
Program Update

Medicare Home Health Initiative: Current Activities and Future Directions

Elizabeth Mauser, Ph.D.

This article describes the Medicare home health benefit and summarizes the growth and change in the use of the benefit and in the industry providing home health care. The article details the progress the Home Health Initiative has achieved in the key areas of quality assurance, administration and operations, and policy. It concludes with a discussion of future directions for reforming Medicare's home health benefit.

INTRODUCTION

Changes in the Medicare home health benefit, the home health industry, and the characteristics of home health care users have influenced recent home health utilization and expenditure trends. The use of the Medicare home health benefit has increased dramatically over the period from 1988 to 1995; annual expenditures alone have grown from \$2.12 to \$15.7 billion during this period. (See Figure 1 for an illustration of the rapid growth in expenditures.) In 1995, home health expenditures were 8.7 percent of total Medicare expenditures. Concern over whether the home health benefit was fully meeting the needs of Medicare beneficiaries, as well as concern over the escalating expenditures for home health care, prompted the Administrator of HCFA to convene an agency-wide workgroup in the spring of 1993 to make a comprehensive assessment of the Medicare home health benefit and to make recommendations for improving it.

The intra-agency workgroup—called the Home Health Initiative—was given the responsibility of enhancing the Medicare home health benefit in order to:

- Make the home health benefit more responsive to beneficiaries' needs.
- Increase the provider's flexibility in structuring care plans.
- Ensure the provision of high-quality care.
- Improve the efficiency of administration and operations.
- Facilitate appropriate utilization of home health care services.
- Ensure appropriate payments for the benefit and enhance efforts to detect fraud and abuse.

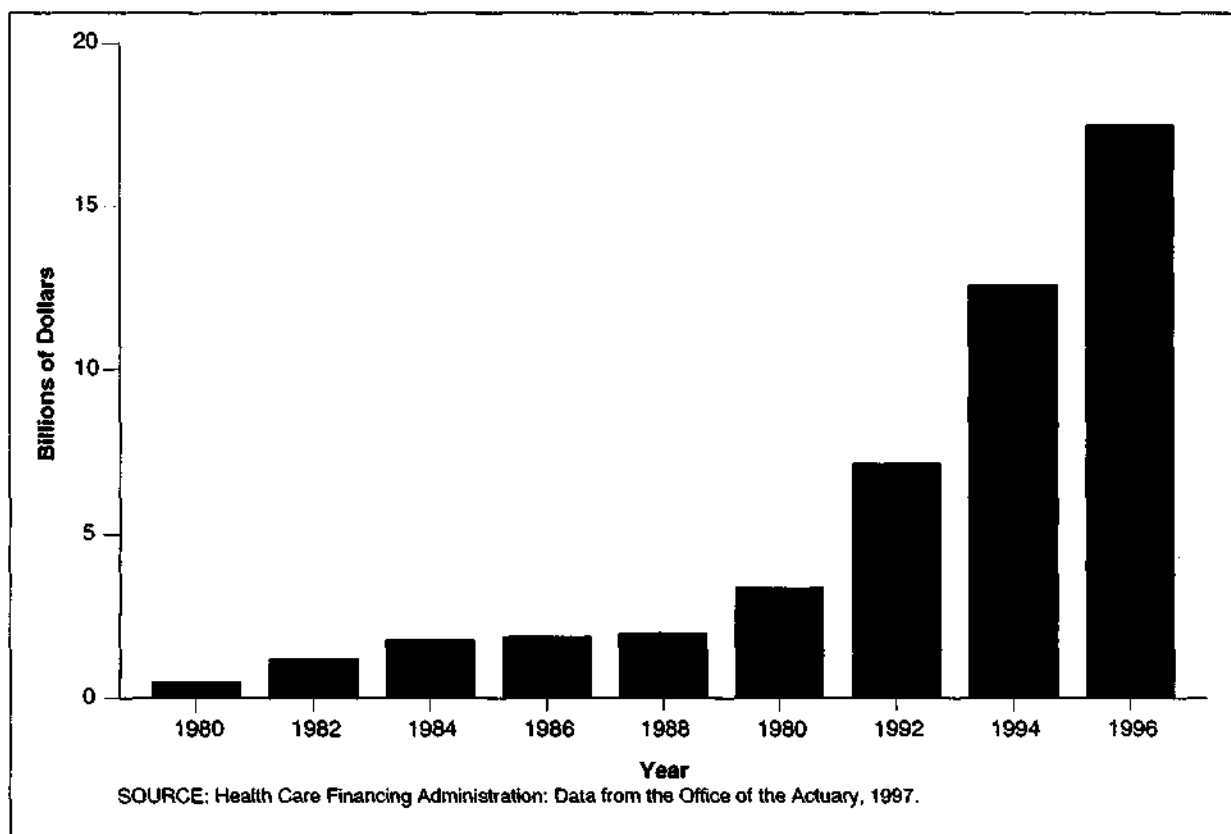
For a detailed discussion of the purpose of the Initiative, see Vladeck and Miller (1994).

To provide input to the Initiative, four meetings were held with representatives from consumer groups, the home health care industry, professional organizations, intermediaries, and States to discuss and recommend improvements to the home health benefit. The four meetings, held over 1994 and 1995, focused on quality assurance, operational and administrative procedures, the role of the physician in home health care, and policy issues such as coverage, eligibility, and payment reform.

The purpose of this article is to highlight some of the recent activities of the Home Health Initiative—these activities encompass quality assurance enhancements, administrative and operational improvements, and work on reforming payment for Medicare home

The author is with the Office of Strategic Planning, Health Care Financing Administration (HCFA). The views expressed are those of the author and do not necessarily reflect those of HCFA.

Figure 1
Program Payments for Medicare Home Health Care: 1980-96



health services. We precede these highlights with information on the home health benefit, a description of home health users, as well as a description of the industry. This background sets the stage for improving the benefit.

