	-39.4
Reduce Routine Cost Limits for HHAs	0.0	0.0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0	-1.6	-2.3	-6.0
Extend OBRA93 Medicare Secondary Payer	0.0	0.0	0.0	0.0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3	-1.2	-3.0	-11.4
Expand Centers of Excellence	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	a	a	0.0	0.0	-0.4	-0.5	-0.5
Extend ESRD Secondary Payer to 24 Months	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.5	-0.6	-1.2
Sub-total, Part A and B	-0.1	-1.4	-2.6	-3.1	-4.5	-8.0	-8.6	-9.2	-10.2	-10.8	-11.7	-19.7	-59.5
Proposed Additions (8/24/94)													
1995 Physician Update	-0.3	-0.6	-0.6	-0.7	-0.7	-0.8	-0.9	-0.9	-1.0	-1.1	-2.9	-3.7	-7.6
HMO Payment Improvement	0.0	-0.1	-0.2	-0.3	-0.4	-0.4	-0.4	-0.5	-0.5	-0.6	-1.0	-1.4	-3.4
Disabled MSP 100 to 20	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.2	-0.4	-0.4	0.0	0.0	-1.0
Part B Interaction	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.9	1.1	2.3
Sub-total, Proposed Additions	-0.2	-0.5	-0.6	-0.8	-0.9	-1.0	-1.0	-1.3	-1.6	-1.8	-3.0	-4.0	-9.7
Offsetting Receipt Changes													
Income-Related Part B Premiums (\$80K/\$100K)	0.0	0.0	-2.0	-2.0	-2.8	-3.5	-4.4	-5.5	-6.9	-8.7	-6.8	-10.3	-35.8
Extend HI Tax to All State/Local Employees	0.0	-1.6	-1.8	-1.5	-1.5	-1.4	-1.4	-1.3	-1.2	-1.2	-6.4	-7.8	-12.9
TOTAL: Part A+B+A and B+Additions+Receipts	-2.0	-6.4	-12.6	-16.0	-23.4	-34.4	-43.1	-54.3	-67.6	-81.6	-69.4	-94.8	-341.4
EXHIBIT													
Mitchell Co-Payment	-0.7	-3.4	-4.2	-4.6	-5.0	-5.4	-5.9	-6.4	-7.0	-7.6	-17.9	-23.3	-50.2
Option 3 Co-Payment	0.0	-1.2	-2.1	-2.3	-2.4	-5.3	-5.8	-6.2	-6.8	-7.3	-8.0	-13.3	-39.4
Difference	-0.7	-2.2	-2.1	-2.3	-2.6	-0.1	-0.1	-0.2	-0.2	-0.3	-9.9	-10.0	-10.8
Total, Proposed Additions	-0.2	-0.5	-0.6	-0.8	-0.9	-1.0	-1.0	-1.3	-1.6	-1.8	-3.0	-4.0	-9.7
NET	-0.5	-1.7	-1.5	-1.5	-1.7	0.9	0.9	1.1	1.4	1.5	-6.9	-6.0	-1.1

MITCHELL BILL—HOME HEALTH CO-PAYMENT OPTIONS
Option 7: 20% Co-payment After First 10 Visits Per Year, Effective 1/1/96
 (by fiscal year, in billions of dollars)

Source: CBO Preliminary Analysis of Sen. Mitchell's Health Proposal, August 9, 1994, Tables 1 and 2 and HCFA Estimates, August 23, 1994.

PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999	1995-2000	1995-2004
Part A													
Inpatient PPS Updates	0.0	0.0	-0.3	-1.6	-3.4	-5.6	-8.0	-10.7	-13.8	-17.4	-5.3	-10.9	-60.8
Reduce Payments for Hospital Capital	0.0	-0.8	-1.0	-1.2	-1.6	-2.1	-2.2	-2.4	-2.7	-2.9	-4.6	-6.7	-16.9
DSH Reductions	0.0	0.0	-1.7	-2.1	-2.3	-2.5	-2.8	-3.1	-3.4	-3.7	-6.1	-8.6	-21.6
Extend OBRA93 SNF Update Freeze	0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.6	-0.8	-1.8
Prohibit PPS Exemptions for New LTC Hosp	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4	-0.3	-0.5	-1.7
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0.0	0.0	0.0	0.0	0.3	0.3	0.3
Sole Community Hospitals	a	a	a	a	a	a	a	a	a	a	0.0	0.0	0.0
Part A Interactions	0.0	0.0	0.1	0.2	0.4	0.6	0.7	0.9	1.1	1.3	0.7	1.3	5.3
Essential Access Community Hospitals													
Medical Assistant Facility Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.5	0.6	1.0
Rural Primary Care Hospitals (RPCH) Paymts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.5	0.7	1.5
Sub-total, Part A	0.2	-0.6	-2.8	-4.7	-7.0	-9.7	-12.4	-15.5	-19.1	-23.1	-14.9	-24.6	-94.7
Part B Reductions													
Reduce Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1	-3.1	-3.5	-3.8
Use Real GDP in MVPS for Physician Services	0.0	0.0	-0.3	-0.8	-1.6	-2.5	-3.3	-4.2	-5.3	-6.6	-2.7	-5.2	-24.6
Correct MVPS Upward Bias	0.0	0.0	0.0	0.0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5	-0.2	-0.8	-14.2
Eliminate Formula Driven Overpayments	-0.8	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1	-7.2	-10.4	-36.3
Prohibition on Balance Billing	0.0	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.7	0.9	2.1
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9	-6.1	-7.9	-17.7
Payments to Eye/Ear Specialty Hospitals	a	a	a	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Competitive Bidding for Part B Services	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.4	-0.5	-1.2
Competitive Bidding for Clinical Lab Services	a	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6	-1.1	-1.5	-3.5
Durable Medical Equipment Price Reduction	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-1.0
Payments for MD Assistants/Nurse Pract	0.0	0.0	0.1	0.2	0.3	0.3	0.4	0.5	0.6	0.7	0.6	0.9	3.1
Reduce Payments to High-Cost Medical Staffs	0.0	0.0	0.0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0	-1.3	-2.1	-5.8
Permanent Extension of 25% Part B Premium	0.0	0.6	0.9	1.4	0.6	-1.0	-2.8	-5.0	-7.7	-9.8	3.5	2.5	-22.8
Sub-total, Part B	-1.9	-2.3	-2.8	-3.9	-6.7	-10.8	-15.3	-21.5	-28.6	-36.0	-17.6	-28.8	-125.7

MITCHELL BILL--HOME HEALTH CO-PAYMENT OPTIONS
Option 7: 20% Co-payment After First 10 Visits Per Year, Effective 1/1/96

(by fiscal year, in billions of dollars)

Source: CBO Preliminary Analysis of Sen. Mitchell's Health Proposal, August 9, 1994, Tables 1 and 2 and HCFA Estimates, August 23, 1994.

PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999	1995-2000	1995-2004
Parts A and B													
Home Health Copayments	0.0	-1.9	-3.5	-3.8	-4.0	-4.5	-4.9	-5.3	-5.8	-6.2	-13.2	-17.7	-39.9
Reduce Routine Cost Limits for HHAs	0.0	0.0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0	-1.6	-2.3	-6.0
Extend OBRA93 Medicare Secondary Payer	0.0	0.0	0.0	0.0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3	-1.2	-3.0	-11.4
Expand Centers of Excellence	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	a	a	0.0	0.0	-0.4	-0.5	-0.5
Extend ESRD Secondary Payer to 24 Months	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.5	-0.6	-1.2
Sub-total, Part A and B	-0.1	-2.1	-4.0	-4.6	-6.1	-7.2	-7.7	-8.3	-9.2	-9.7	-16.9	-24.1	-59.0
Proposed Additions (8/24/94)													
1995 Physicians Update	-0.3	-0.6	-0.6	-0.7	-0.7	-0.8	-0.9	-0.9	-1.0	-1.1	-2.9	-3.7	-7.6
HMO Payment Improvement	0.0	-0.1	-0.2	-0.3	-0.4	-0.4	-0.4	-0.5	-0.5	-0.6	-1.0	-1.4	-3.6
Disabled MSP 100 to 20	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.2	-0.4	-0.4	0.0	0.0	-1.0
Part B Interaction	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.9	1.1	2.3
Sub-total, Proposed Additions	-0.2	-0.5	-0.6	-0.8	-0.9	-1.0	-1.0	-1.3	-1.6	-1.8	-3.0	-4.0	-9.7
Offsetting Receipt Changes													
Income-Related Part B Premium (\$80K/\$100K)	0.0	0.0	-2.0	-2.0	-2.8	-3.5	-4.4	-5.5	-6.9	-8.7	-6.8	-10.3	-35.8
Extend HI Tax to All State/Local Employees	0.0	-1.6	-1.8	-1.5	-1.5	-1.4	-1.4	-1.3	-1.2	-1.2	-6.4	-7.8	-12.9
TOTAL: Part A+B+A and B+Additions+Receipts	-2.0	-7.1	-14.0	-17.5	-25.0	-33.6	-42.2	-53.4	-66.6	-80.5	-65.6	-98.8	-337.8

EXHIBIT													
Mitchell Co-Payment	-0.7	-3.4	-4.2	-4.6	-5.0	-5.4	-5.9	-6.4	-7.0	-7.6	-17.9	-23.3	-50.2
Option 7 Co-Payment	0.0	-1.9	-3.5	-3.8	-4.0	-4.5	-4.9	-5.3	-5.8	-6.2	-13.2	-17.7	-39.9
Difference	-0.7	-1.5	-0.7	-0.8	-1.0	-0.9	-1.0	-1.1	-1.2	-1.4	-4.7	-5.6	-10.3
Total, Proposed Additions	-0.2	-0.5	-0.6	-0.8	-0.9	-1.0	-1.0	-1.3	-1.6	-1.8	-3.0	-4.0	-9.7
NET	-0.5	-1.0	-0.1	0.0	-0.1	0.1	0.0	0.2	0.4	0.4	-1.7	-1.6	-0.6

MITCHELL BILL--HOME HEALTH CO-PAYMENT OPTIONS
Option 8: 20% Co-payment After First 20 Visits Per Year, Effective 1/1/96

(by fiscal year, in billions of dollars)

Source: CBO Preliminary Analysis of Sen. Mitchell's Health Proposal, August 9, 1994, Tables 1 and 2 and HCFA Estimates, August 23, 1994.

PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999	1995-2000	1995-2004
Part A													
Inpatient PPS Updates	0.0	0.0	-0.3	-1.6	-3.4	-5.6	-8.0	-10.7	-13.8	-17.4	-5.3	-10.9	-60.8
Reduce Payments for Hospital Capital	0.0	-0.8	-1.0	-1.2	-1.6	-2.1	-2.2	-2.4	-2.7	-2.9	-4.6	-6.7	-16.9
DSH Reductions	0.0	0.0	-1.7	-2.1	-2.3	-2.5	-2.8	-3.1	-3.4	-3.7	-6.1	-8.6	-21.6
Extend OBRA93 SNF Update Freeze	0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.6	-0.8	-1.8
Prohibit PPS Exemptions for New LTC Hosp	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4	-0.3	-0.5	-1.7
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0.0	0.0	0.0	0.0	0.3	0.3	0.3
Sole Community Hospitals	a	a	a	a	a	a	a	a	a	a	0.0	0.0	0.0
Part A Interactions	0.0	0.0	0.1	0.2	0.4	0.6	0.7	0.9	1.1	1.3	0.7	1.3	5.3
Essential Access Community Hospitals													
Medical Assistant Facility Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.5	0.6	1.0
Rural Primary Care Hospitals (RPCH) Paymts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.5	0.7	1.5
Sub-total, Part A	0.2	-0.6	-2.8	-4.7	-7.0	-9.7	-12.4	-15.5	-19.1	-23.1	-14.9	-24.6	-94.7
Part B Reductions													
Reduce Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1	-3.1	-3.9	-7.9
Use Real GDP in MVPS for Physician Services	0.0	0.0	-0.3	-0.8	-1.6	-2.5	-3.3	-4.2	-5.3	-6.6	-2.7	-5.2	-24.6
Correct MVPS Upward Bias	0.0	0.0	0.0	0.0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5	-0.2	-0.8	-14.2
Eliminate Formula Driven Overpayments	-0.8	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1	-7.2	-10.4	-36.3
Prohibition on Balance Billing	0.0	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.7	0.9	2.1
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9	-6.1	-7.9	-17.7
Payments to Eye/Ear Specialty Hospitals	a	a	a	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Competitive Bidding for Part B Services	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.4	-0.5	-1.2
Competitive Bidding for Clinical Lab Services	a	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6	-1.1	-1.5	-3.5
Durable Medical Equipment Price Reduction	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-1.0
Payments for MD Assistants/Nurse Pract	0.0	0.0	0.1	0.2	0.3	0.3	0.4	0.5	0.6	0.7	0.6	0.9	3.1
Reduce Payments to High-Cost Medical Staffs	0.0	0.0	0.0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0	-1.3	-2.1	-5.8
Permanent Extension of 25% Part B Premium	0.0	0.6	0.9	1.4	0.6	-1.0	-2.8	-5.0	-7.7	-9.8	3.5	2.5	-22.8
Sub-total, Part B	-1.9	-2.3	-2.8	-3.9	-6.7	-10.8	-15.3	-21.5	-28.6	-36.0	-17.6	-28.4	-129.8

