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Medicare Home Health Benefit Primer: Benefit Basics and Issues

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Summary

The Medicare home health benefit provides coverage for home visits by skilled health care professionals. Medicare Parts A and B provide coverage for home health services. To be eligible for the home health benefit, a beneficiary must meet three different criteria. The beneficiary must (1) be homebound, (2) require intermittent skilled nursing care and/or skilled rehabilitation services, and (3) be under the care of a physician who has established that the home health visits are medically necessary in a 60-day plan of care. A beneficiary who meets these requirements is entitled to a 60-day episode of Medicare coverage for home health visits, and is then entitled to an unlimited number of subsequent 60-day episodes so long as he or she continues to meet the eligibility requirements. There is no cost-sharing requirement for home health services. Roughly 9.5% of Medicare fee-for-service (FFS) beneficiaries (or 3.4 million individuals) used home health services in 2011.

Home health services are provided through home health agencies (HHAs), most of which (85%) are freestanding—HHAs not affiliated with an institution such as a hospital or a nursing facility. The number of HHAs participating in Medicare grew by 62% between 2000 and 2011 (from 7,528 to 12,199), with a vast majority of the increase in for-profit freestanding HHAs.

Similar to most Medicare payment methods, Medicare Part A or Part B reimburses HHAs using a prospective payment system (PPS). A PPS reimburses providers with payments that are predetermined by a formula that adjusts payments for beneficiaries' expected care needs and location, among other factors. The home health PPS (HH PPS) was implemented for services beginning on or after October 1, 2000. Generally, the HH PPS provides a single payment for a 60-day episode to HHAs for the estimated costs of home health services. The 60-day episode payment is in contrast to the prior home health payment system that reimbursed HHAs retrospectively on a per visit basis.

While total Medicare FFS expenditures have grown at an average annual rate of roughly 5.6% between 2001 and 2011, Medicare FFS expenditures on home health services have increased at an average annual rate of 8.0% over the same time period. In 2011, Medicare FFS expenditures on covered home health services totaled $18.4 billion. In addition to the high growth rate in Medicare home health payments, the home health benefit has drawn attention due to the consistently high Medicare margins (percentage of Medicare revenue that exceeds costs of services) of participating HHAs. Between 2003 and 2011, aggregate Medicare margins for freestanding HHAs have remained consistently high—from 13.6% in 2003 to 14.8% in 2011.

As deficit reduction pressures increase, the 113th Congress may debate whether to include beneficiary cost-sharing for home health services (a proposal recommended by the Medicare Payment Advisory Commission and various other groups). Congress may also consider proposals to implement a value-based purchasing program for HHAs that would adjust Medicare payments based upon certain HHA quality measures. Similar proposals are currently being implemented in other Medicare payment systems. Congress may also choose to monitor the implementation of the settlement agreement of a recent class-action lawsuit between the Department of Health and Human Services (HHS) and the Center for Medicare Advocacy regarding the so-called "improvement standard" as well as the moratoria on new HHAs in targeted geographic areas.

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Medicare is a federal program that pays for covered health care services of qualified beneficiaries.[1] It was established in 1965 under Title XVIII of the Social Security Act to provide health insurance to individuals 65 and older, and has been expanded over the years to include permanently disabled individuals under 65. Medicare consists of four distinct parts:

- Part A (Hospital Insurance, or HI) covers inpatient hospital services, skilled nursing care, and home health and hospice care.
- Part B (Supplementary Medical Insurance, or SMI) covers physician services, outpatient services, and some home health and preventive services.
- Part C (Medicare Advantage, or MA) is a private plan option for beneficiaries that covers all Parts A and B services, except hospice.[2]
- Part D covers outpatient prescription drug benefits.

Medicare fee-for-service (FFS)—Medicare Parts A or B—provides coverage in a beneficiary's home for certain services and treatments of an illness or injury. Beneficiaries entitled to benefits under Part A do not need to enroll in Part B to receive full coverage for home health visits; however, beneficiaries must meet Medicare's home health eligibility requirements. Beneficiaries who meet the home health eligibility requirements are entitled to a 60-day episode of home health coverage and then to an unlimited number of 60-day episodes, so long as they continue to meet the eligibility requirements.

This report describes home health eligibility criteria, home health services, characteristics of Medicare beneficiaries who use home health services, and home health providers. Further, this report describes in detail the Medicare home health prospective payment system (HH PPS), provides an overview of Medicare home health payments, and discusses issues for Congress related to the Medicare home health benefit. For information on major legislative changes to the home health benefit, see the **Appendix**.

Medicare Home Health Eligibility

To be eligible for Medicare-covered home health services, a beneficiary must meet three requirements:

- he/she must be *homebound,*
- he/she must need part-time or *intermittent skilled nursing care and/or skilled rehabilitation*, or, after establishing prior eligibility, a continuing need for occupational therapy, and
- he/she must be under the care of a physician and need *reasonable and necessary home health services* that have been certified by a physician and established in a 60-day plan of care.[3]

[1] For more background information on the Medicare program, see CRS Report R40425, *Medicare Primer*.

[2] Part C coverage of home health is outside the scope of this report due to a lack of available data on home health users covered under private MA plans.

[3] The physician who approves the home health services as reasonable and necessary must also be an enrolled provider who participates in the Medicare program. For initial Medicare certification of home health services, physicians are required to include documentation that a face-to-face encounter occurred by an approved medical practitioner and the beneficiary between 90 days prior to the first home visit and 30 days after the first home visit.

The following sections describe each of these requirements in greater detail.

Homebound Requirement

To be eligible for covered home health services, beneficiaries must be homebound; however, homebound eligibility criteria have caused confusion and have been misinterpreted by providers and Medicare claims contractors.[4] Congress and the Centers for Medicare & Medicaid Services (CMS) have clarified the definition of homebound over time to better assist beneficiaries, providers, and Medicare claims contractors in the eligibility process.[5] Currently, the regulatory definition of homebound states that a beneficiary must be confined to the home or in an institution that is not a hospital, Medicare-participating skilled nursing facility (SNF), or Medicaid-participating nursing facility.[6] While a beneficiary must be confined to the home, the beneficiary does not have to be bedridden.[7] Beneficiaries are considered homebound if leaving their residence requires a considerable and taxing effort.[8] Absences from the home must be infrequent, or for periods of relatively short duration, or to receive medical treatment. In a March 2012 report, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) concluded from a medical record review sample of 495 Medicare home health claims that in 98% of Medicare home health claims the homebound requirement was met.[9] The HHS-OIG was unable to determine from a medical record review if the remaining 2% of claims met the requirement of homebound.

Intermittent Skilled Nursing and Skilled Rehabilitation Need

For beneficiaries who meet the requirement of homebound, Medicare will provide coverage for reasonable and necessary part-time or intermittent skilled nursing care and skilled rehabilitation services in the home. For purposes of determining eligibility, intermittent skilled nursing care is defined as care that is needed fewer than seven days each week, or less than eight hours of each day for periods of 21 days or less. Prior to 1989, the definition of "intermittent" was interpreted by the Health Care Financing Administration (forerunner to CMS) to mean skilled nursing care provided four days or fewer per week. As part of an agreement reached in a class action lawsuit, *Duggan v Bowen*, the definition of "intermittent," published in 1989 by the Health Care Financing Administration redefined intermittent as fewer than seven days a week.[10]

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[4] Sarah M Donelson et al., *Clarifying the Definition of Homebound and Medical Necessity using OASIS Data: Final Report*, U.S. Department of Health and Human Services, Contract No:100-99-0020, Washington, DC, March 2001, http://aspe.hhs.gov/daltcp/reports/oasisfr.htm.

[5] Section 507 of the Benefits Improvement and Protection Act (P.L. 106-554) clarified that the definition of homebound does not disqualify beneficiaries who leave their home to receive medical treatment at an adult day care center, or to attend religious services.

[6] A beneficiary residing in an assisted living facility (also known as a "group home" or "personal care home") may be considered homebound if the assisted living facility is not primarily engaged in providing medical care and treatment.

[7] 42 C.F.R. §409.42(a).

[8] Centers for Medicare & Medicaid Services, *Medicare Benefit Policy Manual*, Chapter 7 Section 30.1.1.

[9] Department of Health and Human Services Office of Inspector General, *Documentation of Coverage Requirements for Medicare Home Health Claims*, OEI-01-08-00390, March 2012, p. 8, https://oig.hhs.gov/oei/reports/oei-01-08-00390.pdf.

[10] This settlement agreement had a large impact on Medicare home health utilization and expenditures. Between 1980 and 1988, the number of Medicare home health users increased by 44% with an annual rate of growth in home health expenditures of 14.4%. Between 1989 and 1997, the number of home health users increased by roughly 111% with an annual rate of growth in Medicare home health expenditures of 27.2%.

Intermittent skilled nursing care is covered under Medicare if the skills of a registered nurse (RN), or a licensed nurse under the supervision of an RN, are reasonable and necessary to treat a medically predictable recurring need. Beneficiaries who are diabetics may receive an exception to the intermittent requirement if there is no caregiver (or an unwilling caregiver) to administer insulin.[11] Beneficiaries requiring skilled rehabilitation services (e.g., physical therapy, speech-language pathology services, occupational therapy) may be eligible if the services are reasonable and necessary to treat or maintain function affected by their illness or injury and, for the most part, such rehabilitation services cannot be carried out by non-skilled personnel.[12]

Reasonable and Necessary Home Health Services

For beneficiaries who are homebound, the skills or supervision of a registered nurse are reasonable and necessary (and therefore covered by Medicare) based upon the inherent complexity of the service, the condition of the beneficiary, and accepted standards of medical practice.[13] Observation and assessments may also be considered reasonable and necessary if there is a reasonable potential for change in the beneficiary's condition that requires the skills of a registered nurse to identify and evaluate, as well as to ensure that essential non-skilled care is achieving its purpose.

Skilled rehabilitation services are reasonable and necessary if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. In addition to rehabilitation services to improve a beneficiary's function, maintenance therapy may be considered reasonable and necessary to prevent a decline in a beneficiary's functional ability.

Medicare Home Health Services and Beneficiaries

Medicare beneficiaries who meet the home health eligibility criteria are entitled to a 60-day episode of home visits by skilled health care professionals. Beneficiaries can be recertified for an unlimited number of episodes so long as they continue to meet the home health benefit's eligibility criteria. There are no beneficiary cost-sharing requirements associated with the home health episode; however, a 20% coinsurance is required for all covered durable medical equipment and covered Part B drugs and biologics. Roughly 9.5% (or 3.4 million) of Medicare FFS beneficiaries used home health services in 2011.[14]

For beneficiaries who meet the eligibility criteria, covered services include

- skilled nursing care (e.g., administering IV injections, wound care);
- physical therapy (e.g., range of motion exercises);
- occupational therapy (e.g., wood working activities to restore range of motion loss);

[11] Centers for Medicare & Medicaid Services, *Medicare Benefit Policy Manual*, Chapter 7 Section 40.1.3.

[12] An otherwise non-skilled therapy service could be considered skilled if there is clear documentation that skilled personnel are required.

[13] Centers for Medicare & Medicaid Services, *Medicare Benefit Policy Manual*, Chapter 7 Section 40.1.

[14] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013, p. 195, http://www.medpac.gov/chapters/Mar13_Ch09.pdf; Data from Medicare home health users covered under private Medicare advantage plans is unavailable.

- speech and language pathology services (e.g., tasks to restore speech/voice production);
- medical social work services (e.g., assessment of the beneficiary's social and emotional factors related to the illness); and
- home health aide services (e.g., bathing, dressing).[15]

The home health benefit also provides coverage for items such as medical supplies, osteoporosis drugs, durable medical equipment, and items provided on an outpatient basis which cannot be made readily available in the beneficiary's residence.

Since 2000, the proportion of visits has shifted towards more skilled nursing and therapy services. In 2000, roughly 49% of home health visits were for skilled nursing services, 19% for therapy services, 31% for home health aide services, and 1% for medical social services.[16] In 2011, roughly 51% of home health visits were for skilled nursing services, 33% for therapy services, 15% from home health aides, and 1% for medical social services.

