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Primer: Skilled Home Health Care

Emily Egan *July 9, 2012*

Skilled home health care is a critical component of the healthcare system, in which providers care for homebound patients with acute, chronic and rehabilitative needs. The importance of home health care is often overlooked and the use is commonly confused with unskilled custodial care.

As the United States grapples with spiraling federal debt and fiscally unsustainable government programs, policymakers are taking a closer look at the delivery of medical services in home and community settings due to the potential for cost savings.

This primer gives an overview of skilled home health care that focuses on Medicare's home health benefits and costs, provides information on home health agencies and discusses the proposed policy changes and potential alternatives.

What is Skilled Home Health Care?

Skilled home health care can be skilled nursing, physical therapy, occupational therapy, speech therapy or medical social services provided to the patient in their home. Without skilled home health care providers, these services would be provided to beneficiaries in a hospital, skilled nursing facility or rehabilitation center at a higher cost.

Medicare, the health insurance entitlement program for Americans over the age of 65, covers skilled home health care visits for homebound patients with acute or chronic health needs. Home health care has been included in the Medicare

Key Takeaways

Skilled Home Health Benefits

- The skilled home health care benefit covers post-acute care and medical services for homebound individuals needing skilled clinical services.
- The types of medical services offered by Medicare are skilled nursing, occupational therapy, physical therapy, speech therapy and medical social work, with skilled nursing being the most common
- Clinical services in the home are generally less expensive than in other care settings

Payment and Reforms

- Medicare spent $19.4 billion on home health care in 2010
- Medicare Parts A & B reimburse home health care providers for "episodes of care" with a base rate and adjustment factors
- Since Congress repealed the home health copayment in 1972, there has been no patient copayment for home health services but some have suggested reinstituting a copay for the benefit.
- Research indicates that a copayment would cause seniors to forego needed care

Reform Alternatives

- The Affordable Care Act included a cap on "outlier" payments to providers to ensure that aberrant home health agencies do not misrepresent patient conditions
- Home health providers are encouraging policymakers to enact similar reforms that shut down or limit fraudulent providers, and additional program integrity reforms to make participation in Medicare more difficult

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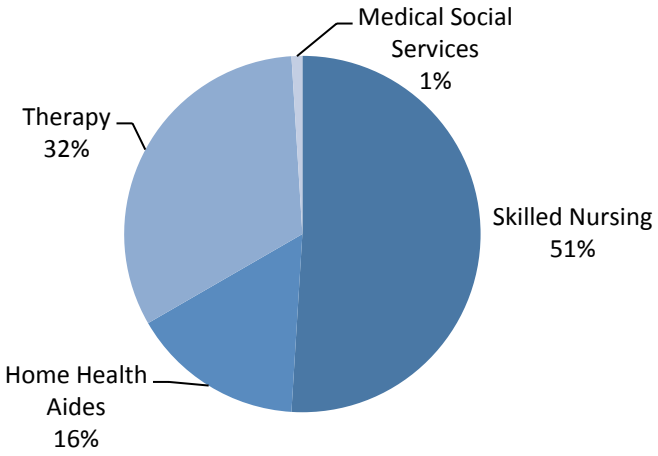
program since its inception in 1965. Medicare reimburses for medical services under Part A, which covers hospital care, and for Part B, which is voluntary coverage for physician visits and other outpatient services. Under Part A, Medicare will pay for patients to receive short-term home health care services immediately following a hospital stay if ordered by a physician. Under Medicare Part B, physicians can order home health care visits for homebound patients. The majority of home health care referrals fall under Part B. "Homebound" is defined as being unable to leave the home except for with the aid of a supportive device (for example, a cane or crutches), special transportation or another person.[i]

As shown in Figure 1, the most common type of home health care provided by Medicare is skilled nursing, which made up 52 percent of home health care visits to Medicare beneficiaries in 2010.[ii] Skilled nursing has a broad scope, including evaluation, medical treatment and instruction to patients or caregivers on how to manage health conditions as well as what signs and symptoms to monitor.