MITCHELL BILL—HOME HEALTH CO-PAYMENT OPTIONS
Option 8: 20% Co-payment After First 20 Visits Per Year, Effective 1/1/96

(by fiscal year, in billions of dollars)

Source: CBO Preliminary Analysis of Sen. Mitchell's Health Proposal, August 9, 1994, Tables 1 and 2 and HCFA Estimates, August 23, 1994.

PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999	1995-2000	1995-2004
Parts A and B													
Home Health Copayments	0.0	-1.7	-3.0	-3.3	-3.5	-3.9	-4.3	-4.6	-5.0	-5.4	-11.5	-15.4	-34.7
Reduce Routine Cost Limits for HHAs	0.0	0.0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0	-1.6	-2.3	-6.0
Extend OBRA93 Medicare Secondary Payer	0.0	0.0	0.0	0.0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3	-1.2	-3.0	-11.4
Expand Centers of Excellence	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	a	a	0.0	0.0	-0.4	-0.5	-0.5
Extend ESRD Secondary Payer to 24 Months	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.5	-0.6	-1.2
Sub-total, Part A and B	-0.1	-1.9	-3.5	-4.1	-5.6	-6.6	-7.1	-7.6	-8.4	-8.9	-15.2	-21.8	-53.8
Proposed Additions (8/24/94)													
1995 Physician Update	-0.3	-0.6	-0.6	-0.7	-0.7	-0.8	-0.9	-0.9	-1.0	-1.1	-2.9	-3.7	-7.6
HMO Payment Improvement	0.0	-0.1	-0.2	-0.3	-0.4	-0.4	-0.4	-0.5	-0.5	-0.6	-1.0	-1.4	-3.4
Disabled MSP 100 to 20	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.2	-0.4	-0.4	0.0	0.0	-1.0
Part B Deductible @ \$150	0.0	0.0	0.0	0.0	-0.7	-1.3	-1.3	-1.3	-1.4	-1.4	-0.7	-2.0	-7.4
Part B Interaction	0.1	0.2	0.2	0.2	0.4	0.6	0.6	0.6	0.7	0.7	1.1	1.7	4.3
Sub-total, Proposed Additions	-0.2	-0.5	-0.6	-0.8	-1.4	-1.9	-2.0	-2.3	-2.6	-2.8	-3.5	-5.4	-15.1
Offsetting Receipt Changes													
Income-Related Part B Premium (\$80K/\$100K)	0.0	0.0	-2.0	-2.0	-2.8	-3.5	-4.4	-5.5	-6.9	-8.7	-6.8	-10.3	-35.8
Extend HI Tax to All State/Local Employees	0.0	-1.6	-1.8	-1.5	-1.5	-1.4	-1.4	-1.3	-1.2	-1.2	-6.4	-7.8	-12.9
TOTAL: Part A+B+Additions+Receipts	-2.0	-6.9	-13.5	-17.0	-25.0	-33.9	-42.6	-53.7	-66.8	-80.7	-64.4	-98.3	-342.1

EXHIBIT													
Mitchell Co-Payment	-0.7	-3.4	-4.2	-4.6	-5.0	-5.4	-5.9	-6.4	-7.0	-7.6	-17.9	-23.3	-50.2
Option 8 Co-Payment	0.0	-1.7	-3.0	-3.3	-3.5	-3.9	-4.3	-4.6	-5.0	-5.4	-11.5	-15.4	-34.7
Difference	-0.7	-1.7	-1.2	-1.3	-1.5	-1.5	-1.6	-1.8	-2.0	-2.2	-6.4	-7.9	-15.5
Total, Proposed Additions	-0.2	-0.5	-0.6	-0.8	-1.4	-1.9	-2.0	-2.3	-2.6	-2.8	-3.5	-5.4	-15.1
NET	-0.5	-1.2	-0.6	-0.5	-0.1	0.4	0.4	0.5	0.6	0.6	-2.9	-2.5	-0.4

Home Health ^{Case} ^{P02/04} *File*

Home Health Alternatives

8/19

Mitchell Bill Provision

The Mitchell bill has 20 percent copayment for all home health visits beginning 7/1/95. This provision saves \$50.3 billion between FY 1995 and FY 2004.

Alternatives

Savings loss figures for alternatives are relative to the Mitchell bill.

Effective date and copayment percent alternatives

- (1) No copayment until 1/1/98, when 20 percent copayment would start.
Savings total: \$34.9 bil. Savings loss: \$15.9 bil.
- (2) 10 percent copayment beginning 1/1/96.
Savings total: \$24.7 bil. Savings loss: \$25.6 bil.
- (3) 10 percent copayment beginning 1/1/96, 20 percent copayment beginning 1/1/00.
Savings total: \$39.4 bil. Savings loss: \$10.8 bil.

Front-end Copayment Alternatives

- (4) 20 percent copayment for first 150 visits per year, effective 1/1/96. No copayments after 150 visits per year.
Savings total: \$38.1 bil. Savings loss: \$12.2 bil.
- (5) 20 percent copayment for first 100 visits per year, effective 1/1/96. No copayments after 100 visits per year.
Savings total: \$32.4 bil. Savings loss: \$17.9 bil.
- (6) 20 percent copayment for first 60 visits per year, effective 1/1/96. No copayments after 60 visits per year.
Savings total: \$24.2 bil. Savings loss: \$26.1 bil.