While the distribution of visits has shifted towards greater therapy, the number of visits home health users receive has been relatively constant, with an average 36.2 visits per home health user in 2011 compared to an average of 36.8 visits per user in 2000. However, prior to payment reductions in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33), the average number of visits per home health user was much higher—72.6 visits per user. This decrease in home health visits per user has important implications since the current Medicare home health payment system uses a base payment rate that was constructed from 1997-1998 Medicare HHA cost reports and home health claims data, as discussed subsequently in this report.

Similar to other Medicare post-acute care services, there is wide variation across the United States in the percentage of beneficiaries who receive Medicare-covered home health services.[17] Geographic variation in home health admissions may in part be explained by demand factors, such as health and illness of residents in a state or treatment preferences, or supply factors, such as the number of home health agencies in the area, local practice preference, reduced nonmonetary costs (e.g., shorter distances for patient travel, shorter wait times).[18] As shown in **Figure 1**, in 2011, Medicare-covered home health admission rates were relatively higher in the West South Central region (i.e., Arkansas, Louisiana, Oklahoma, and Texas).[19] In 2011, the rate of beneficiaries who received covered home health services per 1,000 Part A enrollees was highest in Louisiana (144) and Texas (144), followed by Florida (143). The three states with the lowest rates of home health admissions were Hawaii (23), Alaska (36), and South Dakota (36).

[15] For more information on long-term services and supports, see CRS Report R43495, *Long-Term Services and Supports: In Brief*.

[16] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013, p. 190, http://www.medpac.gov/chapters/Mar13_Ch09.pdf.

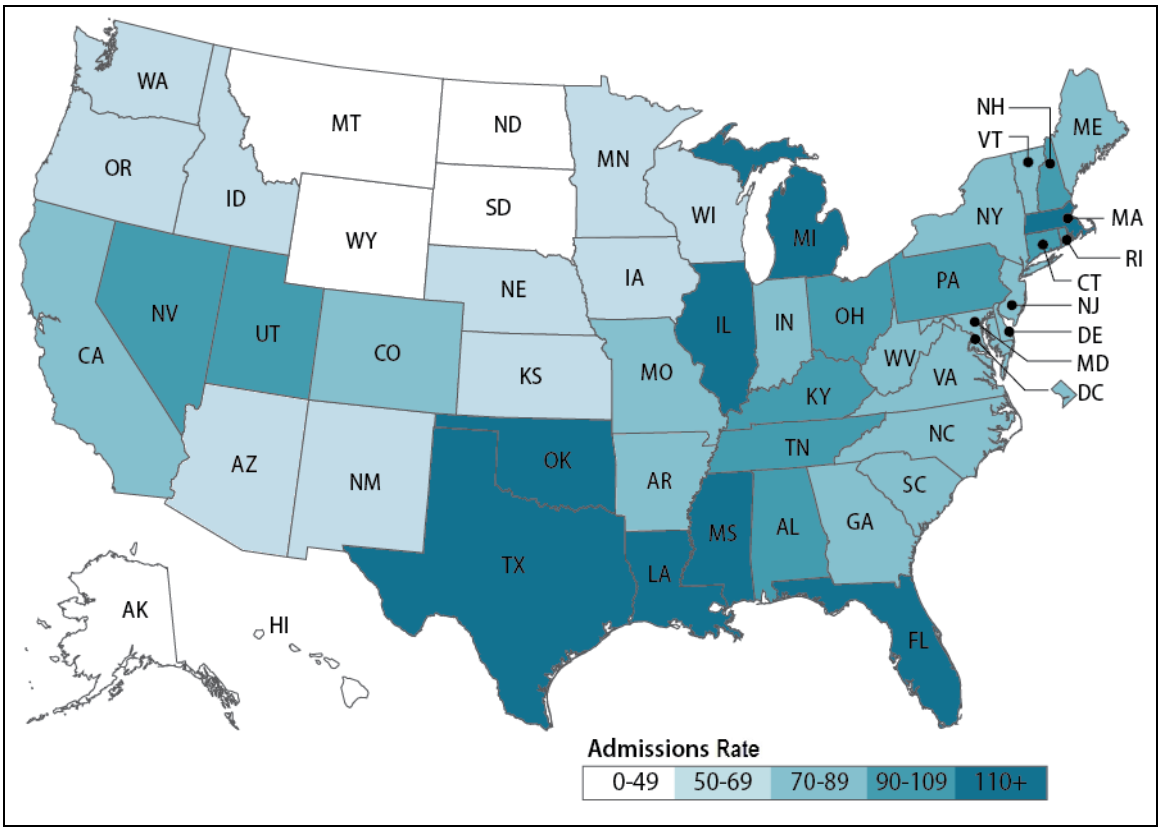
[17] For information on geographic variation of SNFs, see p.3 of CRS Report R42401, *Medicare Skilled Nursing Facility (SNF) Payments*.

[18] Congressional Budget Office, *Geographic Variation in Health Care Spending*, Pub. No. 2978, February 2008, p. 10, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/89xx/doc8972/02-15-geoghealth.pdf.

[19] Centers for Medicare & Medicaid Services, *Health Care Financing Review 2012 Medicare and Medicaid Statistical Supplement*, Table 7.3.

Figure 1. Home Health Utilization

(number of covered home health admissions per 1,000 Medicare Part A enrollees, 201c)



Source: CRS analysis of data from the Centers for Medicare & Medicaid Services, *Health Care Financing Review 2012 Medicare and Medicaid Statistical Supplement*, Table 7.3.

Notes: This table only includes Medicare FFS beneficiaries. A covered home health admission may include multiple back-to-back episodes.

Medicare has covered home health benefits since enactment, and it has been traditionally categorized as a "post-acute care" benefit—providing limited skilled coverage following a beneficiary's hospitalization. However, while more beneficiaries who have been discharged from hospitals or SNFs are certified to receive their first episode of home health coverage (1.9 million episodes in 2010) than beneficiaries admitted from the community (1.3 million episodes in 2010), most home health episodes in a year are provided to beneficiaries who did not have a prior hospitalization.[20] In 2010, for home health users who had a prior hospital or SNF stay, Medicare covered roughly 500,000 subsequent (second or greater) home health episodes following the beneficiaries' initial episode and roughly 3.2 million subsequent home health episodes for home health users admitted from the community. Overall, in 2010, the share of home health episodes for beneficiaries who had a prior hospitalization before beginning home health coverage was 34%. The remaining 66% of home health episodes were for beneficiaries already living in the community who were certified as requiring home health services.

[20] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013, p. 196, http://www.medpac.gov/chapters/Mar13_Ch09.pdf.

Overall, home health services provide coverage for beneficiaries across a wide variety of conditions and/or diseases. **Table 1** shows the percentage of home health users, as well as average Medicare payment per episode(s) and the average number of visits per episode(s) received by the most common primary diagnoses.[21] As shown in **Table 1**, for beneficiaries receiving covered home health services who did not have a prior institutional stay, diabetes was the most common primary diagnosis, at 9.8% of all FFS home health users in 2011. Other common diagnoses were essential hypertension (i.e., high blood pressure) at 8.7%, heart failure at 7.5%, and chronic skin ulcer at 4.4% of all FFS home health users.[22]

Table 1. Average Medicare Payment and Visits for the Most Common Principal Diagnoses in 2011

Principal Diagnosis	Percentage of Home Health Users	Average Medicare Payment per Episode(s)	Average Number of Visits per Episode(s)
All Diagnoses	**100.0%**	**$5,357**	**36**
Diabetes mellitus	9.8%	$5,454	50
Essential Hypertension	8.7%	$3,570	25
Heart failure	7.5%	$3,618	25
Chronic Skin Ulcer	4.4%	$4,959	38
Post-acute care diagnoses	35.6%	$3,650	19

Source: Centers for Medicare & Medicaid Services, *Health Care Financing Review 2012 Medicare and Medicaid Statistical Supplement*, Table 7.6.

Notes: This table only includes Medicare FFS beneficiaries. Beneficiaries can have multiple primary diagnoses. Post-acute care diagnoses refers to the Supplementary Classification of Factors Influencing Health Status and Contact with Health Service (also known as "V" codes) which were not disaggregated by specific factors.

Medicare Home Health Providers

A home health agency (HHA) is an organization that primarily provides skilled nursing and rehabilitation services to beneficiaries in their homes.[23] To be certified by Medicare, HHAs must be licensed and approved by state and local law (if necessary) and meet federal requirements and conditions of participation (e.g., informing a patient of his/her rights). Most Medicare-certified HHAs (85%) are freestanding—not a part of a larger institution (such as a hospital or nursing home).[24]

As noted by MedPAC in their March 2009 *Report to the Congress*, payment reductions from BBA 97 had an effect on the supply of HHAs—decreasing the number of agencies by 34% between 1997 and 2000.[25] Since the implementation of the home health prospective payment system (HH

[21] HHAs generally report separate diagnosis codes (V-codes) for beneficiaries receiving post-acute home health services.

[22] Centers for Medicare & Medicaid Services, *Health Care Financing Review 2011 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, November 2011, Table 7.6.

[23] Section 1861(o) of the Social Security Act.

[24] Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, June 2013, p. 131, http://www.medpac.gov/chapters/Jun13DataBookSec8.pdf.

[25] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2009, p. 189, (continued...)

PPS) in 2000, the number of HHAs has grown steadily with a large majority of the increase in freestanding for-profit HHAs. Between 2000 and 2011, the number of Medicare-certified HHAs increased by 62%, from 7,528 to 12,199.[26]

HHAs have also come under scrutiny due to allegations of fraud within the home health industry.[27] According to the GAO, in 2010, HHAs were under investigation by the HHS-OIG, Department of Justice, or U.S. Attorney's Office in roughly 13% of criminal cases involving health care fraud among entities—a business or organization (as opposed to an individual).[28] Investigations for health care fraud included fraud in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Medicare Home Health Prospective Payment System (PPS)

In general, a PPS reimburses providers using a predetermined payment formula that adjusts payments based upon a beneficiary's expected care needs and area wage differences, among other factors.[29] The Medicare HH PPS was implemented for home health services beginning on or after October 1, 2000. Under the HH PPS, Medicare provides a payment to HHAs for covered home health services on a 60-day per episode basis.[30] This method is in contrast to the prior Medicare payment method that reimbursed HHAs for each home health visit performed on the basis of "reasonable costs."

The HH PPS requires HHAs to bill Medicare Part A or Part B for covered home health services provided during the course of the beneficiary's home health episode.[31] For beneficiaries with only Part A coverage, Part A will provide payment for all covered home health services. For beneficiaries with only Medicare Part B coverage (because they have exhausted their Part A benefit and they are enrolled in Part B), Part B will provide payment for all covered home health services. If a beneficiary is entitled to Medicare Part A and is enrolled in Part B, had a three-day inpatient hospital stay, and received his/her first Medicare-covered home health visit within 14 days after discharge from a hospital or SNF, Part A will provide payment for the first 100 home visits in a series of adjacent episodes and Part B will provide payment for any subsequent home

(...continued)

http://www.medpac.gov/chapters/Mar09_Ch02E.pdf.

[26] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013, p. 194, http://www.medpac.gov/chapters/Mar13_Ch09.pdf.

[27] Michelle Stein, "OIG Urges CMS to Use Surety Bonds as Tool to Stem Home Health Fraud," *Inside Health Policy*, September 27, 2012, pp. http://insidehealthpolicy.com/201209282411549/Health-Daily-News/Daily-News/oig-urges-cms-to-use-surety-bonds-as-tool-to-stem-home-health-fraud/menu-id-212.html.

[28] United States Government Accountability Office, *Health Care Fraud: Types of Providers Involved in Medicare, Medicaid, and the Children's Health Insurance Program Cases*, Washington, DC, September 2012, p. 18. http://www.gao.gov/assets/650/647849.pdf.

[29] Under the prior payment system, Medicare reimbursed HHAs for reasonable costs on a per visit basis.