BACKGROUND

Home Health Benefit

Medicare covers home health services furnished to eligible beneficiaries by Medicare-certified home health agencies (HHAs). HHAs may be either freestanding or facility-based. Covered home health services include part-time or intermittent skilled nursing and home health aide services, speech-language pathology services, physical and occupational therapy, medical social services, medical supplies,

and durable medical equipment (with a 20-percent copayment).

To qualify for Medicare coverage of home health services, beneficiaries must be confined to the home, receiving services under a plan of care established and periodically reviewed by a physician, and be in need of either physical therapy, speech-language pathology services, or intermittent skilled nursing care. An individual whose sole need is for custodial care does not qualify for coverage. There is no prior hospitalization requirement.

With the exception of durable medical equipment, there is no copayment or deductible for home health care. Services are covered as long as they are reasonable and necessary; there is no limit to the number of visits or the length of coverage.

Since Medicare began in 1966, eligibility and coverage requirements for Medicare

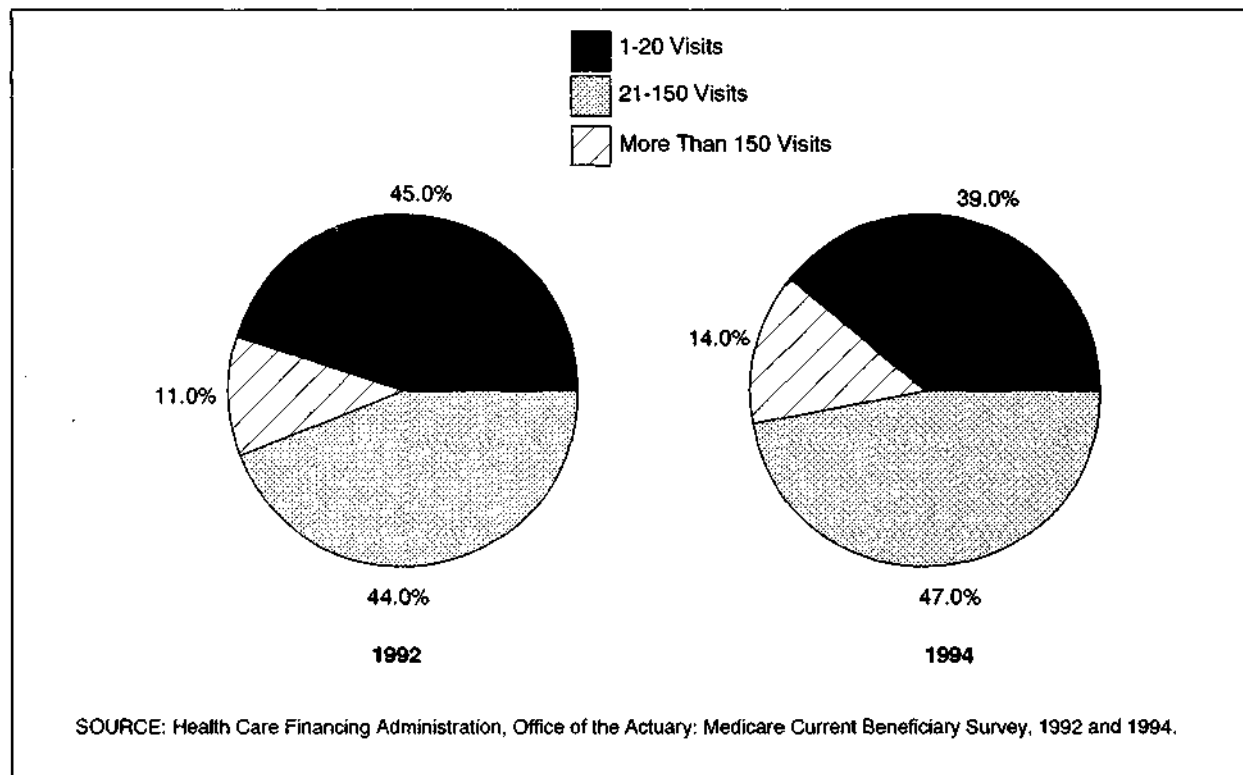
home health care have changed several times. In 1972, Medicare coverage was extended to persons under 65 years of age who were either disabled or had end stage renal disease. In that same year, the 20-percent copayment for home health under Part B was eliminated. The Omnibus Budget Reconciliation Act (OBRA) of 1980 eliminated home health care eligibility requirements of a 3-day prior hospital stay, Part A copayments, and a 100-visit limit. It also allowed for Medicare certification of for-profit HHAs. Most recently, Medicare Home Health Agency manual (HIM-11) revisions (implemented in 1989) clarified coverage criteria in order to reduce inconsistencies in coverage determination by intermediaries and to comply with the settlement of *Duggan v. Bowen* (1988). In this decision, a Federal District court found that Medicare's interpretation of the phrase "part-time or intermittent" was too narrow,

resulting in denial of care for eligible beneficiaries.

Description of Users of Home Health Care

Close to 8 percent of Medicare beneficiaries in 1994 used home health care, with the average home health user receiving 65 visits, increasing from 52 visits in 1992. Although approximately 39 percent of home health users received 20 or fewer visits in 1994, 14 percent received more than 150 visits. Just 2 years earlier, 11 percent of home health users received more than 150 visits. Figure 2 shows the distribution of home health users across visit categories in 1992 and 1994. Home health users receiving more than 200 visits during the calendar year (10 percent of users) needed assistance with 2.4 activities of daily living (ADLs) out of five (eating,

Figure 2
Distribution of Home Health Users, by Visit Category: 1992 and 1994



bathing, toileting, transferring, and dressing) and 3.5 instrumental activities of daily living (IADLs) out of six (shopping, managing money, using phone, light housework, heavy housework, and meal preparation) compared with home health users with fewer than 200 visits who needed help with 1.1 ADLs and 2.2 IADLs (Health Care Financing Administration, 1994). Over the period from 1995 to 2000, it is projected that the average number of home health visits received per user will increase to 82, while total Medicare payments for home health will reach close to \$27 billion.