Back-end Copayment Alternatives

- (7) 20 percent copayment after 10 visits per year, effective 1/1/96. No copayments on first 10 visits per year.
Savings total: \$39.8 bil. Savings loss: \$10.5 bil.
- (8) 20 percent copayment after 20 visits per year, effective 1/1/96. No copayments on first 20 visits per year.
Savings total: \$34.6 bil. Savings loss: \$15.6 bil.
- (9) 20 percent copayment after 40 visits per year, effective 1/1/96. No copayments on first 40 visits per year.
Savings total: \$27.2 bil. Savings loss: \$23.0 bil.

"FRONT" vs. "BACK-LOADING" HHA CO-PAYMENT

Proposal: Impose a 20 percent co-insurance requirement for home health visits

"Front End": Impose co-insurance upon first ____ visits and none thereafter for the year.

"Back End": Impose annual co-insurance only after ____ visits.

Advantages of Front End:

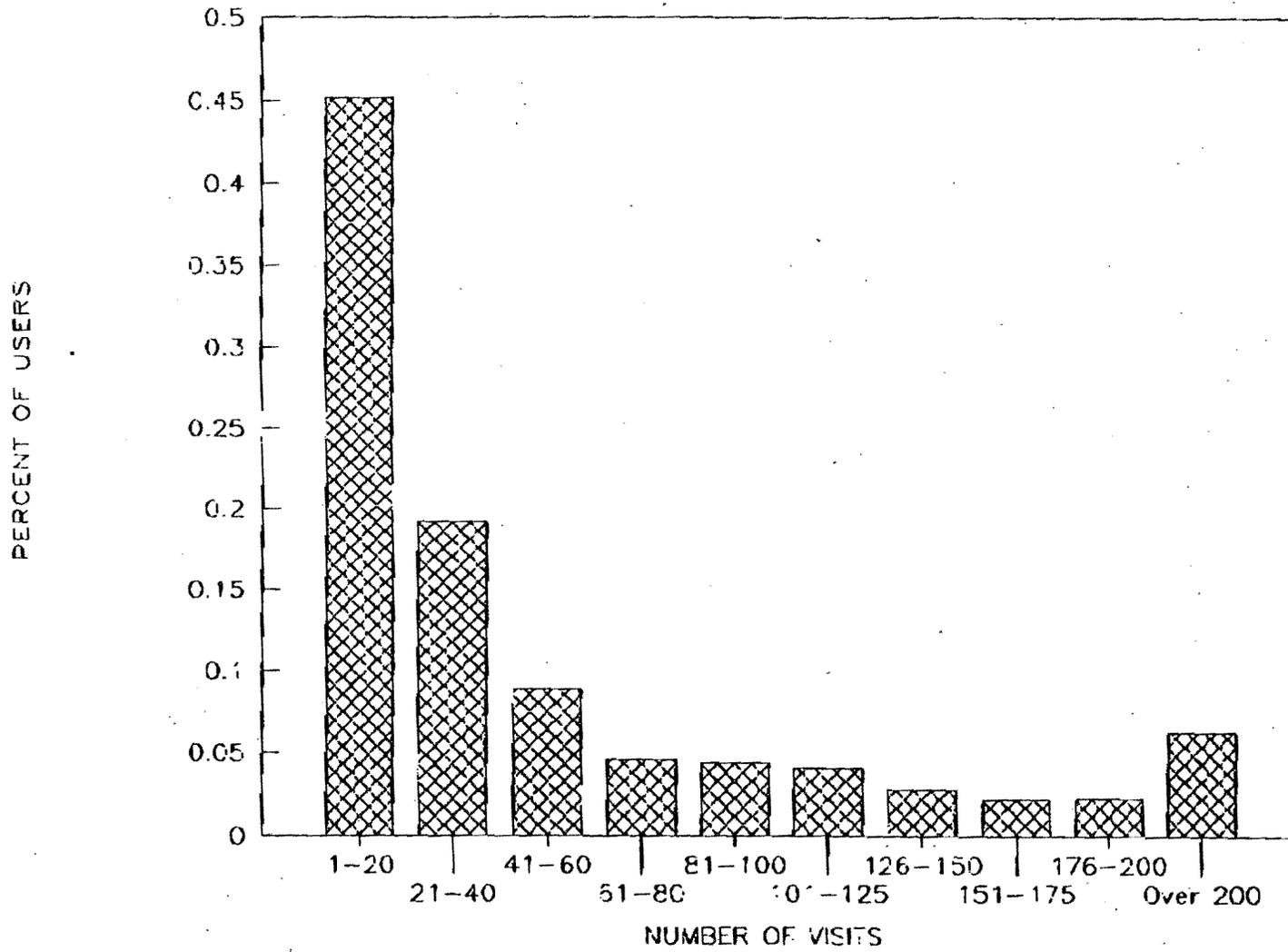
- * Traditional, catastrophic-like insurance policy, which protects the most vulnerable users who require long-term home health care (poorer population with chronic illness or disabilities)
- * Spreads out a relatively reasonable cost-sharing requirement (example: \$689 per year for 53 visits @ \$13) upon the majority of the home health user population
- * Population (relative to chronic users) is younger, with a slightly higher mean income, and more likely to carry Medigap policy to cover the co-pay
- * Brings the home health benefit in line with the cost-sharing principle of most other Medicare benefits

Advantages of Back End:

- * Imposition affects a smaller number of users
- * While long-term users may be poorer, they also may be eligible for Medicaid (QMB) which would cover much of the co-pay requirement

DISTRIBUTION OF VISITS — HOME HEALTH

1992



Home Care ^{Health} File

August 13, 1994

To: Nancy-Ann Min
Chris Jennings
Barry Clendenin

From: John Richardson

Subject: HCFA 8/11 Options to Reduce Medicare Home Health Copayment to 10%

As you requested, we offer the following comments on the list of proposals to offset savings lost by changing a Medicare savings proposal in the Senate Leadership bill.