[30] Adjustments will be made to the 60-day payment if there is an intervening event or if the HHA provides less than five visits. An HHA can submit a Request for Anticipated Payment (RAP) to its fiscal intermediary to be paid 60% of the final Medicare 60-day episode payment and the remaining 40% at the end of the episode for all initial episodes. Subsequent episodes can still submit a RAP, however, the payments at the beginning and end of the episode will be split 50/50.

[31] For more information on what supplies or services are covered under the consolidated billing, see the consolidated billing master code list at http://www.cms.gov/HomeHealthPPS/Downloads/HHCB_Master_Code_List.zip.

visits. Part B would also provide payment for covered home health services in all other instances for beneficiaries who are entitled to Part A and enrolled in Part B. In 2011, Part A home health expenditures totaled $6.9 billion while Part B home health expenditures totaled $11.6 billion.[32]

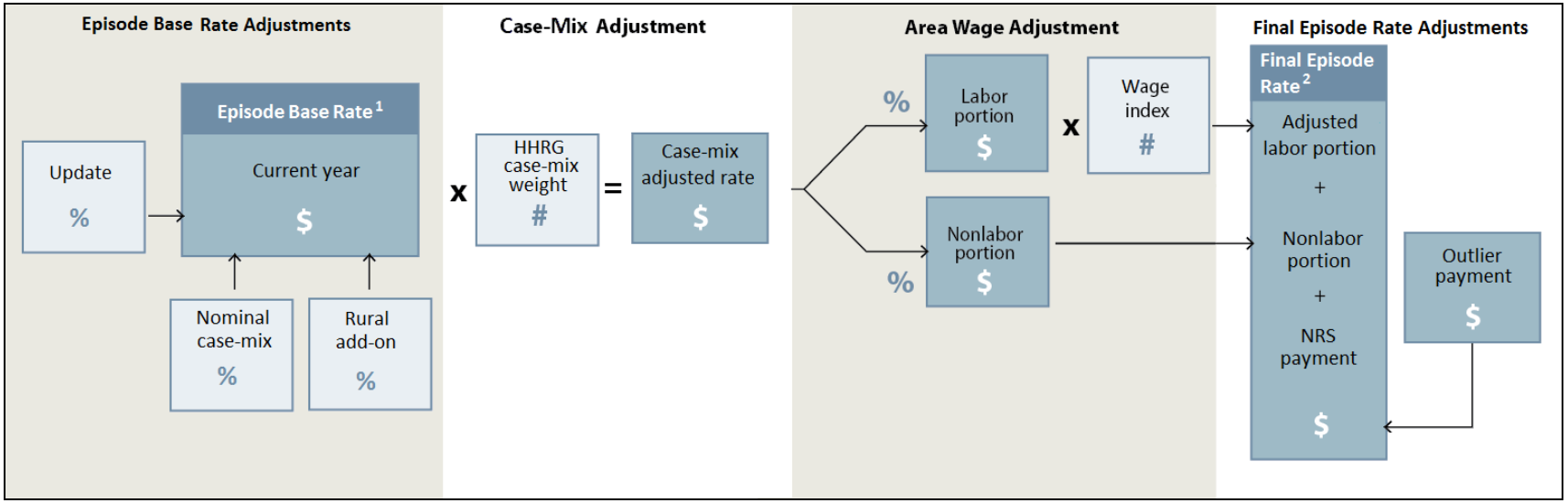
For HHAs that do not provide some of the home health services directly, but instead contract certain services to be furnished by an outside provider (e.g., physical therapist contractor), the HHA is still responsible for submitting a bill to Medicare (not the outside provider). Any agreement on the reimbursement amount the HHA provides to the outside provider is negotiated between the HHA and the outside provider. This practice is referred to as "consolidated billing" and avoids multiple providers billing for the same service.

The following sections explain in greater detail the components of an HHA's Medicare reimbursement under the HH PPS, recent changes to some of the components, and how the payment is calculated. Components within the HH PPS are:

- the *episode base rate* and its annual update and other adjustments;
- a *case-mix adjustment* by assigning beneficiaries into one of 153 Home Health Resource Groups (HHRGs), which adjusts payments based upon a beneficiary's expected care needs;
- an *area wage adjustment*, which adjusts payments based upon area wage differences;
- the *final episode rate* and any applicable adjustments; and
- a low utilization payment amount (LUPA) for episodes with four or fewer home health visits.

[32] Centers for Medicare & Medicaid Services, *Health Care Financing Review 2012 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, November 2012, Table 3.3.

Figure 2. Home Health Prospective Payment System Formula for Episodes with Five or Greater Visits



Source: CRS graphic of HH PPS formula.

Notes:

1. To calculate the current episode base rate, first, the prior year's episode base rate must be multiplied by the market basket update net of any required reductions. Second, the prior step's product may be reduced by a nominal case-mix adjustment which creates the current episode base rate.

2. For episodes that require a discharge before the 60 days to an intervening event, the final episode rate is prorated to reflect the number of days the beneficiary received care as a proportion of 60.

Episode Base Rate Adjustments

The episode base rate (sometimes referred to as the "national standardized rate") is the base reimbursement amount for a 60-day episode of care before adjusting for a beneficiary's expected care needs (case-mix adjustment) or area wage differences, as shown under the *Episode Base Rate Adjustments* heading in **Figure 2**. Prior to CY2014, the HH PPS episode base rate was developed from a sample of 1997-1998 HHA cost reports and home health claims data. and updated annually for changes in the costs of home health services measured by a market basket index. Beginning in CY2014, the episode base rate ($2,869.27 in CY2014) will gradually change to reflect, in part, 2011 cost reports and 2012 home health claims data, inflated by the CY2013 and CY2014 home health market basket updates.[33] This change is a result of section 3131(a) of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148), which required the Secretary of Health and Human Services to "rebase" the home health payment rate with more recent data conducted in equal increments over four years but such increment is not to exceed a 3.5% change in the CY2010 home health payment rate ($80.95 for a 60-day episode).[34] The CY2013 estimated average episode cost, calculated from 2011 cost report and 2012 claims data, was 13% ($386.52) less than the CY2013 60-day episode payment. To reconcile this difference between payment per episode and cost per episode, the base rate would have required an annual reduction that exceeded 3.5% of the CY2010 home health payment rate; therefore, for CY2014 through 2017, the home health episode base rate will be reduced by $80.95 each year to reflect the updated costs of home health services.

In addition to the annual market basket update, and any applicable update adjustments, the episode base rate may also be reduced for trends in case-mix classification and increased for providing home health services to beneficiaries in rural areas. **Figure 3** and **Figure 4** provide examples of how the episode-base rate is adjusted to construct Medicare's 60-day home health reimbursement amount.

Annual Update Adjustments

Changes in an average HHA's costs are calculated with a market basket index—a composition of weighted price levels that is estimated to capture the changes in costs for an average HHA.[35] The annual percentage change in the HHA market basket index from the prior year is referred to as the market basket update. Starting in CY2015, the ACA requires the market basket update to be reduced by a percentage determined by the Secretary to account for increases in productivity. The market basket update may be a negative adjustment. For information on recent changes to the episode base rate and other home health changes by ACA, see Patient Protection and Affordable Care Act (ACA, P.L. 111-148) in the **Appendix**.

Additionally, the home health market basket update may be further reduced for HHAs that fail to submit data for measuring health care quality to Medicare claims contractors.[36] These data are provided from the Outcome and Assessment Information Set (OASIS), an assessment tool that

[33] For more information on the home health payment rate rebasing, see Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update for Calendar Year 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses," 78 *Federal Register* 72256, December 2, 2013. Additionally, in CY2014, the episode-base rate was increased in a budget-neutral fashion to offset a reduction to the case-mix weights.

[34] The CY2010 episode base rate was $2,312.94.

[35] The current home health market basket index was reweighted using 2010 Medicare cost report data.

[36] Section 5201(c) of DRA.

measures patient outcomes and quality improvement for adult home care patients, and the Consumer Assessment of Healthcare Providers and Systems Home Health Care Survey (HHCAHPS). The OASIS and HHCAHPS information is aggregated by agency and publically reported on the Home Health Compare website (http://www.medicare.gov/homehealthcompare/). For HHAs that do not submit quality data, the market basket update will be reduced by 2%. In 2010, less than 1% of HHAs received a 2% reduction to the market basket update.[37] HHAs can receive a full market basket update the following calendar year should they choose to submit their quality data to their Medicare claims contractor.

Nominal Case-Mix Growth

In addition to the annual update and applicable adjustments, the episode base rate may be reduced for all HHAs to address trends in case-mix classification. Since CY2008, CMS has reduced the home health market basket update for trends, referred to as "nominal case-mix growth," that have occurred since the HH PPS was implemented in 2000.[38] Nominal case-mix growth refers to the practice of continually classifying beneficiaries into more resource-intensive, and thus higher paying, case-mix groups (HHRGs), despite evidence of little or no change in the overall patients' health characteristics. Similar changes within other Medicare payment systems have been referred to as "upcoding" or "case-mix creep."[39]

In the CY2008 HH PPS final rule, CMS stated that the national average HHRG case-mix index (the national average of the HHRG case-mix weight shown under the Case-Mix Adjustment heading in **Figure 2**) had increased by 12.78% from September 2000 to December 2005.[40] The increase in the national average case-mix weight suggests that more resource-intensive, and thus higher-reimbursed services were billed to Medicare by HHAs. While CMS noted that patient characteristics within the home health population had changed, CMS stated that 11.75 percentage points of the increase in the national average HHRG case-mix index was not related to treating more resource-intensive patients. To offset the nominal case-mix growth, CMS stated they would reduce the episode base rate by 2.75% for each of CYs 2008, 2009, and 2010, with an additional 2.71% reduction in 2011. More recently, due to the availability of more recent data, CMS reduced the episode base rate by 1.32% in CY2013 to offset the nominal case-mix growth that had increased to 19.03% between September 2000 and the end of December 2009.[41] There was no nominal case-mix adjustment for CY2014.

Rural Add-On

The rural add-on is a 3% increase to the episode base rate for home health services provided to beneficiaries in rural areas. A provision in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) that increased the episode base rate by 5% for home health services for beneficiaries in rural areas

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[37] Department of Health and Human Services Office of Inspector General, *Limited Oversight of Home Health Agency OASIS Data*, OEI-01-10-00460, February 2012, p. 7, https://oig.hhs.gov/oei/reports/oei-01-10-00460.pdf.

[38] For more information, see Alan White et al., *Analysis of 2000-2008 Home Health Case-mix Change*, Abt Associates Inc., July 21, 2010, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Reports.html.

[39] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2001, p. 5, http://www.medpac.gov/documents/Mar01%20Entire%20report.pdf; section 1888(e)(3)(F) of the Social Security Act.

[40] Centers for Medicare & Medicaid Services, "Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008," 72 *Federal Register*, August 29, 2007.

[41] Centers for Medicare & Medicaid Services, "Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality Reporting Requirements, and Survey and Enforcement Requires for Home Health Agencies," 77 *Federal Register*, November 8, 2012.

expired on December 31, 2006. ACA reestablished the rural add-on at a 3% increase to the episode base rate for home health services furnished in a rural area beginning on or after April 1, 2010, and before January 1, 2016.[42]

Case-Mix Adjustment

Medicare requires HHAs to assess beneficiaries who receive covered home health services to measure patient outcomes and quality improvement. Additionally, the information from beneficiary assessments also determines a beneficiary's expected care needs (HHRG assignment) for purposes of the HH PPS.

A beneficiary's assessment data are gathered using the OASIS tool—an assessment tool that measures patient outcomes and quality improvement for adult home care patients. Starting in 2000 and prior to CY2008, the HH PPS used an HHRG-80 classification system, which assigned a beneficiary into one of 80 unique HHRGs by scoring data elements from the beneficiary's OASIS assessment. The sum of the data elements score helped determine a beneficiary's severity level, and thus, expected care needs. Scores were organized by three dimensions with various levels within each dimension: clinical severity (four levels), functional severity (five levels), and services utilization severity (four levels). Clinical severity was based on the beneficiary's diagnoses, functional severity was based on how well the beneficiary performed activities of daily living (e.g., bathing, dressing, walking), and service utilization was based on whether the beneficiary received 10 or more therapy visits and/or whether the beneficiary was recently discharged from a hospital, inpatient rehabilitation facility, or SNF. Scores across these three dimensions (clinical severity, functional severity, service utilization) determined a beneficiary's assignment into one of 80 HHRGs.

