Recent Innovations in Home Health Care Policy Research

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This overview discusses articles published in this issue of the Health Care Financing Review, *entitled "Issues in Reforming Home Health Care." Articles focus on basic policy issues in the financing and delivery of home care services, illustrate how research provides insights into these issues, and report on some recent research and demonstration initiatives that are designed to further our understanding of how to improve the effectiveness and efficiency of home care services under Medicare and Medicaid.*

INTRODUCTION

Home care is a rapidly expanding and evolving industry. As Levit and her colleagues highlight, home health is the fastest growing component of Medicare expenditures. Medicare spending on the home health benefit has grown from $2.12 billion in 1988 to $10.5 billion in 1993 and is projected to exceed $22 billion by the end of this century. Home health care expenditures represented 5.3 percent of total Medicare spending in 1993 and have experienced annual growth rates exceeding 25 percent every year since home health coverage criteria were clarified in 1988.

Medicaid is also a growing source of funding for home care services. In addition to a mandatory home health benefit, Medicaid provides two optional sources of funding for home care services: the personal care optional benefit and the section 1915(c) home and community-based care waiver program. Medicaid home health expenditures have risen from $2 billion in 1988 to $4.5 billion 1993, while home and community-based care waiver dollars have grown from $3.8 million in 1982 to close to $3 billion in 1993.

Factors contributing to increased use of home care services include the aging of the population, the development of complex medical technologies that can be provided in the home, and a growing capacity among home care providers and other community-based agencies to respond to increasing demand. Public policy changes, including the implementation of Medicare hospital prospective payment in 1984 and the clarification of Medicare home health coverage requirements in 1988, have added to the demand for home care services. These trends are consistent with preferences among the elderly and persons with disabilities to receive services in home and community, rather than institutional settings.

There is increasing attention within government and the private sector being focused on the access, quality, and cost of home care services. In particular, HCFA is interested in determining how Medicare and Medicaid can more actively and responsibly address the issues associated with rapid growth of home care services. Research questions central to the policy debate include: Who uses home health services? What is the accessibility and quality of home health services provided under public programs? How do we improve the efficiency, effectiveness, and accountability of skilled and unskilled care services provided in home settings? How does home care relate to other health care services provided under public programs?

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How effective are home health services in new forms of service delivery, such as health maintenance organizations (HMOs) and other forms of managed care?

POLICY RESEARCH THEMES

In the opening article, Vladeck and Miller describe the agency's Medicare Home Health Initiative and current activities under way to improve the structure and administration of the home health benefit. The authors identify strategic goals for improving the Medicare home health program and summarize HCFA initiatives presently in operation to accomplish these goals. Four key areas are addressed: quality assurance, administration and operations, policy, and research. Vladeck and Miller give particular attention to the role of research and demonstrations in providing information to inform policymaking, and highlight some of the more significant projects now under development that will shape the agency's future responses to this rapidly changing industry.

The next series of articles highlights research and demonstration activities sponsored by HCFA to inform the policy debate. The article by Mauser and Miller provides a recent profile of home health users. Relying on data from HCFA's 1992 Medicare Current Beneficiary Survey, the authors analyze the sociodemographic characteristics of Medicare home health users, the differences in use rates and expenditures for various subgroups of Medicare beneficiaries, and the factors that explain beneficiary use of home health care under the program. When compared with Medicare beneficiaries who do not use home health services, Medicare home health users are found to be more likely to be disabled, live alone, have lower income, and, as a result, are more likely to be receiving medical assistance under Medicaid. Home health utilization and expenditures are highly skewed in the Medicare program, with 6.3 percent of Medicare beneficiaries accounting for almost 30 percent of total home health agency (HHA) expenditures. Age, eligibility for Medicaid, and the availability of other post-acute-care services (e.g., skilled nursing facility [SNF] care, outpatient rehabilitation services) affect the likelihood that Medicare beneficiaries will use home health care benefits.

One of the key HCFA policy initiatives outlined in the Vladeck and Miller article is the agency's effort to revise the Medicare home health Conditions of Participation for HHA services. Two articles address quality-of-care research related to home care services. Shaughnessy, Crisler, Schlenker, Arnold, Kramer, Powell, and Hittle report on research sponsored by HCFA since 1988 to develop outcome-oriented quality-of-care indicators for home health services. The authors outline several issues in measuring quality of care in home settings. An outcome-based quality improvement (OBQI) system is discussed, in which outcomes of care are analyzed, adjusted for patient risk factors. While some outcome measures are specific to a given quality indicator group (QUIG) (the stratification scheme used to adjust for patient risk), other outcome measures are useful for multiple QUIGs. The authors further explore the operational and technical issues involved in implementing such an information system as part of a Medicare quality assurance system. They argue that, properly developed and implemented, an OBQI system has the potential to become the framework for a new partnership among payers, providers, and consumers to promote continuous quality improvement in the delivery of home health care services under the Medicare program.