1. Reduce Home Health Copayment from 20 percent to 10 percent: There may be other changes to the Senate Leadership proposal that would reduce the amount of savings lost.
 - The Senate bill would impose home health copayment immediately upon a beneficiary's discharge from an inpatient hospital. This could be inconsistent with other Medicare Part A coinsurance requirements -- inpatient hospital coinsurance is not required until after 60 days and skilled nursing facility coinsurance is not required until after 20 days of care. The Health Security Act (HSA) proposed to wait until after 30 days before requiring 10 percent home health coinsurance.
 - An alternative would be to retain the 20 percent copayment, but not require it until after 20 or 30 days of care. Another alternative would be to require a 20 percent copayment after a certain number of visits, e.g., 20 or 30. The actuary could provide savings estimates for these alternatives.
 - These alternatives would emphasize that home health care is meant to be a relatively short-term benefit to assist in a beneficiary's recovery from a spell of illness. Substantial coinsurance after an appropriate recovery period would provide a strong disincentive to abuse of the home health benefit.
 - Home health expenditures continue to be one of the fastest growing parts of Medicare. Between FY 1994 and 1999, the actuary projects that home health spending will grow by 72%, from \$12.3 billion to \$21.2 billion. In FY 1989, Medicare spent \$2.5 billion on home health services.
2. Further Reduce 1995 Physician Fee Increases: Under the fee system created in OBRA 89, physicians would be "rewarded" for low spending growth in FY 1993 by receiving a "bonus" in their 1995 fee update equal to the difference between the actual FY 1993 growth rate and the volume performance standard (MVPS) for

that year. The HSA proposed to reduce the large projected 1995 increases by 3 percent for surgical and non-surgical services, holding primary care harmless. The Senate Leadership bill would add one percent more reduction to all three categories of physician services.

The 8/11 proposal would eliminate entirely the "bonus" part of the 1995 fee increase, giving all three categories only an inflation adjustment of 2.2%. Eliminating the MVPS "bonus" may be perceived by physician groups, particularly those representing surgeons and primary care doctors, as "reneging on the deal" they believe was made with Congress to enact physician payment reform in OBRA 89. It may also be seen as inconsistent with the HSA policy of holding primary care services harmless from reductions.

If this were a concern, an alternative would be to allow a smaller portion of the MVPS "bonus" without eliminating it entirely. For example, the 1995 surgical fee increase could be reduced by 6.8 percent instead of 4 percent (for a net fee increase of 6.4 percent), which would allow about half of the "bonus."

3. Increase Part B annual deductible from \$100 to \$150: This proposal would be felt directly by beneficiaries, but it has a strong policy rationale. The Part B deductible has been increased only three times since Medicare began in 1966, when it was set at \$50. The deductible has fallen in relation to average annual per capita charges under Part B from 45 percent in 1967 to about 5 percent in 1993. According to CBO, an increase to \$150 effective January 1995 would not increase any Part B enrollee's out-of-pocket costs by more than \$50 in 1995.
4. HMO Payment Improvement: This proposal was included in the HSA. It is intended to encourage efficiency in HMOs operating in counties with above-average Medicare costs, while increasing Medicare reimbursement to HMOs operating in particularly below-average cost counties, encouraging them to accept Medicare beneficiaries.
5. Lower Medicare as Secondary Payer (MSP) threshold for disabled beneficiaries from 100 employees to 20: OBRA 93 extended through 1998 an OBRA 90 provision, applicable to employers with 100 or more employees, making Medicare the secondary payer for disabled enrollees with employer-based health insurance. The 8/11 proposal would lower the employee threshold from 100 to 20 employees effective January 1, 2002.

This proposal was included in the HSA, where it was tied closely to universal coverage -- it was to be effective January 1, 1998. The logic in the HSA was that with broad community rating, small employers would no longer be vulnerable to paying higher premiums for covering disabled or other high-risk individuals.

The 8/11 proposal is most consistent with the HSA if the employer mandate is triggered in the Senate Leadership bill. Absent universal coverage, it may be argued that this proposal exposes small employers (under 100 workers) to high premiums for covering high-risk individuals. On the other hand, the Senate bill's small-market insurance reforms may answer most of these arguments.

6. Increase the reduction in DSH payments from 33% to 50% effective 1/1/2000:
This proposal seems to be duplicative of the DSH reductions already in the Senate Leadership bill. According to Sec. 4103 of the bill, the Secretary is directed to reduce DSH payments by 50% in States as they become "participating States" under the bill.
7. Increase the reduction in DSH payments from 50% to 60% effective 1/1/2002:
Like the fifth item, this proposal makes the most sense if the employer mandate is triggered and universal coverage is achieved. Reductions in DSH payments are directly linked to increasing health insurance coverage, because both policies are designed to reach the same low-income population.

One possible alternative to reducing DSH by 60% on 1/1/2002 would be to reduce DSH by 70% (i.e., by another 20% beyond the reduction already in the Mitchell bill) upon the triggering of universal coverage -- this is the reduction in the HSA.

Attachment (HCFA 8/11 Proposals)

Reduce Home Health Copayment to 10%

8/11

	<u>FY95-04</u>
<u>Drop</u>	
HH Copayment from 20% to 10% <u>1/</u>	-\$24,300
<u>Add</u>	
1995 Physician Update <u>2/</u>	7,150
Part B Deductible @ \$150 <u>3/</u>	7,200
HMO Payment Improvement <u>4/</u>	3,350
Disabled MSP 100 to 20 <u>5/</u>	1,044
Part B Premium Offset	-4,063
DSH @ 50% (1/1/00) <u>6/</u>	7,093
DSH @ 60% (1/1/02) <u>7/</u>	2,347
HI Interaction	-283
Total	\$24,398