Beginning CY2008, CMS implemented refinements to the case-mix adjustment. The new HHRG-153 case-mix classification system continued to use clinical and functional severity dimensions (reducing the number of levels for each dimension to three), added a separate group for beneficiaries in their third or greater episode in a series of adjacent episodes, and established multiple therapy visit thresholds (instead of the previous threshold of 10 or greater therapy visits). CMS stated that including these modifications would significantly improve the case-mix adjustment system.[43] Similar to the HHRG-80 classification system, under the HHRG-153 classification system, the data elements provided by the OASIS tool determine the beneficiary's HHRG assignment. Each HHRG has its own unique case-mix weight. The HHRG case-mix weight adjusts the episode base rate to reimburse HHAs for the beneficiary's expected care needs, as shown under the *Case-Mix Adjustment* heading in **Figure 2**.

Area Wage Adjustment

After determining the case mix adjusted rate, a share of this rate is further adjusted for area wage differences. The case-mix adjusted rate is split into a labor-related share and a non-labor-related share, with the labor-related share representing the average amount of labor-related costs relative to total costs for home health services to beneficiaries. This labor-related share has historically been roughly 77% of the case-mix adjusted rate, with the remaining 23% allocated as the non-labor-related share. As shown under the *Area Wage Adjustment* heading of **Figure 2**, the labor-

[42] Section 3131(c) of ACA.

[43] Centers for Medicare & Medicaid Services, "Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008," 72 *Federal Register* 25359, May 4, 2007.

related share of the case-mix adjusted rate is multiplied by an area wage index specific to the beneficiary's residence to account for differences in wages across the country. This method is in contrast to other Medicare payment systems, which usually assign area wage indexes based on the provider's geographic area.[44]

The home health wage index is calculated and updated annually from a survey of wages and wage-related costs from acute care hospitals (because specific home health wage data do not exist).[45] For areas with no hospitals and no wage-related data available, adjacent areas are used as a proxy measure for the missing cost information.

Final Episode Rate Adjustments

As shown under the *Final Episode Rate Adjustments* heading of **Figure 2**, the final episode rate is the sum of the (1) labor-adjusted portion, (2) non-labor portion, and (3) payment for non-routine medical supplies (NRS). Episodes with at least five home health visits receive an NRS payment to reimburse HHAs for items such as IV supplies, syringes, and blood glucose monitoring strips.[46] Durable medical equipment (DME), DME supplies, prosthetics, and orthotics are not considered NRS and are reimbursed outside of the HH PPS.[47] NRS payment can be one of six different levels based on the patient's clinical conditions. The NRS payment is adjusted annually by the market basket update and may receive a rural add-on adjustment, a nominal case-mix growth adjustment, and a quality data submission adjustment. For CY2014, at a minimum, an HHA that submitted quality data would receive an NRS payment of $14.47 and a maximum of $581.63.[48]

The final episode rate is a bundled Medicare (Part A or B) payment of covered home health services for a 60-day episode of care. However, in addition to the previously discussed adjustments, the final episode rate also may be adjusted for extraordinarily costly cases (i.e., outlier payments) and for intervening events within the 60-day episode of care.

Outlier Payment Adjustment

In addition to the final episode rate, outlier payment adjustments may be made in cases when an HHA has provided an extraordinarily costly episode of care to a beneficiary, as shown under the *Final Episode Rate Adjustments* heading of **Figure 2**. The amount of the outlier payment adjustment is jointly determined by a formula and the additional visits incurred by the HHA. Unlike the final episode rate, the amount of the outlier payment is not predetermined but rather is based on the cost of care already provided.

The outlier payment formula includes a fixed dollar loss (FDL) amount, which is the amount of additional costs in excess of the final episode rate that must be spent before receiving any outlier payments. The fixed dollar amount is equal to 45% of the final episode rate.[49] If the amount of

[44] Section 4604 of the BBA 97 changed the payment location from the provider's location to the beneficiary's residence.

[45] The HH PPS uses a version of the hospital wage index called the "pre-floor, pre-classification hospital wage index."

[46] Centers for Medicare & Medicaid Services, *Medicare Benefit Policy Manual*, Chapter 7 Section 50.4.1.3.

[47] Centers for Medicare & Medicaid Services, *Medicare Benefit Policy Manual*, Chapter 7 Section 50.4.1.1.

[48] Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update for Calendar Year 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses," 78 *Federal Register* 72306, 72308, December 2, 2013.

[49] The FDL was lowered from 67% to 45% in the Medicare home health CY2013 *final rule* to better meet the 2.5% industry-level cap.

additional costs is greater than the sum of the final episode rate and the FDL amount, determined retroactively, Medicare may provide an outlier payment adjustment for 80% (the loss-sharing ratio) of the costs that exceed this threshold. The outlier payment policy only reimburses the cost of visits to the beneficiary (e.g., not NRS).

Two capitations exist for Medicare home health outlier payments beginning January 1, 2010: agency-level and industry-level caps. The agency-level outlier cap limits outlier payments to HHAs at no more than 10% of their total Medicare home health payments. Additionally, total Medicare home health outlier payments are capped at 2.5% of total Medicare home health payments. These capitations exist to limit potential fraud and abuse that may occur for home health payments. According to an analysis conducted by CMS, 44% of episodes that qualified for outlier payments were for patients with a primary diagnosis of diabetes of any type or complication, even though patients with a primary diagnosis of diabetes represented roughly 10% of all home health users in 2011 (see **Table 1**).[50] Across episodes that resulted in an outlier payment over $10,000, 95% of such episodes were for patients with a primary diagnosis of diabetes or long-term use of insulin, and, on average, such outlier episodes had 160 skilled nursing visits over the 60-day episode—or, on average, more than two skilled nursing visits per day.

Partial Episode Payment Adjustment

A partial episode payment (PEP) adjustment may be made if there is an intervening event during the beneficiary's 60-day episode, which would necessitate a reduction in the final episode rate that would otherwise apply. Some examples of events that would trigger a PEP adjustment could be: a beneficiary is discharged because he/she has reached his/her treatment goals, a beneficiary has enrolled in a Medicare Part C plan during his/her 60-day episode, or a beneficiary elects to be transferred to a different HHA. A PEP adjustment will not be made if the transfer is between organizations of the same owner, or if the beneficiary returns to the same HHA after having been hospitalized during his/her 60-day episode.[51]

The PEP adjustment is calculated by the remaining days of the beneficiary's care since the last billable visit as a proportion of 60. For instance, if the beneficiary's last billable visit was on the 20th day after the first billable visit, the PEP adjustment would reduce the final episode rate by 66% [(60-20) ÷ 60].

Low Utilization Payment Amount

For 60-day episodes that consisted of four or fewer visits, the HH PPS provides a low utilization payment amount (LUPA) to reimburse the HHA for each visit performed. The LUPA is increased annually by the market basket update and any applicable adjustments (i.e., failure to submit quality data, rural add-on). The LUPA is not reduced for nominal case-mix growth or an NRS payment. In CY2007, roughly 11% of home health episodes were reimbursed using the LUPA.[52]

[50] Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update for Calendar Year 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses," 78 *Federal Register* 72310, December 2, 2013.

[51] Centers for Medicare & Medicaid Services, *Medicare Benefit Policy Manual*, Chapter 7 Section 10.8.

[52] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2009, p. 194, http://www.medpac.gov/chapters/Mar09_Ch02E.pdf.

Rather than providing a 60-day payment that is assigned an HHRG, LUPA reimbursement for an HHA is based upon six different visits and disciplines that could have been performed: home health aide, medical social services, occupational therapy, physical therapy, skilled nursing, and speech language pathology therapy. For CY2014, the per visit reimbursement amounts for the six different disciplines are:

- home health aide is $54.84,
- medical social worker is $194.12,
- occupational therapist is $133.30,
- physical therapist is $132.40,
- skilled nurse is $121.10, and
- speech language pathologist is $143.88.[53]

Similar to the 60-day episode base rate rebasing, beginning CY2014, section 3131(a) of the ACA requires the Secretary to "rebase" the LUPA episodes with more recent data conducted in equal increments over four years but such increment is not to exceed a 3.5% change in the CY2010 home health payment rate. To reflect more recent data, the CY2013 LUPAs across the six disciplines were reconciled against the 2013 average cost per visit amounts for each discipline. CY2013 cost per visit amounts were estimated using 2011 cost report information inflated by the CY2012 and CY2013 market basket updates. The estimated average 2013 cost per visits was between 19.5% and 33.1% (depending on the discipline) greater than the LUPAs in CY2013. To reconcile this underpayment between payment per visit and cost per visit, the LUPA for the six disciplines would have required an annual increase that exceeded 3.5% of the LUPAs in CY2010; therefore, for CY2014 through 2017, the LUPA for each discipline will be increased at 3.5% of each discipline's 2010 reimbursement level. The annual increase for each discipline's LUPA varies in dollar terms—from a low of $1.79 increase each year for home health aides to a high of $6.34 increase each year for medical social workers.

LUPA episodes that occur as the only episode or occur as the initial episode in a series of adjacent episodes receive an add-on payment to reimburse the additional upfront costs associated with a beneficiary's first home health visit. For CY2014, the LUPA add-on payment is $99.89 and can be increased if the initial visit of a LUPA episode is provided by a skilled nurse, physical therapist, or speech language pathologist. LUPA is also adjusted by the wage index to account for area wage differences.

Examples of Home Health Prospective Payment System Reimbursement

To better understand the HH PPS, the following are a few hypothetical reimbursement calculations. **Figure 3** provides an example of an episode reimbursement for home health services provided in an urban area and **Figure 4** provides an example of an episode reimbursement for home health services provided in a rural area.

Figure 3 provides an example of how much an HHA would be reimbursed by Medicare for a first or second episode of care to a beneficiary living in Los Angeles who was classified with high

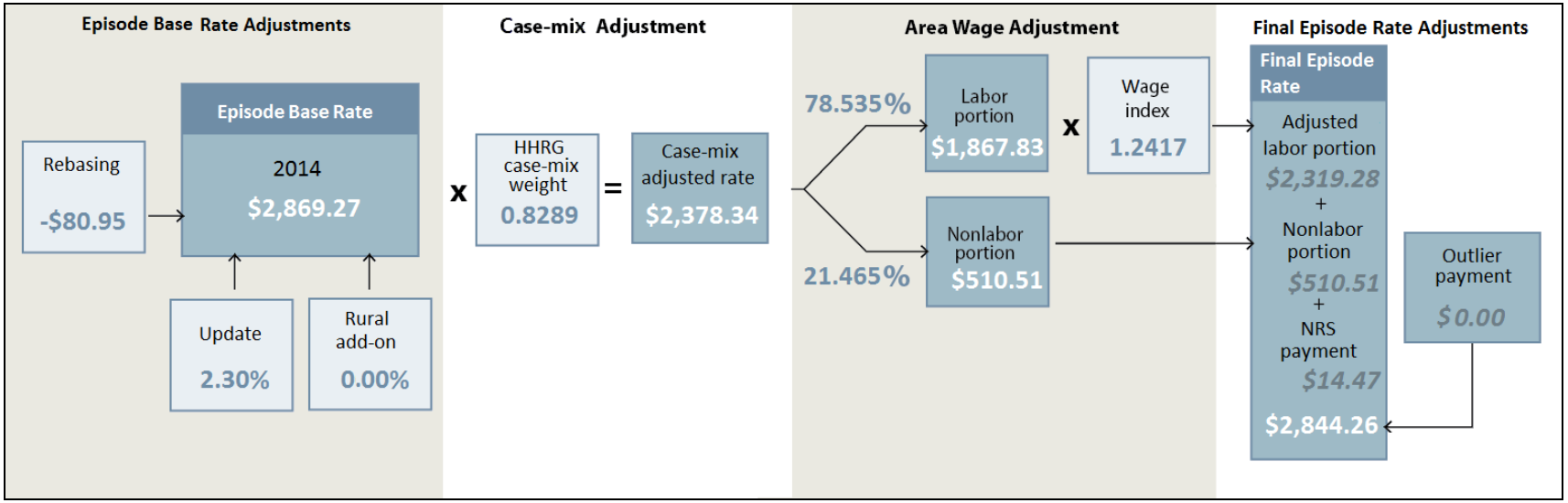
[53] Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update for Calendar Year 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses," 78 *Federal Register* 72304, December 2, 2013.

clinical severity and moderate functional severity, and who received no therapy visits. As shown in **Figure 3**, the prior year's episode base rate receives a reduction of $80.95 as part of the episode rebasing and a market basket update of 2.3% to create the CY2014 episode base rate of $2,869.27. There are no further adjustments to the episode base rate since the services are provided in an urban area, there is no adjustment for nominal case-mix growth in CY2014, and the HHA submitted the quality data elements to the Medicare claims contractor. The CY2014 episode base rate is multiplied by the applicable HHRG case-mix weight to create the case-mix adjusted rate. The case-mix adjusted rate is then split between the labor-related share, which is multiplied by the wage index for Los Angeles, and the non-labor-related share. The final episode rate is calculated by summing the adjusted labor-related share, non-labor-related share, and an NRS payment at the minimum severity level. There are no outlier payments or PEP adjustments for this calculation.