Figure 1. Medicare Home Health Services Segregation



Medicaid also covers skilled home health care for post-acute and rehabilitative care as do many private commercial insurance companies. The specific benefits of Medicaid programs vary between states and among private insurance plans, but are generally similar to Medicare's benefit in that they cover skilled rehabilitative services.

The Department of Veterans' Affairs (VA) also uses home health care providers to care for the sickest, elderly, veterans in their homes through the Home Based Primary Care Program (HBPC). One study of the program found that providing home health care along with a broad array of services and supports achieved a dramatic 24 percent reduction in HBPC participants' total healthcare costs.[iii]

Receiving medical services in their home, whether the ability to age in place or recuperate from a hospitalization, is preferred. A study conducted by Harris Interactive found that more than four out of five Americans surveyed (82

percent) express a preference for home care over institutional care, agreeing with the statement, "If I required medical services, I would prefer to receive it in my home if possible, rather than in a hospital or nursing home."[iv]

An important distinction for services provided in the home is that skilled home health care is different from the ongoing home health assistance known as long-term care, which is needed by many seniors for an indefinite period of time. Home health aides and direct care workers who work in the home generally provide custodial care that assists the individual with dressing, bathing, eating and other daily activities. When needed indefinitely, this is considered unskilled long-term care and not medical care or rehabilitative care, and therefore is not covered by Medicare or most private health insurance plans.

Provider Landscape

Currently, there are 11,900 Medicare-certified home health agencies serving beneficiaries.[v] According to the 2012 MedPAC report, 99 percent of Americans have one home health agency located within their zip code and 98 percent have two.[vi]

The home health provider community continues to grow to address the needs of an aging population. An additional 420 Medicare-certified home health agencies started in 2011. The industry is labor intensive and as a result employment has grown much faster than other industries. Health care employment as a whole is growing in an otherwise stagnant economy. As of June 2012, 63,100 of the 228,000 new payroll jobs created in 2012 were in the ambulatory health care field, which includes home health care.[vii]

Payment & Costs

Home health care providers bill Medicare for a group of visits, called “an episode,” rather than on a per visit basis. There is a set payment for home health care services within a 60 day period, adjusted for patient severity and wage costs in that geographical area, with an allowance for additional payments if the patient needs more home health care visits than the norm.[viii] These additional “outlier payments” are necessary to ensure that home health care is available to the sickest patients, and that home health agencies are compensated fairly for treating patients who may need more intensive care. Outlier payments are relevant to the recently enacted payment reforms discussed in detail below. There are also Low Utilization Payment Adjustment (LUPA) reimbursements for providers if the home health episode consists of fewer than four visits.[ix]

Overall, 3.4 million Medicare beneficiaries use home health care services every year. According to 2009 data from the Centers for Medicare and Medicaid Services (CMS), the average home health care spending per user was roughly $5,700.[x] In the past decade, Medicare’s aggregate spending on home health care has more than doubled, from $8.5 billion in 2000 to $19.4 billion in 2010.[xi]

Despite rising aggregate spending, post-acute care delivered by home health agencies is significantly less expensive than care received in other settings. An Avelere Health study looking at 2005-2006 Medicare claims data on post-

acute care after a hospitalization demonstrated the cost differential between average home health costs and other, more expensive settings, for a particular set of diseases, as shown in Table 1.[xii]

Table 1: Comparing Post-Acute Care Settings, Avalere		
Disease	**Home Health Care Cost**	**Other Post-Acute Care Cost**
Diabetes	$6,120	$9,441
Chronic Obstructive Pulmonary Disease	$5,453	$10,725
Congestive Heart Failure	$4,588	$8,010

An additional study performed by Dobson DaVanzo healthcare consultants, the Clinically Appropriate and Cost-Effective Placement project examined Medicare claims for different diagnoses (via Diagnostic Related Groups or DRGS) and evaluated both the hospitalization and the 60 days of care following. Researchers found that home health care represents 38.7 percent of all post-acute care episodes, but only 27.8 percent of the costs, confirming that home care is less costly than other alternatives.[xiii] Table 2 summarizes the average Medicare costs for a major joint replacement according to the patients' first care setting following the hospital.