Proposals

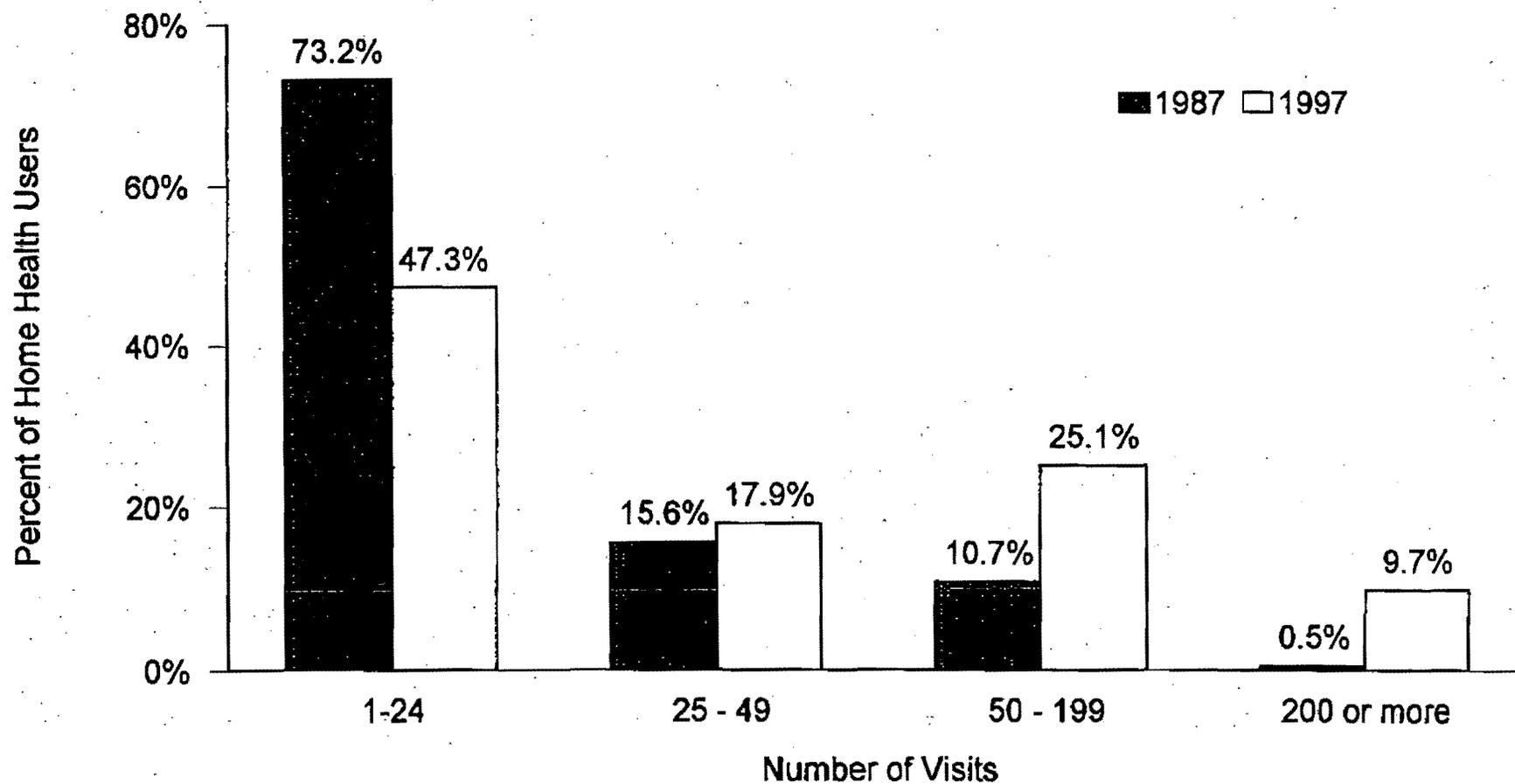
- 1/ Reduce the proposed home health copayment from 20 percent to 10 percent.
- 2/ Reduce the 1995 physician update from the Senate bill level of 9.2 percent for surgical services, 8.4 percent for primary care and 2.7 percent for other services to 2.2 percent, the level of the Medicare Economic Index (the physician inflation factor). This would reduce the Senate bill physician update by an additional 7 percentage points for surgical services, 6.2 percentage points for primary care and 0.5 percentage points for other services.
- 3/ Effective 1/1/99, increase the Part B deductible to \$150 from \$100 . (The Part B deductible was raised to \$100 in 1990, and raised to \$75 in 1982).
- 4/ Beginning with 1995, establish separate national maximum and minimum standards for the Part A and Part B portions of the AAPCC rates. The standards would be phased-in over five years (e.g., 20 percent in the first year, 40 percent in the second year, etc.) and be based on 95 percent of the USPCC.

Counties whose Part A AAPCC is above 170 percent of 95 percent of the Part A USPCC would be limited to that amount unless the Part B portion of their rate was below 95 percent of the Part B USPCC. The standard for the Part B portion of the rate would be the same except the standard would be set at 150 percent of 95 percent of the Part B USPCC.

The minimum standard would not be phased in. Counties whose Part A AAPCC is below 80 percent of 95 percent of the Part A USPCC would be increased to that amount unless the Part B portion of their rate was above 95 percent of the Part B USPCC. The standard for the Part B portion of the rate would be the same.
- 5/ Effective 1/1/02, lower the threshold from 100 to 20 employees for disabled persons for application of the Medicare secondary payor provisions.
- 6/ Effective 1/1/00, increase the reduction in Medicare DSH payments from 33 to 50 percent.
- 7/ Effective 1/1/02, increase the reduction in Medicare DSH payments from 50 percent (effective 1/1/00) to 50 percent.