The typical home health user is more often female, black, poor, and functionally frail than the average Medicare beneficiary. To illustrate, in 1994 the average home health user needed assistance with 1.2 ADLs out of 5 and needed help with 2.4 IADLs out of 6. One-third of home health users lived alone; the majority (68 percent) were female; 84 percent were white and 12 percent were black; and approximately one-quarter were eligible for Medicaid. The average age of home health users was 77. In contrast, almost one-quarter of Medicare beneficiaries lived alone; 57 percent were female; 87 percent were white and 9 percent were black; and 15 percent were eligible for Medicaid. The typical Medicare beneficiary tends to be younger (72 years of age) relative to the typical home health user. Satisfaction is high among home health users. Approximately 78 percent of users are satisfied with the overall number of hours of care provided per week; 95 percent report that the overall quality of care is excellent or good; and 90 percent reported that they were very comfortable or comfortable with the instructions on care (Phillips, 1995). Similarly, a recent survey by the Office of the Inspector General has

found that Medicare beneficiaries are satisfied with home health care. Specifically, 95 percent of Medicare home health users said that home health personnel did an adequate job, while 96 percent said they received the number of home health visits they thought they needed (Department of Health and Human Services, 1997).

Changes in the Composition of Home Health Industry

Over the last 15 years, the home health industry has grown and changed significantly. As of December 1996, there were 9,838 Medicare-certified home health agencies, an increase from 5,663 in 1990. The mix of agencies in the industry has also changed substantially since the benefit began. Today, hospital-based and proprietary agencies dominate the home health industry, whereas in the late 1960s visiting nurse associations and public agencies were the major players. Currently, largely because of the effects of OBRA 1980, which allowed certification of for-profit HHAs, 53 percent of all certified agencies are proprietary. Additionally, the percentage of hospital-based Medicare-certified agencies has grown from 12.3 percent in 1980 to 27 percent in 1996. An analysis of the impact of organizational form in the home health industry suggests that beneficiaries receiving care from for-profit HHAs receive on average 21 more visits than those receiving care from non-profit agencies, controlling for differences in health and functional status of the beneficiary, as well as age, sex, and living situation (Mauser, 1995). In terms of reforming the home health benefit, it is important to have a better understanding of the impact of these utilization differentials across home health providers on quality of care and patient outcomes.

QUALITY ASSURANCE IMPROVEMENTS

HCFA has the responsibility as the single largest payer for home health services to assure that quality care is provided to its beneficiaries. Home health care is provided to a diverse population of patients with complex acute and chronic care needs. It is challenging to measure the quality of home health care due to the heterogeneous population of home health users; the difficulty in monitoring patient compliance to care plans in the home; the fact that the provider is a guest in the patient's home; and differences in the home environment and level of informal caregiving support across home health users.

As previously mentioned, in 1994 the Home Health Initiative sponsored a meeting with consumer, provider, research, and State Medicaid agency representatives to elicit recommendations concerning improving the quality of home health care. A number of recommendations came out of this meeting that guided HCFA's approach to revising the HHA Conditions of Participation (COPs), which are the requirements an agency must meet to be Medicare-certified. These recommendations include the following:

- Revise the COPs to include a standard assessment instrument and patient-centered, outcome-oriented performance expectations to stimulate continuous quality improvement.
- Use defined and validated data-based quality indicators.
- Create a continuous, flexible, data-driven evaluation process that focuses on patient rights, outcomes of care, and patient, physician, and provider satisfaction.

The HHA COPs were revised in direct response to the input from the home health industry. As well, revisions reflected HCFA's overall interest in revising COPs for health care providers in order to place more emphasis on improving outcomes of care and patient satisfaction; reducing the burden on providers from extensive process-oriented requirements such as explicit requirements concerning personnel policies; increasing provider flexibility in terms of how they provide care with an emphasis on continuous improvement; and increasing the amount and quality of information available to everyone on which to base health care choices and efforts to improve quality.

The basic principles that guided the development of the HHA COPs include the following:

- The COPs should focus on a continuous, integrated care process that a patient experiences centered around patient assessment, care planning, coordination of service delivery, and quality assessment and performance improvement.
- The COPs should provide flexibility to HHAs in terms of how they meet performance requirements.
- The COPs should eliminate unnecessary administrative and enforcement structures.
- The COPs should incorporate requirements that ensure program integrity, such as the current requirement governing the disclosure of ownership and management information or a proposed requirement that a percentage of total skilled professional visits are provided directly rather than under contract.

A set of four "core conditions" has been developed for home health which include

Patient Rights, Patient Assessment, Care Planning and Coordination of Services, and Quality Assessment and Performance Improvement. These core conditions are a set of requirements that HHAs must meet in order to be Medicare-certified. The revised COPs were published in a Notice of Proposed Rulemaking on March 10, 1997, giving the public a chance to comment on the revisions prior to the publication of a final rule.

Patient Rights

Patient Rights emphasizes an HHA's responsibility to respect and promote the rights of each home health patient. These rights include, for example, the right for a patient to have his or her property treated with respect; the right to be informed in advance about the care to be furnished, and any changes, in the care to be furnished; the right to participate in the planning of the care; and the right to confidentiality of the clinical records maintained by the HHA. Under this condition, the revised COPs add to past patient rights protections the requirement to inform patients about "expected outcomes" and "barriers to treatment."

Patient Assessment

Patient Assessment stresses the critical nature of a comprehensive assessment in determining appropriate treatments and achieving desired health outcomes. Each patient must receive from an HHA an accurate and comprehensive assessment at defined time points that identifies the patient's need for home care and that meets the patient's identified needs for specific medical, nursing, rehabilitative, social, and discharge planning services. HCFA plans to require agencies to collect information from a core standard assess-

ment data set as part of the comprehensive assessment.

Care Planning and Coordination of Services

Care Planning and Coordination of Services incorporates an interdisciplinary team approach to providing home health care. A home health care patient generally receives a variety of services from several different disciplines. This condition specifically links the plan of care to the comprehensive assessment and its updates, emphasizes the importance of coordination of services, and stresses the necessity of an interdisciplinary team to develop a system and level of coordination that meets the individual patient's needs.