The second home care quality article, by Kane, Kane, Illston, and Eustis, focuses on

the issue of defining, measuring, and monitoring the quality of non-clinical home care services. The authors note that personal care and other support services are among the most important services that HHAs provide to assist persons with disabilities in maintaining their independence as well as supplementing informal care provided by family and friends. The authors analyze the importance of these aspects in evaluating the overall quality of home care services. They note the importance of identifying and measuring the enabling factors that might supplement structure, process, and outcome measures of the clinical aspects of home health services delivery, in order to provide a more complete picture of quality assurance in home settings. The authors examine the relationship between non-clinical dimensions of home care worker performance—such as courtesy, punctuality, reliability, and honesty—and client satisfaction.

The authors also note the different perspectives and priorities that various stakeholders have in addressing quality-of-care issues in home care, and the need for a partnership among all affected parties—payers, regulators, providers, and consumers—to meet effectively the challenges of improving home care services in the 1990s. Again, as in the Shaughnessy et al. article, the authors' findings suggest that a priority among all affected groups is the development of outcome-based quality-of-care performance indicators that reflect both clinical and non-clinical aspects of home care services.

The next two articles focus on another major policy research initiative within HCFA—the development of a prospective payment system for Medicare home health services. Currently, Medicare reimburses HHAs on a reasonable-cost basis. In the Omnibus Budget Reconciliation Act of 1986, Congress mandated that the Department of Health and Human Services research and test the feasibility of paying HHAs on a prospective basis for services provided to Medicare beneficiaries.

Phillips, Brown, Bishop, Klein, Ritter, Schore, Skwara, and Thornton report on the first-year findings of the first phase of a two-part HCFA-sponsored HHA prospective payment demonstration. This phase of the demonstration tested the feasibility of paying HHAs on a prospectively determined per-visit rate for each of the six basic service categories that Medicare covers in the benefit—skilled nursing services, physical therapy services, occupational therapy services, speech therapy services, home health aide services, and medical social work services. Based on data from the first year of operation, the authors find no significant effect of prospective payment on HHAs' cost per visit, the volume of services rendered, agency revenues, surplus revenue (profitability), or quality of care. The HHAs under prospective payment did not appear to avoid patients who required more expensive care. The authors caution that these findings must be considered preliminary, and that a final assessment of the prospective payment demonstration should await the receipt and analysis of data for the full 3 years of the demonstration.

The second article on prospective payment, by Goldberg and Schmitz, reports on the findings of research conducted as part of a development effort for the second phase of the HCFA-sponsored HHA prospective payment demonstration. This phase of the demonstration tests a payment system that sets rates for each episode of HHA-provided care. The authors report on research designed to establish the length of episode for which agencies would be paid. The authors examine a variety of approaches to defining a home care episode. The analytical issues addressed in

the study include establishing the length of the episode, establishing outlier policies for visits that fall outside of the episode period, analyzing how different definitions of episode length affect utilization patterns across agencies of different types, and estimating how they are likely to respond to prospective payment incentives under different episode definitions.

The authors' results indicate that establishing episode lengths is difficult in home health care, given the tail of very long episodes (averaging 265 days) that skews the distribution of average annual HHA visits and charges. Also, these episode differences vary by agencies of different types, with rural agencies, proprietary agencies, large agencies, new agencies, and freestanding agencies having longer episode lengths than urban, non-profit, and smaller, well-established agencies that were hospital-based. Importantly, many of the differences in reimbursement per episode are not driven by reimbursement per visit, but by the quantity of visits provided during the episode. This is precisely what the per-episode payment demonstration is designed to test: the ability of agencies to change the number, type, and duration of visits under a payment system that compensates on the basis of an entire episode of care rather than on a visit-by-visit basis.

Kane, Finch, Chen, Blewett, Burns, and Moskowitz examine home care services in the broader context of post-hospital care, focusing specifically on the factors that determine the decision to discharge patients to their home and whether those going home receive home health services. Using information obtained from medical records, patient interviews, and Medicare administrative claims data, the authors developed a model for predicting the likelihood a hospital patient would be discharged home and, if so, what clinical, functional, and cost outcomes are associated with that discharge decision. The authors examine patient outcomes for five high-volume hospital diagnosis-related groups (DRGs) in three cities. Home care patients' use of other formal and informal care, and total Medicare expenditures, are also measured.