For comparison, **Figure 4** provides an additional example of how much an HHA would be reimbursed by Medicare for the third episode of care provided to a beneficiary living in a rural California area, who was classified with moderate clinical severity and moderate functional severity, and who received 10 therapy visits. As shown in **Figure 4**, the prior year's episode base rate receives a reduction of $80.95 as part of the episode rebasing and a market basket update of 2.3% and a rural add-on increase of 3% to create the CY2014 episode base rate of $2,955.35. There are no further adjustments to the episode base rate for nominal case-mix growth or for failing to submit quality data. The CY2014 episode base rate is multiplied by the applicable HHRG case-mix weight to create the case-mix adjusted rate. The case-mix adjusted rate is then split between the labor-related share, which is multiplied by the wage index for rural California, and the non-labor-related share. The final episode rate is calculated by summing the adjusted labor-related share, non-labor-related share, and an NRS payment at the minimum severity level (which has also received the rural add-on increase). There are no outlier payments or PEP adjustments for this calculation.

Figure 3. CY2014 Home Health Prospective Payment System

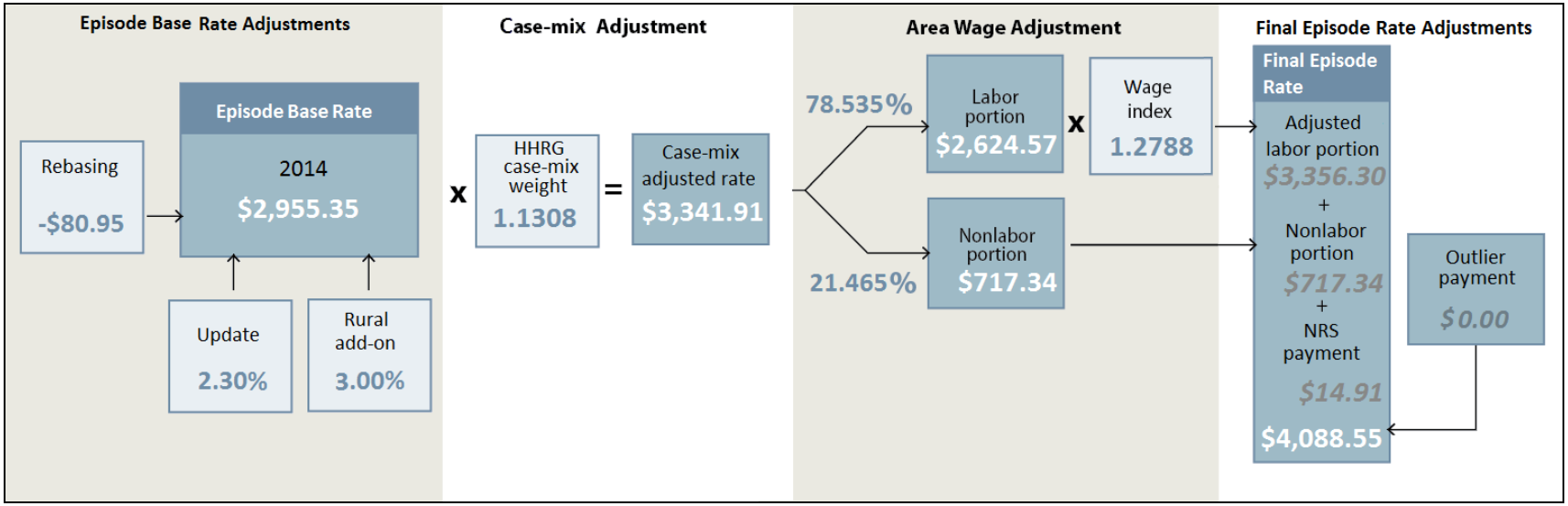
(urban example)



Source: CRS analysis of Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update for Calendar Year 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses," 78 *Federal Register* 72256, December 2, 2013.

Figure 4. CY2014 Home Health Prospective Payment System

(rural example)



Source: CRS analysis of Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update for Calendar Year 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses," 78 *Federal Register* 72256, December 2, 2013.

Medicare Home Health Financial Trends

Total Medicare FFS home health payments increased from $8.5 billion in 2001 to roughly $18.4 billion in 2011—an average annual rate of growth of 8.0%.[54] Between 2001 and 2011, the rate of FFS enrollees who used the Medicare home health benefit increased by 33.8%, from a rate of 71 per 1,000 FFS enrollees to 95 per 1,000 FFS enrollees.[55] While the episode base rate increased by a total of 3.7% from FY2001 to CY2011 ($2,115.30 to $2,192.07), the Medicare home health payments per user increased from $3,545 in 2001 to $5,357 in 2011, a 51% increase at an average rate of growth of roughly 4.2% per year.[56] The change in home health payments per user may reflect the increase in case-mix classification and the increase in the number of episodes per home health user (from 1.6 episodes per home health user in 2002 to 2.0 in 2011).[57]

Home Health Margins

Under the HH PPS, freestanding HHAs have had consistently high Medicare margins—the percentage difference in Medicare home health payments relative to the HHA's costs in providing home health services to beneficiaries (a positive margin is a profit, a negative margin a loss). In 2003, the aggregate Medicare margin for freestanding HHAs was 13.6%, as shown in **Table 2**.[58] Prior to 2011, the aggregate Medicare margin for freestanding HHAs had increased to 19.1% in 2010 before declining to 14.8%. The drop in Medicare margins in 2011 is most likely attributed to the reduction in Medicare's home health reimbursement from nominal case-mix adjustments and required ACA reductions. Among freestanding HHAs, 75% of freestanding HHAs had a Medicare margin at or greater than -0.3%, and 25% of freestanding HHAs had a Medicare margin at or greater than 22.8%.[59] Due to higher overhead costs (e.g., rent, insurance), hospital-based HHAs had a lower aggregate Medicare margin of -10.9% in 2011. MedPAC has suggested that HHAs with high margins have relatively lower costs, which may be attributed to economies of scale from higher patient volume. Additionally, in the March 2009 *Report to the Congress*, MedPAC cautioned that "(t)o the extent that these high margins reflect profits that stem from high payments, these margins suggest that neither beneficiaries nor taxpayers are receiving appropriate value for the funds Medicare spends on home health."[60]

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[54] Centers for Medicare & Medicaid Services, *Health Care Financing Review 2012 Medicare and Medicaid Statistical Supplement*, Table 3.3.

[55] Ibid., Table 7.1.

[56] Centers for Medicare & Medicaid Services, "Medicare Program; Home Health Prospective Payment System for Home Health Agencies," 65 *Federal Register*, July 3, 2000; Centers for Medicare & Medicaid Services, "Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011," 75 *Federal Register*, November 7, 2010; Centers for Medicare & Medicaid Services, *Health Care Financing Review 2012 Medicare and Medicaid Statistical Supplement*, Table 7.1.

[57] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013, p. 195, http://www.medpac.gov/chapters/Mar13_Ch09.pdf.

[58] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2005, p. 111, http://www.medpac.gov/publications%5Ccongressional_reports%5CMar05_Ch02d.pdf

[59] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013, p. 201, http://www.medpac.gov/chapters/Mar13_Ch09.pdf.

[60] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2009, p. 190, http://www.medpac.gov/chapters/Mar09_Ch02E.pdf.

Table 2. Aggregate Freestanding Home Health Agency Medicare Margins, 2003-2011

Type of HHA	2003	2004	2005	2006	2007	2008	2009	2010	2011
All	13.6%	16.0%	17.3%	15.9%	16.5%	17.0%	18.2%	19.1%	14.8%
Urban	14.1	15.9	16.5	16.5	16.7	17.3	18.5	19.1	14.8
Rural	10.6	11.8	14.1	15.8	15.4	16.0	17.0	19.4	15.3
For profit	n.a.	18.1	19.2	19.3	18.3	18.6	19.8	20.3	15.7
Nonprofit	n.a.	12.4	13.8	13.9	12.0	12.3	13.6	15.1	12.2

Source: Medicare Payment Advisory Commission Report to the Congress: *Medicare Payment Policy*, 2005-2013.

Notes: A Medicare margin is the percentage of total Medicare home health payments that exceed the costs of home health services to beneficiaries. N.a. = not available. Determination of an urban or rural HHA is based on the majority of the HHA's patients' location.

Part A and Part B Home Health Payments

In addition to Medicare margin trends, Medicare Part B home health expenditures have seen a noticeable increase relative to Part A home health expenditures. As noted earlier, Medicare Part A provides payment for the first 100 visits within 14 days of a beneficiary's discharge from a three-day inpatient hospital stay or SNF stay, or for all home health episodes if the beneficiary has not enrolled in Medicare Part B. For beneficiaries who have enrolled in Medicare Part B (roughly 93% of Medicare beneficiaries in recent years), Part B would provide payment in all other instances.