Quality Assessment and Performance Improvement

The Quality Assessment and Performance Improvement condition charges the HHA with the responsibility for designing and implementing a data-driven quality assessment and continuous performance improvement program. This is one of the key revisions to the COPs. HCFA plans to require HHAs to incorporate a core standard assessment data set (as noted later), into their quality assessment and performance improvement systems.

Core Standard Assessment Data Set

The core standard assessment data set, which forms the foundation for HCFA's outcome-based quality improvement approach to home health care, was developed under a HCFA-funded research project by the Center for Health Policy Research, University of Colorado (Shaughnessy, Crisler, and Schlenker, 1994a) and with input from a workgroup of professional and

provider representatives that was convened by HCFA's Health Standards and Quality Bureau. The core standard assessment data set, called the Outcome and Assessment Information Set (OASIS), includes items measuring sociodemographic, environmental, support system, health status, functional status, and health service utilization characteristics of patients. Although all of the items included in the OASIS are essential for a comprehensive assessment, the OASIS is not a comprehensive assessment and must be supplemented by additional items, such as blood pressure, by an agency. The OASIS will provide the information necessary to measure individual patient outcomes, to evaluate agency performance, and to foster improved home health care outcomes nationally. On March 10, 1997, in a separate notice of proposed rulemaking from the revised COPs, HCFA published a notice of proposed rulemaking requiring agencies to begin to collect the OASIS items, giving agencies an opportunity to obtain experience using the OASIS prior to a requirement for submission of these data to HCFA.

To test and refine Medicare's approach to outcome-based quality improvement for home health care, HCFA is currently sponsoring the Medicare Quality Assurance and Improvement Demonstration, being conducted by the Center for Health Policy Research, which uses the OASIS. This approach to quality improvement includes the assessment of outcomes at regular intervals, forming the basis for a continuous quality improvement system. The principal goal of this demonstration is to form the foundation for a partnership between home health agencies and the Medicare program to collect and analyze patient status information, with the intent of analyzing patient outcomes. This analysis is expected to improve agency performance, as well as to ensure the most effective approach to providing home care to Medicare beneficia-

ries and other patients. Currently, 50 agencies in over 20 States are participating in the demonstration. The agencies were phased into the demonstration from January 1, 1996, through March 1, 1996. Agencies will participate in the demonstration for 3 years. The experience gained from this demonstration will help guide Medicare's implementation to outcome-based continuous quality improvement for home health care.

As a result of HCFA's new emphasis on outcomes, the revised COPs retain structure and process-oriented requirements only if they tend to be predictive of high-quality patient care such as the training requirements for home health aides. Consequently, the revised COPs provide agencies with increased flexibility by limiting the number of procedural requirements and should stimulate HHAs to identify performance problems, as well as solutions to them. The intent of the revised COPs is for agencies to continuously strive to improve patient outcomes and satisfaction.

ADMINISTRATIVE AND OPERATIONAL IMPROVEMENTS

In addition to these quality assurance improvements, HCFA has initiated administrative and operational changes geared toward improving program efficiency and integrity. Through the Home Health Initiative, HCFA has been working to improve its ability to ensure that the program pays only for services that are medically reasonable and necessary and that meet home health coverage requirements.

The Home Health Initiative held a meeting in 1994 with industry and consumer representatives to discuss possible home health administrative and operational improvements. Two areas that the meeting focused on were documentation and billing

procedures and the informational needs of beneficiaries, providers, and physicians. Several recommendations from this meeting have helped shape HCFA's focus for improving administrative and operational procedures. These recommendations include waiting to change billing and documentation requirements until the implementation of the previously discussed standard core assessment instrument; improving the dissemination of informational materials to beneficiaries and physicians, including developing a comprehensive, user-friendly pamphlet explaining the home health benefit to be distributed to physicians and beneficiaries; and exploring the use of an explanation of medical benefits statement to inform beneficiaries of the services being billed on their behalf. Related to the issue of fiscal integrity, the Home Health Initiative also sponsored a pilot testing the impact of increasing the sharing of information between State survey agencies and regional home health intermediaries to ensure that HCFA pays only for services that meet home health coverage requirements.

Documentation Requirements

While the home health industry has grown and changed substantially over the past 10 years, the billing process and documentation requirements have essentially remained the same. It is clear that the billing and documentation process needs to be improved to better evaluate the medical necessity of the home health services furnished to beneficiaries. The lack of information about the types of services provided during home health visits makes it difficult to evaluate the necessity of care.

At the Administrative and Operational Meeting, consumer and provider representatives agreed that their documentation requirements should include more clinical

information, and accurate diagnosis and treatment information; however, there was general consensus that no changes should be made until the standard core assessment instrument was implemented as part of the COPs enabling HCFA to determine the impact of this instrument on the information requirements of agencies.

Physician and Beneficiary Outreach

In order to increase beneficiary and provider understanding of the Medicare home health benefit, HCFA launched a series of three pilot projects in partnership with its intermediaries. Activities included explaining and clarifying the Medicare home health benefit and its coverage criteria and instructing physicians and beneficiaries about whom to contact with questions regarding eligibility requirements as well as where to report aberrancies noted during the plan of care. The goal of these activities was to help ensure that appropriate care is provided by educating beneficiaries and providers about the benefit.

To explore the usefulness of different education strategies, each of the three projects included a combination of activities designed to educate physicians. To measure the extent to which physicians understand the Medicare home health benefit, Blue Cross and Blue Shield of New Mexico distributed 1,213 surveys to physicians in Louisiana. This survey asked physicians general questions about the home health benefit, in addition to questions regarding the home health services that they have prescribed for their patients. In another project, Palmetto Government Benefits Administrators sent brochures describing the Medicare home health benefit coverage criteria to 2,000 physicians in the Nashville, Tennessee metropolitan area. From information gleaned from these projects, it was

clear that many physicians lacked detailed knowledge about the Medicare home health benefit.