Table 2. Comparing Post-Acute Care Settings, Dobson DaVanzo				
Expenditures by First Post-Hospital Setting for MS-DRG 470 (Major Joint Replacement)				
First Setting	Percent of Total Episodes	Medicare Episode Payment	Index Hospital Payment	Total Medicare Payment
Home Health Agency (HHA)	32.4%	$3,267	$11,432	$18,068
Skilled Nursing Facility (SNF)	38.0%	$8,981	$11,711	$26,861
Inpatient Rehab Facility (IRF)	11.4%	$13,073	$11,745	$33,538
Long-Term Care Hospital (LTCH)	0.1%	$27,339	$13,567	$57,896
Short-Term Acute Care Hospital (STACH)	0.2%	$10,386	$11,553	$30,302

Fraud and Abuse by a Select Few Hurts the Majority

Home health care suffers from problems of fraud and abuse perpetuated by a small minority of criminal providers who successfully defraud the Medicare and Medicaid programs. Common fraudulent practices include performing services that are not medically necessary, billing for non-existent services, misrepresenting patient diagnoses to be more serious than they are, giving kickbacks to referring physicians and misrepresenting patients who do not meet the homebound criteria as homebound.[xiv]

MedPAC was able to identify certain geographical areas and counties with particularly high home health care utilization and costs. MedPAC identified the 25 counties in 5 states (Florida, Louisiana, Mississippi, Tennessee, and Texas) where aberrant utilization suggests fraud is occurring.[xv]

Proposed Home Health Care Payment Changes

In today's economic environment, policymakers are looking through all federal healthcare spending programs for potential savings. There have been efforts to cut down on Medicare's home health care spending in a variety of ways especially by using copays. Copays are not a new idea; when the Social Security Act created Medicare in 1965, the home health care benefit included a patient copay. In 1972, in order to increase the supply and access to home health care, the program was amended to make it easier for home health agencies to participate in Medicare and the patient copay was eliminated.[xvi]

A 10 percent patient copay for Medicare home health care users beginning in 2013 was included in the Congressional Budget Office's (CBO) 2011 report entitled "Reducing the Deficit: Spending and Revenue Options." CBO estimates that this copay would save $40.1 billion over 10 years.[xvii] The yearly savings are detailed in Table 3. The report noted, however, that this policy would increase costs for the average home health care user by $600 annually and consequently may cause seniors to forego needed care.[xviii]

Table 3: CBO Estimate of Effects of a 10% Home Health Care Copay on Federal Outlays[xix]

Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2012-2016	2012-2021
Change in Outlays (Billions)	0	-2.6	-3.6	-3.8	-4.1	-4.4	-4.7	-5.2	-5.7	-6.1	-14.0	-40.1

Changes to Medicare's home health care reimbursements, both in the form of reduced base payments and copays, were discussed by the Joint Committee on Deficit Reduction,[xx] but the committee's failure to reach a compromise between new tax revenues and spending cuts resulted in the lack of any committee proposal.

Lastly, President Obama's proposed budget for FY 2013, which was released in February 2012, included a $100 copay for new Medicare beneficiaries receiving home health care visits under Part B.[xxi] Obama's proposed copay would begin in 2017 and was scored to save Medicare $350 million between 2017 and 2023.

What are the Alternatives?

As an alternative to across the board cuts or patient copays, Medicare-certified home health providers have recommended Congress and CMS to go after the above mentioned fraudulent providers for cost savings. Reform that only impacts the providers and beneficiaries with above average utilization could save money without harming the majority of home health care providers or patients using the benefit.

The ACA's caps on outlier payments at the provider level for home health agencies billing the Medicare program proved to be very successful: in 2010 alone the caps achieved $850 million, largely as a result of putting some providers who overbilled Medicare out of business.[xxii] Since the payment system allowed for unlimited outlier payments for patients with above average utilization, some home health agencies took advantage of the outlier payments and claimed that the majority of their patients were outliers in order to receive a higher reimbursement rate, which is considered "upcoding." The ACA's outlier caps ensure that no home health agency can receive more than 10 percent of their payments as outlier payments.[xxiii] This move was largely supported by home health agencies who saw the reform as targeting fraudulent providers with egregious billing practices without hurting reputable agencies or seniors who are genuine outliers.