Distribution of Home Health Users by Number of Visits, 1987 and 1997

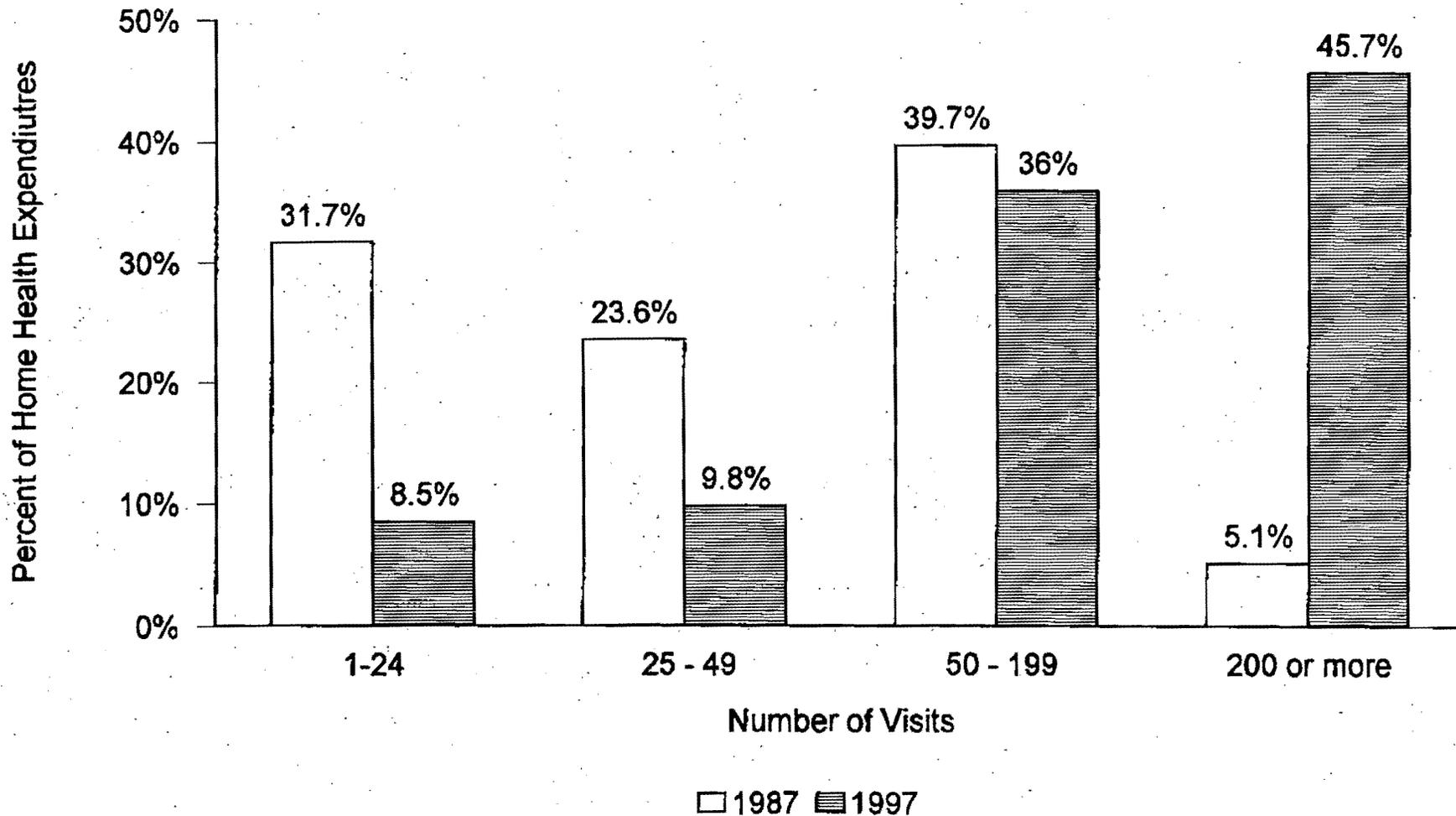
The proportion of users receiving 200 or more visits has grown substantially.



Source: HCFA unpublished data.

Distribution of Home Health Expenditures by Number of Visits, 1987 and 1997

Users with 200 or more visits now account for nearly half of home health spending; in 1987 they accounted for only one-twentieth.



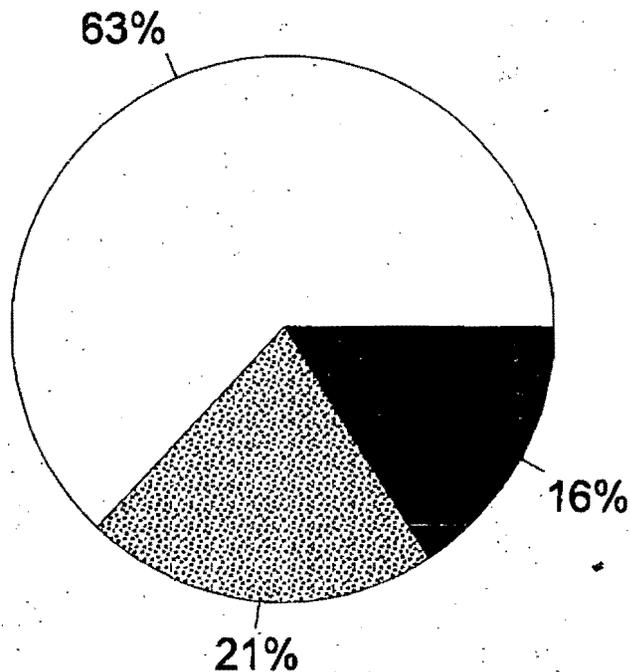
Note: The percentages cited for 1987 data do not sum to 100% due to rounding.

Source: HCFA unpublished data.

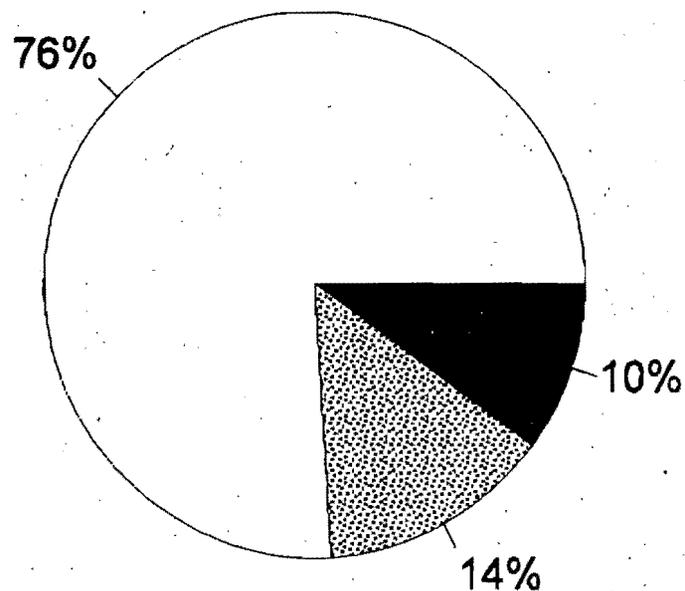
Distribution of Home Health Users by level of Visits and Income

Home health users who receive over 100 visits tend to have lower incomes than those who receive under 100 visits.