The intermediaries that conducted the pilot projects did find some positive outcomes from their educational activities. For example, during presentations to physicians, Palmetto Government Benefits Administrators provided physicians with home health utilization data. These data permitted physicians to compare the amount of home health services that they were ordering with that of their peers. Physicians stated that after receiving information about the benefit, as well as utilization patterns, they were able to make more informed decisions when referring beneficiaries to home health care and were more inclined to monitor patient care once a patient started using home health.

Two of the three pilot projects included a component to educate Medicare beneficiaries about coverage and eligibility for home health. Additionally, in the fall of 1995, HCFA produced a new pamphlet for beneficiaries that explains the Medicare home health benefit. Copies were distributed to governmental entities such as the Administration on Aging and the Social Security Administration field offices, State and Area Offices on Aging, beneficiary and professional organizations, and outreach organizations in order for them to share the pamphlet with Medicare beneficiaries. The pamphlet covers the following topics: qualifying for home health care, what is and is not covered by Medicare, what is a plan of care, how long will services continue, what can a beneficiary be billed for, how to find an approved home health agency, and detecting and reporting fraud and abuse. This pamphlet benefitted greatly from the input of consumer and provider representatives. Plans are currently underway to update the pamphlet and distribute additional copies to beneficiaries.

As a result of these education pilots, the regional home health intermediaries will be conducting several outreach activities. These activities will include the distribution of education material through outreach meetings, public seminars, congressional offices, and public libraries. Additionally, they will develop home health public service announcements, and material to educate physicians and their staffs regarding developing a plan of care, monitoring patient progress, and detecting fraud and abuse.

Use of "Explanation of Medical Benefits"

In response to the recommendation from consumer and industry representatives to issue explanations of medical benefits, HCFA designed two pilot projects to determine the benefits of issuing notices of utilization to beneficiaries and providers. Currently, beneficiaries do not receive any explanation of medical benefits for home health care. One of the pilot projects focused on beneficiaries, while the other one concentrated on physicians. The purpose of both projects was to measure the effect of utilization information on physician and beneficiary likelihood of reporting possible fraud and abuse of the benefit.

In the first project, the intermediary sent Notices of Utilization (NOUs) for home health services provided to a sample of Medicare beneficiaries in four States (Alabama, Florida, Georgia, and Mississippi). Beneficiaries received letters explaining the purpose of the project and a short survey to complete if they believed that the NOU contained incorrect information. The NOU explained the home health services billed to Medicare by the beneficiary's HHA. During a 4-month period, 20,236 beneficiaries received NOUs and 365 replied to their intermediary. Of the 365 responses

received, the intermediary found cause to investigate 102 cases further and retrieved more than \$46,000 in inappropriate payments made to HHAs.

The intermediary conducted followups with beneficiaries that revealed that beneficiaries had begun tracking more carefully the home health visits they received. However, the pilot showed that in more than one-third of the cases when a beneficiary claimed not receiving a service, the intermediary found that the service had actually been rendered. Beneficiaries indicated that they would like to continue receiving the NOUs.

In the second project, the intermediary sent reports to a sample of Florida and Georgia physicians explaining the home health services for which Medicare paid for their patients. The intermediary asked the physician to validate the information based on his or her knowledge of the patient's health care needs. Of more than 4,000 physicians who received the report, only 136 responded. The intermediary found cause to investigate 89 of those responses to determine what was provided to the patient. The intermediary's investigations resulted in the collection of more than \$72,000 for services that were later denied.

Based on the findings from these pilots, the regional home health intermediaries began routinely sending NOUs to beneficiaries for home health services in the early part of 1997. The NOU will inform beneficiaries about the claims submitted by the HHA on their behalf and Medicare's payment determination based on that claim.

Sharing of Information

One of the goals of the Home Health Initiative is to increase the fiscal integrity of the home health benefit. To work toward this goal, the initiative decided to explore the value of State survey agencies (SAs) and the regional home health intermediaries

(RHHIs) working together by sharing information to be able to better detect cases where services are billed but either do not meet coverage requirements or are not provided.

RHHIs traditionally identify HHA activities that constitute fraud and abuse through the medical review process, whereby the RHHI reviews a sample of beneficiary records and conducts onsite fiscal audits of suspicious providers. Due to staffing and budgetary restraints, the capacity of the RHHI to conduct onsite audits has decreased, increasing the reliance on the review of beneficiary medical records. It is difficult to detect HHAs that are providing care to patients who are not homebound or billing for services and supplies that are not provided when reviewing medical records. A "perfect" medical record masks many of these activities, which can only be documented by an onsite audit. On the other hand, the annual certification surveys performed by the SA generally do not look at coverage and eligibility issues, but State surveyors frequently identify patients who are not homebound and services/supplies that are billed but are not provided. Such situations are referred to the RHHI, but no other action is taken by the SA, since these activities do not constitute a violation of the HHA conditions of participation.

The HCFA Dallas regional office conducted a pilot study¹ during the period from March 1995 through September 1995, which capitalized on the ability of the State surveyors to act as the eyes and ears of the RHHI. The SA was asked to identify and gather information on behalf of the RHHI concerning the homebound status of beneficiaries, home health services billed but not rendered, and inappropriate billing of supplies. The SAs

¹ This pilot was jointly sponsored by the Home Health Initiative and Operation Restore Trust—a collective effort among Federal and State agencies to prevent and detect health care fraud for home health agencies, nursing facilities, and medical equipment and supplies.

in Texas and Louisiana were chosen to participate in the pilot study. The HCFA Dallas regional office and the RHHI conducted training on coverage and eligibility issues, as well as on the pilot survey process.

As part of this pilot project, the RHHI provided a list of 75 "at risk" agencies to the SAs, in addition to a list of 20 beneficiaries per HHA. The surveyors selected and visited 10 beneficiaries from each list in order to evaluate compliance with coverage and eligibility rules. The surveys for this pilot project were conducted as an additional survey, separate from the standard certification survey.