In general, the authors found that none of the clinical measures of severity or comorbidity explained the decision of discharge planners to send a patient home; functional measures were much more predictive of these decisions. However, the predictive variables associated with a discharge home were not necessarily the variables that predicted a better outcome for such patients. Also, for the most part, the relationships differed by DRG. The authors conclude that the discharge planning decision is complex, and that more sophisticated information technology is needed to assist discharge planners in selecting the best modality of post-hospital care for Medicare beneficiaries.

The article by Manton, Stallard, and Woodbury provides another perspective on profiling Medicare home health users by examining longitudinal trends in Medicare home health and SNF utilization and expenditures from 1982-90. Relying on three waves of data from the National Long-Term Care Survey, they analyze changes in disability status within the Medicare population during the 1980s and how these trends affected use of Medicare home health and SNF care. Their findings regarding the growth of home care services since 1982 are consistent with the more recent trends noted by Mauser and Miller: (1) both the number of beneficiaries using home health benefits and the average number of visits per user have increased steadily, and (2) the presence of disability plays an important role in

determining the amount of home care services an individual will use.

The authors report increases in use at all levels of disability, with increases most pronounced among Medicare beneficiaries who were identified as having problems with instrumental activities of daily living and mobility, those whose impairments presented problems with heavy housework, and those who were cognitively impaired.

The authors conclude that there is a complementarity in HHA and SNF use; HHA services tend to be used by persons with serious health problems whose disability appears to be more of a consequence of illness, whereas SNF use seems to be concentrated among those with serious functional disability of potentially longer standing. An implication of this study is that a better understanding of the relationship between health and functioning may lead to more cost-effective methods of targeting extended Medicare home health and SNF benefits to meet the most serious and acute aspects of disabled persons' long-term care needs.

Another area of increasing policy interest is the role of home care services in managed care settings. Shaughnessy, Schlenker, and Hittle compare the health status outcomes of Medicare beneficiaries who receive home health services in HMOs and in the fee-for-service (FFS) system. Relying on longitudinal data collected on patient demographics, clinical and functional outcomes, and characteristics of the home environment during 1989 and 1991, the authors analyze changes in utilization, mortality, and patient outcomes during a 12-week period following admission into a home care program.

Adjusting for case-mix differences between patients in both settings, the authors find that Medicare beneficiaries obtaining home health services in the FFS sector have a greater tendency to improve or stabilize during the interval between home health admission and 12 weeks later or discharge (whichever occurred first). According to the authors, the inferior HMO outcomes were accompanied by lower utilization and cost of home health services for HMO patients, a pattern that was particularly evident among contractual HMO patients. The authors conclude that although more research clearly is needed to better understand the relationship between the organization of home health care services in HMO settings and patient outcomes, more attention should be given to outcome-based quality assurance and care practices in HMO settings that may be overly restrictive in terms of the use of home health care services.

The article by Silberberg, Estes, and Harrington examines the role of uncertified home care agencies in the home care delivery system, and analyzes different perspectives among key stakeholders at the State level regarding the funding and regulation of these providers. Whereas only certified HHAs may participate in the Medicare program, States may reimburse uncertified agencies and independent providers, as well as certified agencies, under the Medicaid personal care services option and the home and community-based care waiver program. Based on interviews with representatives of government, industry, and consumer groups in the States of California, Texas, and Pennsylvania, the authors analyze different perspectives on issues associated with the cost, access, and quality of services provided by uncertified agencies, and the implications for funding and regulating of these programs under Medicaid.

The authors find that the issue of the quality of care provided by uncertified agencies is the most prevalent policy concern across all stakeholder groups. Providers and government representatives reportedly are most concerned about regulation of agency practices; consumer groups representing persons with disabilities are most concerned about the level of consumer control and the ability of consumers to direct agency services independent of regulatory control and oversight. On access issues, the authors report that providers and consumers are most concerned about the availability of public funding for non-medical home care services, while government stakeholders are more likely to desire a balance between cost containment and concerns of access and quality.

An implication of the authors' findings is that the development of effective public policy regarding the provision of home care services by uncertified agencies will require greater communication and negotiation among various stakeholders on how to accommodate different perspectives on regulation and consumer-directed services, and how to reconcile the desire among many groups to increase overall spending levels for home care services in an environment increasingly sensitive to the growing costs of long-term care services in States.

CONCLUSION

The continued growth of home care programs will increase policymakers' interest in finding ways to improve the effectiveness and efficiency of home care services for Medicare and Medicaid beneficiaries. The articles in this issue are illustrative of the ways in which research and demonstrations can provide information to monitor the continuing evolution of the home care industry and test new innovations to inform the policy development process. HCFA will continue to monitor the performance of its current home care programs as well as explore new approaches to home care coverage, payment, service delivery, and quality assurance. All of these initiatives will be aimed at improving the overall capability of Medicare and Medicaid home care programs to better serve beneficiaries who increasingly rely on these services to maintain their independence and quality of life in community-based settings.