Users with 1-100 Visits



Users with Over 100 Visits

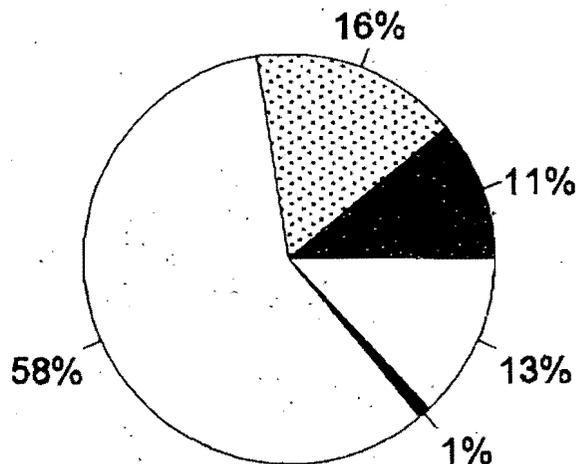


□ Less than \$15,000 ▨ \$15,000 - \$25,000 ■ Over \$25,000

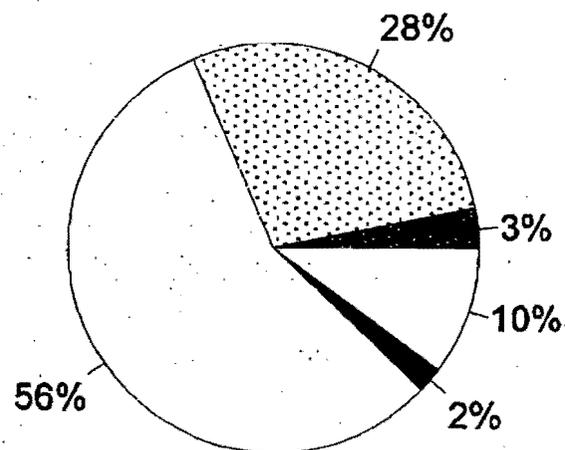
Insurance Coverage for Home Health Users and Non-Users

A greater percentage of home health users have some Medicaid coverage than non-users.

Non-Home Health Users



Home Health Users



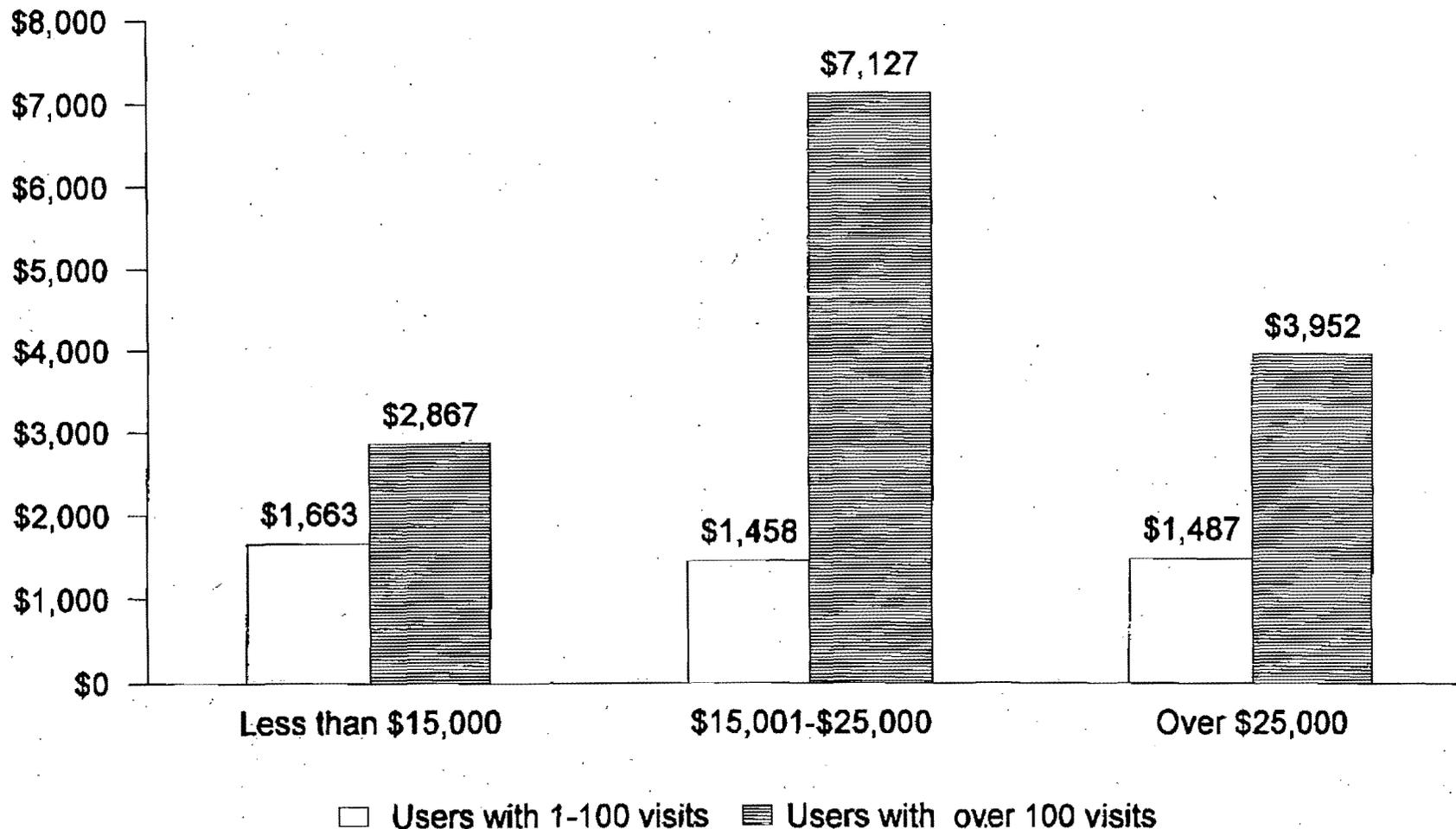
■ Medicare HMO ▨ Medicaid □ Private Health Insurance ■ Other □ Medicare Only

Note: Individuals in Medicare HMOs may have had additional or different insurance coverage sometime during the year. The percentages do not sum to 100 percent due to rounding.

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Out-of-Pocket Total Health Care Costs for Home Health Users, by Visit Level

Because they are less likely to qualify for Medicaid but cannot afford supplemental coverage, individuals with over 100 visits and incomes from \$15,001-\$25,000 have the highest total out-of-pocket health care costs.



Note: Total out-of-pocket costs includes coinsurance, copayments and deductibles. Medicare Part B premiums and private premiums are not included.

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.