Further reforms that target the fraudulent providers and those that over-bill the program are likely to be successful in reducing Medicare's costs without driving patients away from legitimate home health providers. Other fraud fighting opportunities include criminal background checks, improved screening and competency standards, heightened compliance and ethical requirements, and temporary entry limitations to prevent excess provider growth. Additionally, because MedPAC found the fraud to be highly concentrated in certain counties, it is possible to target fraud-fighting programs in specific areas where there will be the largest return on investment.

Policy makers will benefit from a greater understanding of home health care and the impact it has on patients and the healthcare system. Reforming Medicare's home health care in a smart way to ensure access for beneficiaries will become even more important as the Baby Boomers age become Medicare-eligible and seek care in their homes.

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References

[i] Center for Medicare and Medicaid Services. "Home Health Prospective Payment System, Payment System Fact Sheet Series." January 2011. https://www.cms.gov/MLNProducts/downloads/HomeHlthProsPaymt.pdf

[ii] Medicare Payment Advisory Commission. "Report to the Congress: Medicare Payment Policy." March, 2012. http://www.medpac.gov/documents/Mar12_EntireReport.pdf

[iii] Edes, Thomas. "Innovations in Homecare: VA Home-Based Primary Care" Journal of the American Society on Aging. Summer 2010.

[iv] American Association for Homecare Website. Available: http://www.aahomecare.org/displaycommon.cfm?an=1&subarticlenbr=475

[v] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy." March, 2012. http://www.medpac.gov/documents/Mar12_EntireReport.pdf

[vi] Ibid.

[vii] Authors calculations based on Bureau of Labor Statistics Data.

[viii] Center for Medicare and Medicaid Services. "Home Health Prospective Payment System, Payment System Fact Sheet Series." January 2011. https://www.cms.gov/MLNProducts/downloads/HomeHlthProsPaymt.pdf

[ix] Ibid.

[x] Authors calculations based on Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy." March, 2011. http://medpac.gov/documents/Mar11_EntireReport.pdf

[xi] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy." March, 2012. http://www.medpac.gov/documents/Mar12_EntireReport.pdf

[xii] Avalere Health LLC, "Medicare Savings and Reductions in Rehospitalizations Associated with Home Health Use" June 2011. Available: http://www.avalerehealth.net/pdfs/avalere_savings_analysis_20110623.pdf

[xiii] Dobson DaVanzo Healthcare Consulting, "CACEP Project." Available: http://www.dobsondavanzo.com/news/2012/04/05/news/landmark-home-health-research-released-today/

[xiv] Government Accountability Office. "Improvements Needed to Address Improper Payments in Home Health." March 13, 2009. Available: http://www.gao.gov/products/GAO-09-185

[xv] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy." March, 2011. http://medpac.gov/documents/Mar11_EntireReport.pdf

[xvi] Benjamin, A. "An Historical Perspective on Home Care Policy." The Milbank Quarterly. Vol 71, No 1. (1993). http://www.jstor.org/stable/3350277

[xvii] Congressional Budget Office "Reducing the Deficit: Spending and Revenue Options." March, 2011. http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf

[xviii] Ibid.

[xix] Ibid.

[xx] Taylor, Andrew. "Deficit Super Committee Struggles To Make Progress As Clock Ticks." Associated Press. October 10, 2011. http://www.huffingtonpost.com/2011/10/10/deficit-super-committee-taxes-cuts_n_1003328.html

[xxi] Office of Management and Budget. "Fiscal Year 2013 Budget of the US Government." http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/budget.pdf

[xxii] "Documented Impact of Outlier Payment Policy Reform." Partnership for Quality Home Healthcare. http://www.homehealth4america.org/images/pdf/payment-reform.pdf

[xxiii] Center for Medicare and Medicaid Services. "Home Health Prospective Payment System, Payment System Fact Sheet Series." January 2011. https://www.cms.gov/MLNProducts/downloads/HomeHlthProsPaymt.pdf