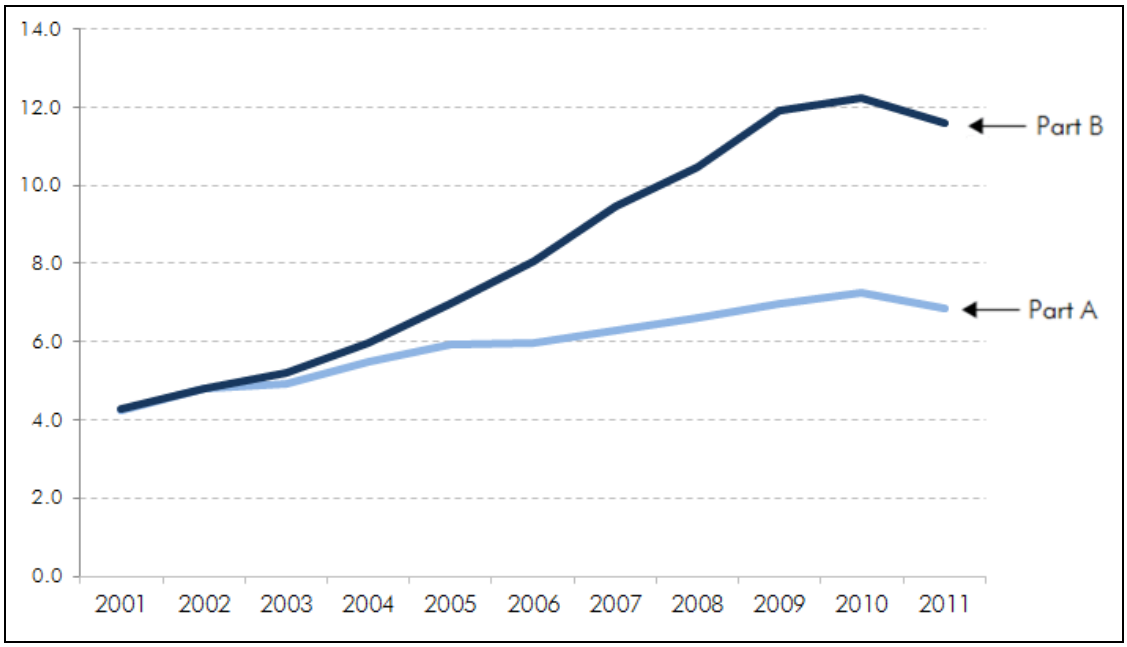
Between 1981 and 1998, nearly all of Medicare-covered home health services were reimbursed under Medicare Part A. BBA 97 included a provision that gradually transferred some home health expenditures from Part A to Part B. For beneficiaries enrolled in Part B who received home health services that were not associated with a prior hospital or SNF stay, Part B provided payment. As shown in **Figure 5**, since the HH PPS was implemented on October 1, 2000, Medicare Part B home health expenditures have increased at a faster rate than Part A home health expenditures. Between 2001 and 2011, total Medicare home health expenditures (Parts A and B) increased at an average annual rate of 8.0%.[61] Over the same time period, Part A home health expenditures increased at an average annual rate of 5% while Part B home health expenditures have increased at an average annual rate of 10.5%. In 2001, Medicare paid approximately $8.5 billion in home health services, with $4.2 billion under Part A and $4.3 billion under Part B. In 2011, Medicare expenditures on home health were $18.4 billion, with approximately $6.8 billion under Part A and approximately $11.6 billion under Part B.[62] While home health expenditures have increased at an average rate of 8.0% per year since 2001, in 2011, home health expenditures under Parts A and B declined from their 2010 levels. This decline in home health expenditures could be the result of payment reductions from nominal case-mix growth and ACA-required reductions or new documentation requirements also included in the ACA (see "Patient Protection and Affordable Care Act (ACA, P.L. 111-148)" in the **Appendix** for more information.)

[61] Centers for Medicare & Medicaid Services, *Health Care Financing Review, Medicare and Medicaid Statistical Supplement 2003-2012.*

[62] The amount of Hospital Insurance Home Health Services Payments in the 2012 Medicare & Medicaid Research Review Statistical Supplement is $6,867 million. This figure was rounded downwards to be consistent with other total Medicare home health expenditures of $18.4 billion found in Table 3.3 of the 2012 Medicare & Medicaid Research Review Statistical Supplement and MedPAC's March 2013 Report to Congress.

Figure 5. Home Health Expenditures by Part A and B, 2001-2011

(in billions of U.S. dollars)



Source: CRS analysis of data from the Centers for Medicare & Medicaid Services, *Health Care Financing Review, Medicare and Medicaid Statistical Supplement 2003-2012.*

Notes: The Balanced Budget Act of 1997 required a gradual transfer of previously Part-A covered home health services to Part B. The types of home health episodes transferred to Part B are episodes that were not preceded by a hospitalization or SNF stay or exceeded the 100-visit Part A cap. BBA 97 required home health services covered under Part B phase-in to be complete beginning in 2003.

The rapid increase in Part B home health expenditures may be a result of a changing home health population. In 2001, beneficiaries with a prior hospitalization (and were most likely reimbursed under Part A) represented 48% of all home health episodes, while community-admitted home health episodes (and generally reimbursed under Part B) represented 52%.[63] By 2010, only 34% of home health episodes were for beneficiaries who had a prior hospitalization. Additionally, subsequent community-admitted home health episodes (a second or additional 60-day episode[s]) increased from a 32% share of all home health episodes in 2001 to a 46% share of all home health episodes in 2010. In summary, the distribution of home health services has shifted toward beneficiaries that are generally admitted from the community rather than an institution and receiving home health services for longer periods of time.

Geographic Distribution of Part A and Part B Home Health Payments

Another notable difference between Part A payments for home health and Part B payments for home health is the geographic variation in per user expenditures at the county level. Part A home health payments per user have less variation at the county level when compared to Part B home health payments and the high expenditure outliers are less concentrated in a particular region. To illustrate this difference, **Figure 6** and **Figure 7** categorize counties in terms of Medicare standardized home health payments per user by the number of standard deviations from the

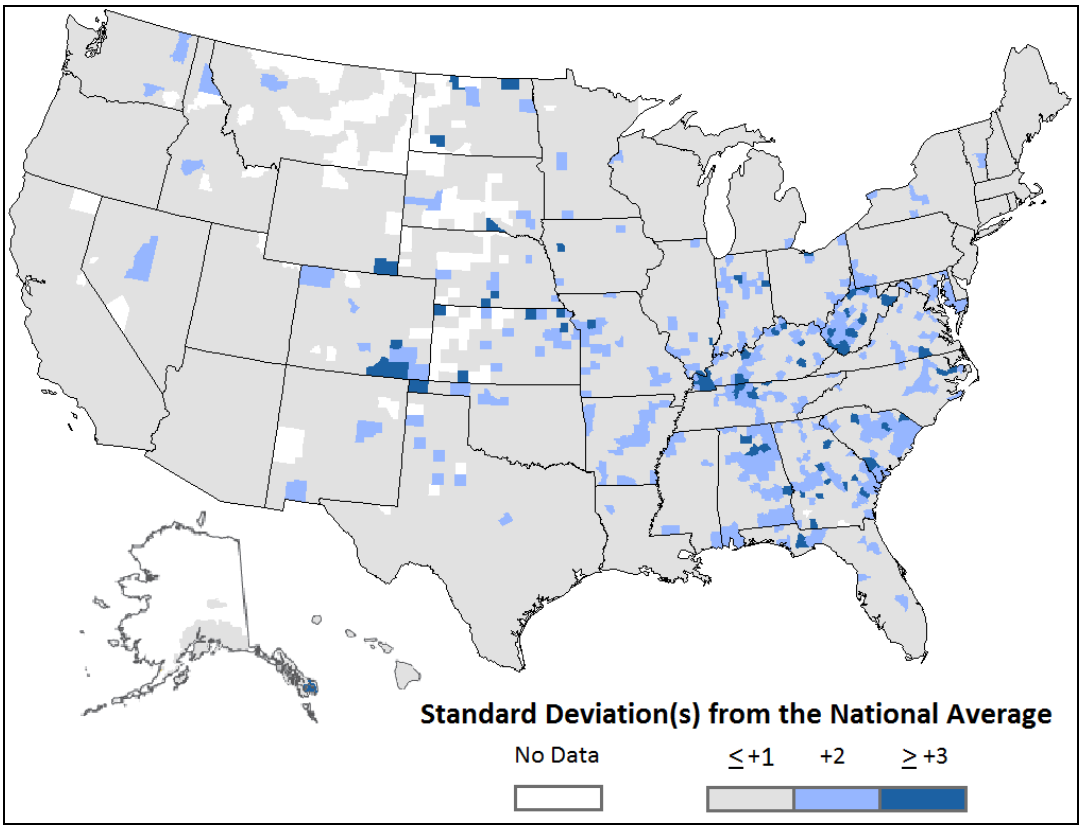
[63] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013, p. 196, http://www.medpac.gov/chapters/Mar13_Ch09.pdf.

national average. Standardized home health payments are Medicare payments for home health services that have removed geographic wage adjustments that are included in the PPS. Such payments are then divided by the number of beneficiaries who used Medicare-covered home health services to calculate standardized home health payments per user. For each county, standardized home health payments per user reflects both the differences in the home health user population and the volume of home health episodes per user.

Figure 6 illustrates Part A standardized payments per home health users enrolled in Medicare Parts A and B by county in 2011. For Part A, the national average home health payment per user is $2,125 and three standard deviations more than the average is at least $3,007. In 2011, 78 counties in 22 different states contained the counties with at least three standard deviations more than the national average. West Virginia, Kentucky, and Georgia were the states with the largest concentration and comprised 34 of the 78 (44%) counties within this category.

Figure 6. Standardized Part A Home Health Payments per User in 2011

(by county)



Source: CRS analysis of data provided by the Centers for Medicare & Medicaid Services on September 13, 2013.

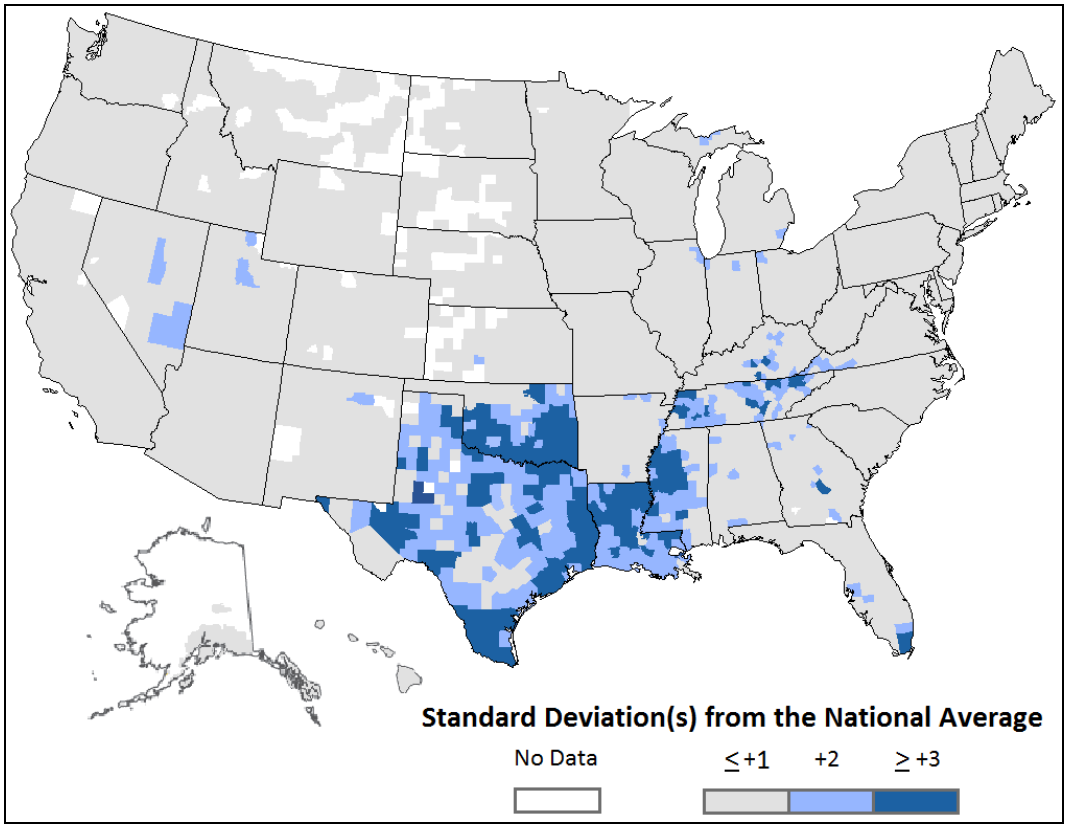
Notes: Data excludes beneficiaries only enrolled in Part A or Part B. Counties are categorized based on the number of standard deviations from the Part A standardized home health spending per user national average. Data may be unavailable for certain low population counties. Standardized data removes required geographic wage adjustments to home health payments for comparison of spending patterns across different labor markets.

Figure 7 illustrates standardized Part B home health payments by home health users enrolled in Medicare Parts A and B by county in 2011. For Part B, the national average home health payment per user is $3,070 and three standard deviations more than the national average is at least $6,843. In 2011, eight different states contained the 197 counties in which payments were at least three standard deviations from the national average; however, all but 6 of the 197 counties (97%) were

concentrated in five of the eight states: Louisiana, Mississippi, Oklahoma, Tennessee, and Texas. A similar type of concentration of total home health episodes (both Parts A and B) has been noted by MedPAC. In MedPAC's March 2013 *Report to Congress*, the top five states in terms of home health utilization (Florida, Louisiana, Mississippi, Oklahoma, and Texas) accounted for 35% of home health episodes despite accounting for only 17% of beneficiaries.[64] Additionally, at the county level, a number of counties within high utilization states had average home health episodes per user at or greater than 4.0—at least twice the national average of 2.0 episodes per user.