Pilot surveys were conducted at 74 HHAs. The SA surveyors forwarded their recommendations for denials of claims to the RHHI, accompanied by supporting documentation. Of 740 beneficiaries evaluated by the SAs, State surveyors recommended that some portion of the claims for 289 beneficiaries be denied. Seventy percent of the recommended denials were due to beneficiaries not being homebound, 30 percent were due to supplies billed but not provided, and less than 1 percent was due to services billed but not rendered. The cost of 74 pilot surveys was \$116,527, and the RHHI denied claims amounting to \$790,197 based on SA recommendations and supporting documentation. As a result of this pilot, similar pilot surveys are being funded in California and Illinois. Additionally, HCFA is exploring options for integrating the RHHI beneficiary selection into the traditional standard survey, as well as expanding this survey process to other States.

POLICY REFORM

HCFA has been working on developing payment methodologies for home health that promote efficiency, foster appropriate

decisionmaking regarding the use of home health care relative to other post-acute care services, recognize and appropriately price acute and chronic home health use, and encourage quality of care, as well as establishing a mechanism to reimburse physicians for home health care plan oversight. To attain the goal of more efficiently providing home health care, it is critical to increase our understanding of the relationships between home health resource use and patient characteristics, and between outcomes of care and resource use. In an effort to revise the current payment system, HCFA has been sponsoring demonstrations to test both per visit and per episode prospective payment, to test capitated payment models for home health care that incorporate additional Part B Medicare services, as well as sponsoring related research needed to reform payment for home health care such as studies related to case-mix adjustment and the use of the benefit by beneficiaries with chronic care needs.

Home health care is one of the few Medicare services that is still paid on a retrospective cost basis subject to cost limits, that are updated annually. These limits are set at 112 percent of the mean national cost per visit for freestanding agencies. OBRA 1993 froze the limits at the 1993 level from July 1, 1994, to July 1, 1996.

The current reimbursement system for home health care creates little incentive for agencies to provide care in a cost-effective manner. Furthermore, payment per visit diminishes the incentive agencies have to focus their attention on the full episode of care, which is critical as we shift our focus to patient outcomes. Payment reform is complicated by our lack of knowledge regarding both the resources used, including the variation in time required to provide a visit, and the relationship between the amount of care provided and

patient outcomes. Nonetheless, payment reform is essential to increase the flexibility of HHAs in meeting patients' needs, to increase the efficiency of service provision, and to simplify the administration of the home health benefit.

Prospective Payment

Currently, HCFA is sponsoring the National Home Health Agency Prospective Payment Demonstration, which is testing two alternative methods of paying HHAs on a prospective basis for service furnished under the Medicare program. Phase I of the demonstration tested per visit prospective payment by visit discipline. Phase II of the demonstration is testing per episode prospective payment. HHA participation in both phases of the demonstration is voluntary. In each phase, HHAs are randomly assigned to either the prospective payment method or to a control group that continues to be reimbursed in accordance with the Medicare current retrospective cost system. Each HHA participates in the demonstration for 3 years.

Per Visit Prospective Payment

Phase I of the demonstration tested a per visit payment method, that sets a separate prospective payment rate for each of the six types of home health visits covered under current law. Prospective payment per visit gives agencies the incentive to cut costs per visit in order to keep the difference between the payment rate and the cost of a visit as profit. Forty-seven agencies participated in Phase I over the period from October 1, 1990, through September 31, 1994. Findings from this phase of the demonstration suggest that the prospectively paid agencies were more likely than control agencies to keep their

cost increases below inflation; however, the differences in costs between treatment and control agencies were fairly small. The demonstration had no significant effect on the number of visits provided, quality of care, access to care, and other Medicare costs (Brown et al., 1995). Results from this phase of the demonstration suggest that per visit prospective payment does not create strong incentives to provide home health care more efficiently.

Per Episode Prospective Payment

Per episode prospective payment should be more promising in terms of reducing the number of visits provided during an episode of care since agencies have the incentive to reduce the costs of the entire home health episode and carefully monitor the appropriateness of each visit in order to retain the difference between the cost of providing the episode of care and the episode payment rate as profit. When the Home Health Initiative sponsored a policy meeting in March 1995 to elicit recommendations from representatives for consumers, providers, professional associations, physicians, States, and intermediaries on reshaping the home health benefit, there was widespread support at this meeting for moving toward a per episode prospective payment system. Per episode payment was seen as a way to encourage the efficient provision of home health care and to increase agencies' flexibility in determining the amount and mix of visits provided by the various home health disciplines during an episode of care.

Like Phase I, HHAs participating in Phase II of the demonstration² were assigned to a control group that receives reimbursement in accordance with the

² For Phase II of the demonstration, Abt Associates, Inc. is the implementation contractor, Mathematica Policy Research, Inc. is the evaluator, and the Center for Health Policy Research, University of Colorado, is the quality assurance contractor.

existing Medicare retrospective cost method or a per episode payment group that receives an agency-specific episode payment based on 120 days of care and outlier payments for episodes that extend beyond 120 days. Outlier visits are reimbursed at per visit prospective rates. A new episode of care does not begin until there has been a gap in home health services for 45 or more days after the initial 120 days. (For a more detailed discussion of how the episode definitions were chosen, see Goldberg and Schmitz, 1994). According to Medicare claims data for 1992, approximately 74 percent of home health patients complete their home health episodes within 120 days after home health admission. Agencies receiving per episode payments are subject to stop-loss and profit-sharing provisions as well as case-mix adjustments. The first group of agencies participating in the demonstration began on June 1, 1995, while the last group of agencies entered the demonstration on January 1, 1996. Preliminary evaluation results should be available in the fall of 1997, while final results will not be available until all of the agencies have completed their 3 years of demonstration operations.

Case-Mix Adjustment

The per episode demonstration includes a case-mix adjuster that controls for changes in an agency's caseload; variables include limitations in activities of daily living, intervening hospital stays, the need for wound care, hospital as the pre-admission location, decubitus stage 3 or 4, diabetes, cancer, and stroke (Mauser and Goldberg, 1995). A classification-based payment system is needed to reduce the incentive to avoid caring for patients whose resource requirements exceed some type of average payment, while seeking patients

with fewer resource needs than average. However, additional work needs to be done to develop a more accurate case-mix adjuster that can be used in a national prospective payment system. One of the major problems in developing a case-mix adjuster is there is very little information to accurately measure the resources used during a visit. The biggest obstacle to accurately measuring resource use is there is no standard definition of a visit, which may last 15 minutes or more than 4 hours. An accurate measure of resource use is not only important for developing a case-mix adjuster but also is important for choosing a unit of payment. Additionally, there is almost no information available about what procedures are performed during a visit, as well as no information about the timing of visits during the period covering a home health claim.