Figure 7. Standardized Part B Home Health Payments per User in 2011

(by county)



Source: CRS analysis of data provided by the Centers for Medicare & Medicaid Services on September 13, 2013.

Notes: Data excludes beneficiaries only enrolled in Part A or Part B. Counties are categorized based on the number of standard deviations from the Part B standardized home health spending per user national average. Data may be unavailable for certain counties. Standardized data removes required geographic wage adjustments to home health payments for comparison of spending patterns across different labor markets.

Issues for Congress

Recent efforts to increase payment efficiency and improve quality for the Medicare home health benefit have been recommended to Congress for consideration. Various deficit reduction

[64] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013, p. 199, http://www.medpac.gov/chapters/Mar13_Ch09.pdf.

proposals have recommended cost-sharing for beneficiaries receiving covered home health episodes in an effort to encourage appropriate utilization. Additionally, as required by ACA, CMS recently issued a plan to implement a value-based purchasing (VBP) program for HHAs in addition to the existing Medicare VBP programs currently being implemented for acute-care hospitals and physicians. The home health VBP program is an effort to base Medicare payments on quality of care delivered to beneficiaries and has been recommended by MedPAC. Further, additional issues for congressional consideration stems from a proposed settlement agreement, which requires CMS to revise its existing Medicare benefit guidelines as a result of a recent class-action lawsuit between HHS and the Center for Medicare Advocacy, and the temporary moratoria on new HHAs in targeted geographic areas. These issues are explained in more detail below.

Cost-Sharing for Home Health Services

Currently, the home health benefit does not require beneficiary cost-sharing for home health services. Originally, home health services covered under Part B were subject to a 20% coinsurance of the Medicare-approved amount and the Part B deductible. The Social Security Amendments of 1972 (P.L. 92-603) eliminated the 20% coinsurance, and the Omnibus Budget Reconciliation Act of 1980 (OBRA 80, P.L. 96-499) eliminated the Part B deductible for home health services. Reintroducing cost-sharing for home health services has been recommended and/or analyzed as a deficit reduction policy. Below are different home health cost-sharing proposals and/or analyses:

- In the March 2013 *Report to the Congress*, MedPAC recommended introducing an episode copayment for non LUPA episodes not preceded by a hospitalization or other post-acute care use.[65] MedPAC estimated that introducing a copayment in 2014 of $150 per 60-day episode would reduce Medicare spending between $1 billion and $5 billion over five years.
- To assist the Joint Select Deficit Reduction Committee, the Bipartisan Policy Center released a set of recommendations that included policies related to Medicare savings.[66] One recommendation suggested introducing copayments for home health services. The Bipartisan Policy Center's proposal included an estimated savings of $40 billion over 10 years. The proposal did not specify the amount of the copayment or if the copayment would apply to a LUPA episode or an episode following a hospitalization.
- The President's FY2014 budget included a proposal to introduce $100 copayment per home health episode for newly enrolled beneficiaries beginning in 2017.[67] Similar to MedPAC, the copayment would apply to non LUPA episodes that were not preceded by a hospitalization. The Congressional Budget Office (CBO) estimated this proposal would reduce Medicare spending by $700 million between 2014 and 2023.[68]

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[65] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013, p. 209, http://www.medpac.gov/chapters/Mar13_Ch09.pdf.

[66] Bipartisan Policy Center, *How to "go big" within the Budget Control Act (BCA) Framework*, p. 2, http://bipartisanpolicy.org/sites/default/files/3-step%20Compilation.pdf.

[67] Office of Management and Budget, *The President's Plan for Economic Growth and Deficit Reduction*, September 2011, p. 39, http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf.

[68] Congressional Budget Office, *Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's 2014 Budget*, May 17, 2013, http://www.cbo.gov/publication/44247.

- While CBO does not recommend proposals, it does provide options for congressional consideration. In its March 2011 publication on deficit reduction options, CBO included an option to require coinsurance for Medicare home health.[69] According to CBO, a coinsurance amount equal to 10% per home health episode, which CBO estimated would cost on average $600 per beneficiary, implemented in 2013, would reduce the deficit by $40 billion over 10 years (between 2012 and 2022). The proposal did not specify if copayments would apply to LUPA episodes or episodes following a hospitalization.

As noted by MedPAC, increased cost-sharing for home health episodes may decrease Part B home health expenditures which in turn could lead to lower Part B premiums (since Part B premiums are determined, in part, by expected Part B expenditures).[70] Additionally, state and federal Medicaid expenditures may increase from covering the copayments of Medicare home health users who are also entitled to Medicaid coverage.[71] Further, home health copayments may increase Medicare supplemental policies' expenditures, thereby increasing Medicare supplemental policy premiums.[72]

Beneficiary advocates contend that some beneficiaries who would have to pay for the copayments themselves will forgo needed home health services, which may lead to more expensive hospitalizations.[73] It is unclear whether or not including home health cost-sharing requirements will raise current hospitalization rates. According to MedPAC, roughly 30% of home health users are hospitalized during their home health stay or within 30 days following their discharge from the HHA.[74] The prominent diagnoses among home health beneficiaries who are hospitalized are respiratory infection, urinary tract infection, and heart failure.

Home Health Value-Based Purchasing Program

ACA required the Secretary of HHS to establish plans for implementing a value-based purchasing (VBP) program for the Medicare home health benefit.[75] A VBP program can reward providers based upon established quality measures. CMS considers VBP programs to be an important step towards rewarding providers based on quality and efficiency.[76] VBP programs are currently being implemented or will be implemented in other Medicare payment systems (e.g., acute-care hospitals, physicians).

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[69] Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options*, Pub. No. 4212, March 10, 2011, p. 48, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf.

[70] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2012, p. 217, http://www.medpac.gov/chapters/Mar12_Ch08.pdf. For further information on Medicare Part B premiums, see CRS Report R40082, *Medicare: Part B Premiums*.

[71] For more information on the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*.

[72] Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options*, Pub. No. 4212, March 10, 2011, p. 48, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf.

[73] Center for Medicare Advocacy, *CMA Alerts: The President's Proposed 2013 Budget: Impact on Medicare*, February 17, 2012, http://www.medicareadvocacy.org/2012/02/17/the-presidents-proposed-2013-budget-impact-on-medicare/.

[74] Medicare Payment Advisory Commission, "Reducing the hospitalization rate for Medicare beneficiaries receiving home health care," transcript, November 1, 2012, http://www.medpac.gov/transcripts/Nov2012Transcript.pdf.

[75] Section 3006 of the ACA.

[76] Centers for Medicare & Medicaid Services, *Report to Congress: Plan to Implement a Medicare Home Health Agency Value-Based Purchasing Program*, March 2012, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Stage-2-NPRM.pdf.

In 2012, CMS released the *Report to the Congress: Plan to Implement a Medicare Home Health Agency Value-Based Purchasing Program*, which highlighted several elements as important to designing and implementing a VBP program for the Medicare home health benefit. One consideration will be the performance measures used to score HHA quality. The National Quality Forum (NQF), a public-private nonprofit organization, has already endorsed several measures currently used on the Home Health Compare website.[77] Such measures include a clinical domain (e.g., improvement in walking/bathing), a process domain (e.g., whether or not the beneficiary received an influenza immunization), a utilization domain (e.g., whether or not the beneficiary was hospitalized), and beneficiaries' rating of the HHA's care.[78]

An additional consideration will be how the financial incentives of a VBP program (e.g., penalties and/or rewards) are implemented and how the quality targets or benchmarks are determined (e.g., exceeding a certain score/rank, improvement in score/rank over time). In a 2007 *Report to the Congress*, MedPAC provided some recommendations for the financial aspect of a VBP program for the home health benefit.[79] MedPAC recommended that the VBP program be budget-neutral—redistributing 1% to 2% of total home health payments from poor performers to high performers. The commission also recommended that high performers be based on attaining or exceeding certain benchmarks and a benchmark for improvement.

Jimmo v. Sebelius and the "Improvement Standard"[80]

In January 2011, the Center for Medicare Advocacy filed a class-action lawsuit, *Jimmo v. Sebelius*,[81] against HHS claiming that the Medicare program had improperly denied thousands of beneficiaries coverage for a range of skilled care services because they could not show that their health would improve. This so-called "improvement standard" was a sub-regulatory rule-of-thumb used by some Medicare claims contractors over the past several decades, which required that persons with chronic conditions and disabilities show a likelihood of medical or functional improvement before Medicare would pay for skilled care and therapy services in the home or institutional setting.[82] This "improvement standard" effectively denied coverage for home health care, SNF care, and outpatient therapy services on the basis that an individual was not improving.

Neither the Medicare statute nor its implementing regulations[83] require beneficiaries to show a likelihood of improvement, and, in the lawsuit, Medicare officials denied that such a policy exists. However, some provisions of the Medicare Benefit Policy Manual suggest coverage should be denied or terminated if a patient reaches a plateau or is not improving or is stable. In

[77] NQF is a voluntary consensus standards-setting organization with the mission of improving the quality of health care, specifically through setting national goals for improvement, through endorsing quality measures, and through education and outreach to facilitate the realization of the quality goals it has recommended. Currently, NQF is the only body that meets the criteria of a voluntary consensus standards-setting organization for health quality measures.

[78] Centers for Medicare & Medicaid Services, *Report to Congress: Plan to Implement a Medicare Home Health Agency Value-Based Purchasing Program*, March 2012, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Stage-2-NPRM.pdf.

[79] Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare*, June 2007, p. 79, http://www.medpac.gov/chapters/Jun07_Ch04.pdf

[80] This section was written by Kathleen S. Swendiman, legislative attorney in the American Law Division, Congressional Research Service.

[81] Jimmo v. Sebelius, (No. 11-cv-17 (D.Vt.), filed January 18, 2011.

[82] G. Deford, M. Murphy, J. Stein, *How the "Improvement Standard" Improperly denies Coverage to Medicare Patients*, 43 Clearinghouse Rev. 422 (Jan.-Feb. 2010).

[83] *See* 42 C.F.R. §409.32(c), 42 C.F.R. §409.44(b)(3)(iii), 42 C.F.R. §409.44(c).

addition, coverage denials by contractors processing claims allegedly included such language as "maintenance services only," "chronic," or "medically stable."[84] This standard affected many Medicare beneficiaries with disabilities and chronic conditions such as stroke, Alzheimer's disease, multiple sclerosis, traumatic brain injury, and Parkinson's disease. Many of these patients were denied coverage for skilled services needed to manage their chronic condition, maintain their existing function, and/or prevent or limit deterioration of function, because of the "improvement standard."

On January 24, 2013, a federal district court in Vermont granted final approval of a proposed settlement agreement in *Jimmo v Sebelius*.[85] The agreement requires CMS to revise its existing guidelines in the Medicare Benefit Policy Manual for the home health benefit, as well as for the SNF, outpatient therapy, and inpatient rehabilitation facility benefits.[86] Specifically, the manual's revisions for the home health benefit would be clarified to provide that home health coverage is based on an individualized assessment of the beneficiary's medical condition and need for skilled care, and not on whether the beneficiary's condition has the potential to improve, even if the therapy would simply maintain the beneficiary's current condition or slow further deterioration. While a showing that a patient's condition is expected to improve would no longer be required for home health care, a physician would still be required to certify that the patient is, in fact, homebound, and could prescribe treatment that only a skilled practitioner can provide. Further, CMS would be required to implement a nationwide educational campaign to communicate the revised standards to providers, contractors, and adjudicators.