HCFA is currently sponsoring a study being conducted by Abt Associates Inc. to develop a case-mix adjuster that could be used in a national prospective payment program. As part of this research, HCFA is attempting to characterize home health resource utilization more accurately than has previously been done by obtaining information from agencies about the length of home health visits, specified procedures, and events which occurred during these visits. Using information on resource utilization in conjunction with primary data available through the OASIS supplemented by additional items to predict resource utilization, HCFA is working on developing a case-mix adjuster that is based as much as possible on patient characteristics rather than treatment codes, is easy to administer, has as much clinical meaning as possible, explains as much resource variation as possible, and is not subject to manipulation. The results from this study will feed into HCFA's development of a national

home health prospective payment system for Medicare home health. Recruitment of 90 agencies in 8 States to participate in this study began in April 1997, and preliminary results from this study should be available January 1999.

Relationship Between Home Health Utilization and Patient Outcomes

Developing a prospective payment system is further complicated by the wide variation across the United States in the number of home health visits provided per home health user. In 1995, the average number of home health visits per user ranged from 43 in Maryland to 158 in Louisiana. Some of this variation is due to differences in the service environments. For example, in a study comparing home health users receiving care from managed care organizations and fee-for-service providers, the study found managed care home health patients received fewer visits and had poorer patient outcomes than fee-for-service patients. This suggests that there may be a volume-outcome relationship between home health utilization and patient outcomes (Shaughnessy, Schlenker, and Hittle, 1994b). In setting payment rates for a prospective payment system, it is important to know within a range the appropriate amount of care needed to produce the best possible patient outcomes. If agencies are currently over- or under-providing home health care, we do not want to create incentives in a prospective payment system that continues the current utilization patterns. HCFA is sponsoring a study being conducted by the Center for Health Policy Research at the University of Colorado to examine the relationship between the volume of home health services received and patient outcomes. This study is being conducted in 89 HHAs in 20 States and is focusing on

four common home health conditions (stroke, open wounds, surgical hip procedures, and congestive heart failure). If this study is able to identify lower and upper thresholds below and above which home health does not contribute to better outcomes, this will help us eventually develop prospective payment rates that reflect the level of care that should be provided to produce the best possible patient outcomes.

Other Payment Issues

In addition to examining issues directly related to prospective payment, HCFA is also exploring related issues surrounding capitated payment for home health care and the growth of the number of chronic care patients using the benefit. Furthermore, recognizing the importance of physicians in home health care plan oversight, HCFA has recently implemented reimbursement for this service.

Capitated Payment for Home Health Care

HCFA is sponsoring the Community Nursing Organization (CNO) Demonstration, testing a nurse-managed health care delivery system that provides Medicare-covered home health services, ambulatory care services, and durable medical equipment, in addition to nurse case management to eligible beneficiaries using a capitated payment method modeled after the adjusted average per capita cost payment used with health maintenance organizations. Four sites are participating in the 3-year demonstration, which began in January 1994. In this demonstration, HCFA is examining the provision of home health care when providers are given the flexibility to decide whether and how much home health care is needed and are given the incentive to provide care efficiently through

capitated payments. Further, this demonstration examines the role of nurses in authorizing care plans and providing ongoing case management. Consequently, this demonstration begins to examine how home health care fits into a broader service delivery system.

Acute Versus Chronic Care Home Health Users

Originally, the home health benefit was conceptualized as a post-acute care benefit following an inpatient stay. Over time, the benefit has changed. Currently, approximately one-third of home health users come from the community, and home health users are receiving care for extended periods of time. In 1994, approximately 10 percent of home health users received over 200 visits within the year. One of the issues that the home health industry brought up at the March 1995 Home Health Initiative Policy Meeting was that they were managing more and more patients with ongoing, chronic care needs. Some providers at the meeting expressed their frustration at the challenges in trying to treat a chronic care patient using an acute care benefit. As a result of this meeting, HCFA started to consider whether it is possible to develop a payment system that explicitly recognizes and pays differently for post-acute and chronic care home health users. It is reasonable to think that payment for a post-acute episode of care for a more medically complex and fragile person likely using more skilled nursing and therapy services might differ from payment for more chronic care home health use involving more non-skilled, maintenance services and case management/monitoring.

Related to the issue of whether there are two distinct groups of home health users, a recent study has found that roughly 14 percent of a national sample of Medicare

home health patients had home health episodes lasting 6 months or longer (Phillips and Zambrowski, 1995). Among a sample of patients receiving home health care for at least 180 days in this study, 44 percent had been receiving home health care for more than 6 months to a year, 31 percent for more than 1 year to 2 years, and 25 percent for more than 2 years. This same study found that at admission the primary diagnosis of very-long-stay home health users is very similar to those of Medicare home health patients in general, making it difficult to distinguish long-stayers from other home health patients at admission. Long-stay home health users tend to be older, are more functionally impaired, and are more likely to be incontinent of urine relative to other home health users. Additionally, long-stay home health users tend to have multiple conditions, including both chronic and acute conditions. The information from this study will feed into HCFA's examination of the feasibility of creating a home health benefit that pays differently for post-acute and chronic care home health users.

Physician Payment

Physician involvement in home health care is critical, especially since the home health care population has been becoming increasingly frail with more complex health care needs. The physician's role in home health care and care plan oversight emerged as a central issue in early meetings with representatives of various groups. In followup, a meeting was sponsored by the Home Health Initiative focusing on the role of the physician and other professionals in home health care with consumer and industry representatives (prior to the implementation of physician payment for home health care plan oversight). The discussion centered

on the importance of physicians in planning patient care, as well as on ways to improve coordination between physicians and other professionals. As of January 1995, HCFA implemented reimbursement for physician home health care plan oversight. Recent regulations increased the reimbursement rate to better reflect the work performed by the physician.

SUMMARY

As HCFA continues its efforts to develop a prospective payment system that will be responsive to the needs of Medicare beneficiaries, a wide range of issues are being examined through our research and demonstration activities. These issues include what is the appropriate definition of a home health episode, how this episode should be priced, how to case-mix adjust prospective payments to ensure that patients receive the appropriate level of care, whether it is feasible to pay differently for acute versus chronic care, and how a new payment system will fit into an outcome-based quality improvement system.

FUTURE DIRECTIONS

Legislative Reform

The Home Health Initiative has provided HCFA with opportunities to consider proposals to enhance and refine the benefit through legislation. Clearly, not all needed operational, quality assurance, and payment reform changes can be accomplished through agency rulemaking and other administrative actions. It has been the intent of the Home Health Initiative to develop a legislative agenda that carries out short- and long-term policy goals.

Initiative members and senior HCFA policy personnel have begun to formulate

legislative proposals consistent with the goals underlying the Initiative. Some proposals have been considered to accomplish minor, technical, or short-term refinements to the benefit. Other proposals, still under development, would make more sweeping, longer-term structural changes to the benefit. These proposals can be finalized only after HCFA has drawn appropriate conclusions from the various research and demonstration projects described earlier in this article.

Development of home health-related legislative proposals has become driven, in part, by a larger effort initiated by the Clinton Administration to reform publicly financed health insurance benefits in the context of obtaining a balanced budget. The broad goals of a balanced budget have provided a new framework under which some of the legislative proposals have been considered. In addition, HCFA has welcomed discussions with home health industry representatives on industry-initiated proposals to reform Medicare payment for the home health benefit.

The President's balanced budget proposals are designed to protect and strengthen the Medicare and Medicaid program and benefits. Among other goals, the proposals attempt to interject new efficiencies in the Medicare and Medicaid programs; extend the life of the Medicare Hospital Insurance Trust Fund without imposing new costs on Medicare beneficiaries; establish new protections against fraud and abuse in the health care system; and improve Medicare by offering new choices of high-quality health plans and delivery systems, and by providing new preventive benefits and a new respite care benefit for families coping with Alzheimer's disease.

Included in the President's budget package is a two-stage proposal for home health payment reform. The proposal

would establish control over home health expenditure growth in the near term by imposing a new cost limit on the existing payment methodology, and introduce in 1999 a prospective payment system based on episodes of home health care. The intent is to position HCFA and the industry to implement a fully-tested, reliable prospective payment system—one that pays for services in a manner that is embraced by the home health industry and payment policy experts as the most effective way to contain costs without sacrificing access or quality. To the extent possible, our research and demonstration activities will inform the development of a prospective payment system.

This payment reform initiative, along with other home health-related proposals currently proposed by the Administration, are a part of the national debate on Medicare reform in the context of a balanced budget. As of press time, it is unclear how the debate will be resolved. Regardless of the outcome, HCFA will remain committed to the development of short- and long-term legislative proposals that address the important goals of the Home Health Initiative.

ACKNOWLEDGMENTS

This article benefitted from the contributions of the members of the Home Health Initiative. The author would like to acknowledge the following members of the Initiative for their contributions: Jennifer Carter, Janice Flaherty, Beth Giebelhaus, Jacqueline Gordon, John Hammarlund, Susan Levy, Clare McFarland, Nancy Miller, Michael Notzon, Janet Samen, John Thomas, Mary Vienna, Gerald Walters, and Lisa Zone.

REFERENCES

- Brown, R., Phillips, B., Bishop, C. et al.: *The Effects of Predetermined Payment Rates for Home Health Care*. Princeton, NJ. Mathematica Policy Research, Inc., December 1995.
- Department of Health and Human Services: *Home Health Services: Medicare Beneficiary Satisfaction and Understanding in 1995*. Pub. No. OEI-04-93-00153. Washington, DC. Office of the Inspector General, April 1997.
- Duggan v. Bowen*: U.S. District Court for the District of Columbia, Number 87-0383. August 1, 1988.
- Goldberg, H., and Schmitz, R.: *Contemplating Home Health PPS: Current Patterns of Medicare Service Use*. *Health Care Financing Review* 16(1):109-129, Fall 1994.
- Health Care Financing Administration: *The Role of Medicare and Medicaid in Long-Term Care: Opportunities, Challenges, and New Directions*. Baltimore, MD. September 1995.
- Mausser, E.: *Does Organizational Form Matter: Implications for the Home Health Care Industry*. Baltimore, MD. Health Care Financing Administration, September 1995.
- Mausser, E., and Goldberg, H.: *Case-Mix Adjustment for Phase II of the National Home Health Agency Prospective Payment Demonstration*. Unpublished paper. Fall 1995.
- Phillips, B.: *The Effects of Per-Visit Rate Setting for Medicare Home Health Care on the Quality of Care*. Princeton, NJ. Mathematica Policy Research, Inc., July 1995.
- Phillips, B.R., and Zambrowski, A.: *A Profile of Very-Long-Stay Medicare Home Health Patients*. Princeton, NJ. Mathematica Policy Research, Inc., July 1995.
- Shaughnessy, P.W., Crisler, K.S., Schlenker, R.E., et al.: *Measuring and Assuring the Quality of Home Health Care*. *Health Care Financing Review* 16(1): 35-67, Fall 1994a.
- Shaughnessy, P.W., Schlenker, R.E., and Hittle, D.F.: *Home Health Outcomes Under Capitated and Fee-for-Service Payment*. *Health Care Financing Review* 16(1):187-222, Fall 1994b.
- Vladeck, B.C., and Miller, N.A.: *The Medicare Home Health Initiative*. *Health Care Financing Review* 16(1): 7- 16, Fall 1994.

Reprint Requests: Elizabeth Mauser, Ph.D., Health Care Financing Administration, Office of Strategic Planning, 7500 Security Boulevard, C3-21-06, Baltimore, Maryland 21222. E-mail: EMauser@hcfa.gov