It is unclear how the settlement would affect home health eligibility, utilization, and subsequent Medicare expenditures. There is currently no adequate estimate of the number of home health claims that are denied due to the misinterpretation of Medicare provisions or the amount of home health coverage that was forgone by providers in anticipation of a claims rejection. However, regarding the proposed settlement agreement, Robert Resichauer, a trustee of the Medicare program, was quoted in *The New York Times* regarding the "improvement standard" settlement saying "(u)nquestionably that would increase costs."[87] Others argue that the change could save money for Medicare by increasing access to covered home health services, thereby reducing beneficiaries' need for more expensive care in hospitals and skilled nursing facilities.[88]

Temporary Moratorium on New Home Health Agencies

As a fraud and abuse prevention measure, Section 6401 of the ACA provided the Secretary the authority to impose temporary moratoria on the enrollment of new Medicare, Medicaid, or State Children's Health Insurance Program (CHIP) providers and suppliers, including categories of providers and suppliers. The Secretary may impose such a temporary moratorium on newly

[84] *See* Center for Medicare Advocacy, Inc., *Lawsuit Filed to Block Illegal Denials of Services to Medicare Patients with Chronic Illness*, press release, January 18, 2011, at http://www.medicareadvocacy.org/2011/01/18/lawsuit-filed-to-block-illegal-denials-of-services-to-medicare-patients-with-chronic-illness/.

[85] The order granting final approval of the settlement is available at http://www.medicareadvocacy.org/wp-content/uploads/2013/01/Order-Granting-Final-Approval.012413.pdf

[86] *See* an update on *Jimmo v. Sebelius* by the Center for Medicare Advocacy, November, 1, 2012. http://www.medicareadvocacy.org/2012/11/01/jimmo-v-sebelius/.

[87] Robert Pear, "Accord To Ease Medicare Rules In Chronic Cases," *The New York Times*, October 22, 2012, p. A1, New York edition.

[88] Center for Medicare Advocacy, Inc., "Lawsuit Filed to Block Illegal Denials of Services to Medicare Patients with Chronic Illness," press release, January 18, 2011, http://www.medicareadvocacy.org/2011/01/18/lawsuit-filed-to-block-illegal-denials-of-services-to-medicare-patients-with-chronic-illness/.

enrolling Medicare providers or suppliers if they determine that there is a significant potential for fraud, waste, or abuse with respect to a particular provider/supplier type, a particular geographic area, or both.[89] The moratorium would last six months in duration and may be extended in six-month increments. A moratorium may be lifted if the Secretary believes the moratorium is no longer needed (e.g., the potential for fraud has been abated) or an emergency situation arises.[90]

Effective July 30, 2013, CMS issued temporary moratoria on HHAs applying to participate in the Medicare, Medicaid, or CHIP programs from the Chicago and Miami areas.[91] These moratoria were implemented due to the large increase in the number of HHAs in the Miami and Chicago areas compared to the national average, the high ratio of HHAs to Medicare FFS beneficiaries when compared to similar areas, and the high average Medicare home health per user payment when compared to similar areas. Additionally, CMS announced it would continue the moratoria in the Chicago and Miami areas for an additional six months, and, effective January 30, 2014, expand the moratoria to new HHAs applying to participate in Medicare, Medicaid or CHIP in four additional areas: Broward County, FL, and the Dallas, Detroit, and Houston metropolitan areas.[92] CMS analyses showed target areas: Broward County, FL; Wayne County, MI (which contains the City of Detroit); Dallas County, TX (which contains the City of Dallas); and Harris County, TX (which contains the City of Houston), consistently ranked near the top of potential fraud risk metrics.[93] CMS expanded the target areas to include bordering counties to prevent the relocation of potential fraudulent providers to new geographic areas. In addition to the moratoria, CMS continues to implement other fraud prevention measures, such as payment suspensions and revocation of provider/supplier numbers in target areas.

Concluding Observations

With the establishment of Medicare, the home health benefit has been traditionally categorized as a "post-acute care" benefit. However, home health coverage is provided to beneficiaries whether or not they have had a recent hospitalization. Prior regulatory and legislative changes have expanded Medicare's home health services and eligibility requirements, as well as eliminated cost-sharing requirements. Many of the changes to the home health benefit were in response to efforts of deinstitutionalization, moving individuals out of nursing facilities and back into the community, as well as avoiding hospitalizations.[94]

In 2001, beneficiaries with a prior hospitalization represented 48% of all home health episodes. By 2010, only 34% of home health episodes were for beneficiaries who had a prior hospitalization. While more initial home health episodes are certified to beneficiaries who were

[89] See 42 C.F.R. §424.570 for more information on the moratoria.

[90] Such a situation would be if the President declares an area a disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act or the Secretary has a declared a public health emergency under Section 319 of the Public Health Services Act in the area subject to the temporary moratorium.

[91] Centers for Medicare & Medicaid Services, "Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Temporary Moratoria on Enrollment of Ambulances Suppliers and Providers and Home Health Agencies in Designated Geographic Locations," 78 *Federal Register* 46339, July 31, 2013.

[92] Centers for Medicare & Medicaid Services, "Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of New and Extended Temporary Moratoria on Enrollment of Ambulances and Home Health Agencies in Designated Geographic Locations," 79 *Federal Register* 6475, February 4, 2014.

[93] Such fraud risk metrics include above average increase in the number of HHAs, high ratios of HHAs to Medicare FFS beneficiaries, and high average Medicare home health per user payments.

[94] U.S. Congress, House Select Committee on Aging, Subcommittee on Health and Long Term Care, *Home Health Care for the Elderly*, 96th Cong., 1st sess., August 13, 1979 (Washington: GPO, 1979), p. 2.

recently hospitalized (1.9 million episodes in 2010) than for beneficiaries admitted from the community (1.3 million episodes in 2010), most home health episodes over an entire year are provided to beneficiaries who did not have a prior hospitalization.[95] In 2010, for home health users who had a prior hospitalization, Medicare covered roughly 500,000 subsequent (second or greater) home health episodes following the beneficiaries' initial episode, an increase from 300,000 in 2001. For home health users admitted from the community, Medicare covered roughly 3.2 million subsequent home health episodes, an increase from 1.3 million subsequent episodes in 2001. These figures may suggest that Medicare is providing a greater amount of home health coverage to beneficiaries suffering from chronic illnesses, who may require longer treatment plans than beneficiaries recovering from acute illnesses.

Additionally, since the implementation of the HH PPS in October 2000, Medicare FFS home health payments have grown rapidly at an average annual rate of 8.0% between 2001 and 2011. Additionally, the aggregate Medicare margin for freestanding HHAs has remained consistently high: 13.6% in 2003 and 14.8% in 2011. The high rate of Medicare margins may suggest that estimating the costs of home health services through the HH PPS proves to be difficult. This difficulty may arise from large variation in agency costs of home health care, even after controlling for a beneficiary's clinical and functional factors. Further, the decline in the share of home health services that are related to prior hospital and SNF stays and the resulting rise in Medicare Part B expenditures and the notable difference in geographic variation of Part B per user payments, as shown in **Figure 7**, may illustrate the changing care needs and geographic differences in health status among Medicare beneficiaries. However, it may also point to potential overutilization, as noted by MedPAC, and the potential complexity in administering home health eligibility criteria where some may look to changes in the Medicare home health benefit and home health payment policy that address greater payment efficiencies.[96]

[95] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2012, p. 219, http://www.medpac.gov/chapters/Mar12_Ch08.pdf.

[96] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013, p. 199, http://www.medpac.gov/chapters/Mar13_Ch09.pdf.

Appendix. Legislative History of Selected Changes to the Medicare Home Health Benefit

The appendix summarizes selected key changes to the home health benefit that have been included in the following pieces of legislation.

Social Security Amendments of 1965 (P.L. 89-97)

Title XVIII of the Social Security Amendments of 1965 established the Medicare program. The legislation provided eligible Medicare beneficiaries with up to 100 "post-hospital" home health visits each year under Part A and up to 100 home health visits each year under Part B. Medicare provided payment for each covered home health visit based on reasonable costs the HHA incurred, up to certain limits. To be eligible for home health visits under Part A or Part B, beneficiaries must have been in need of part-time or intermittent skilled nursing care or physical, occupational, or speech therapy, with a plan of care established 14 days after discharge. At that time, to be eligible for home health visits under Part A, beneficiaries must have had a three-day inpatient hospital stay. No hospitalization requirement was necessary for Part B home health coverage; however, beneficiaries were required to enroll in Part B to receive home health coverage under Part B. Home health services covered under Part B were subject to the Part B deductible and a 20% coinsurance of the Medicare-approved cost of care.

Social Security Amendments of 1972 (P.L. 92-603)

A provision in the Social Security Amendments of 1972 eliminated the 20% coinsurance requirement for Part B covered home health services beginning on or after January 1, 1973.

Omnibus Budget Reconciliation Act of 1980 (OBRA 80, P.L. 96-499)

OBRA 80 eliminated the annual 100 home health visit limitation for both Parts A and B. The Part A 3-day inpatient hospitalization requirement was eliminated and Part B home health services were no longer subject to the Part B deductible. With the elimination of the 3-day hospitalization requirement, both Parts A and B had the same home health eligibility requirements. The parity in eligibility requirements transferred nearly all of Medicare Part B home health expenditures (except for beneficiaries who were only covered under Part B) to Part A because Section 1833(d) of the Social Security Act prohibits Part B paying for services that could also be covered under Part A.

Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)

With the passage of BBA 97, Congress reallocated some of Medicare home health expenditures from Part A to Part B. Medicare Part A provided payment if a beneficiary did not enroll in Part B and/or received home health services 14 days after discharge from a 3-day inpatient hospitalization or SNF. Part B provided payment for covered home health services in all other instances. Beginning October 1, 1997, BBA 97 established an interim payment system that reduced the Medicare reimbursement limits for home health services. Beginning on or after October 1, 1999 (but implemented on October 1, 2000), BBA 97 required a home health prospective payment system (HH PPS) to supplant the interim payment system and reimburse home health agencies (HHAs) based upon a beneficiary's expected care needs and geographic location, among other factors.

Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554)

BIPA established a 10% increase to the episode base rate for home health services furnished in rural areas on or after April 1, 2001, and before April 1, 2003. Additionally, Congress specified that beneficiaries may not be disqualified from meeting the homebound requirement for home health care as a result of leaving their home to attend adult day care or religious services or to receive medical treatment.

Medicare Prescription Drug, Improvement, and Modernization Act (MMA, P.L. 108-173)

MMA reestablished the rural add-on by including a one-year increase of 5% to the episode base rate for home health services furnished to beneficiaries living in rural areas beginning on April 1, 2004, and before April 1, 2005. Further, MMA changed home health payment rates to be updated on a calendar year basis instead of a fiscal year basis and reduced the home health market basket update by 0.8 percentage points beginning with services provided on or after April 1, 2004, through December 31, 2006.

Deficit Reduction Act of 2005 (DRA, P.L. 109-171)

DRA reestablished the rural add-on as a 5% increase to Medicare payments for home health services provided to beneficiaries living in rural areas provided on or after January 1, 2006, and before January 1, 2007. DRA also eliminated the market basket update for 2006 and, as implemented by the Centers for Medicare & Medicaid Services (CMS), required HHAs to submit quality data from patient assessments and surveys beginning in 2007. HHAs that did not submit quality data would receive a two percentage point reduction in their market basket update.

Patient Protection and Affordable Care Act (ACA, P.L. 111-148)

ACA included modifications to the current HH PPS. Provisions in ACA reduced the episode base rate by 1.0 percentage point in each of 2011, 2012, and 2013, and by a productivity adjustment starting in 2015. ACA reestablished the rural add-on which increases the episode base rate by 3% for home health services provided to beneficiaries in rural areas between April 1, 2010, and January 1, 2016. ACA also requires the Secretary of Health and Human Services (HHS) to update or "rebase" the home health payment rate with more recent cost report and home health claims data beginning CY2014. The provision requires a four-year phase-in of the rebased rate with each phase-in limited to a 3.5% change of the 2010 reimbursement rate. Further, ACA also requires physicians to include documentation that a face-to-face encounter had occurred between an approved medical practitioner and the beneficiary for initial home health episodes of care.[97] While physicians are not required to perform the face-to-face encounter, the physician must be the individual who certifies the encounter occurred and that the home health services are reasonable and necessary.

[97] Approved medical practitioners are: nurse practitioners, certified nurse specialists, certified nurse-midwives authorized under state law, and physician assistants.

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