THE BALANCED BUDGET ACT OF 1997: EFFECTS ON MEDICARE'S HOME HEALTH BENEFIT AND BENEFICIARIES WHO NEED LONG-TERM CARE

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EXECUTIVE SUMMARY

In response to rapidly rising Medicare home health costs, the Balanced Budget Act of 1997 (BBA) significantly modified the home health benefit, most importantly by changing Medicare's method of paying for home health services. Initially, the BBA tightens Medicare's payment limits for home health agencies, mainly by capping the amount it will pay toward each agency's costs per beneficiary. Then, it replaces this interim payment system with a prospective payment system (PPS), beginning on October 1, 1999, and imposes a cut of about 15 percent in total home health spending for fiscal year 2000 (even if the PPS is delayed). Although these changes are intended to encourage agencies to improve efficiency and eliminate unnecessary services, they run the risk of reducing access to appropriate care. The highest users of the benefit, who often need a mix of acute and long-term care services, are the most likely to be affected.

RAPIDLY RISING USE OF THE HOME HEALTH BENEFIT

During the past several years, rapid growth in the use of home health care has made this benefit one of the most rapidly expanding areas of the Medicare program. From 1990 to 1996, Medicare spending for home health grew an average of 29 percent a year, from $3.9 billion to $18.3 billion. About half this increase was attributable to a rise in visits per user, which more than doubled over the time period. More than a third was due to a greater share of beneficiaries using the benefit. Relatively little of the increase was because of higher costs per visit. Several factors contributed to the surge in home health care use. Among these are regulatory changes that broadened the benefit's eligibility and coverage criteria, a loosening of regulatory oversight, changing medical practices, and incentives to shorten hospital stays. At the same time, the cost-based reimbursement system for home health encouraged agencies to provide a high volume of services, with little consideration of cost.

CHANGES IN HOME HEALTH PAYMENT POLICY

The BBA's changes in home health payments are intended to slow spending and improve agencies' incentives to deliver care efficiently. During the next two years, agencies will continue to be paid based on costs, but the payments will be subject to tighter limits. Specifically, the lower of two limits will apply. The first is a limit on each agency's average cost per visit based on national costs per type of visit, adjusted by the agency's mix of visit types. This limit is similar, although tighter, than the payment limit under pre-BBA law. The second is a new limit on each agency's costs per beneficiary served. It is based on a blend of the agency's costs (75 percent) and average costs per beneficiary for agencies in its census region (25 percent) during a base year. For most agencies, the per beneficiary limit is expected to be the more restrictive of the two limits, because the average number of visits per home health user has increased substantially since the base year (agencies' cost reporting periods ending during fiscal year 1994).

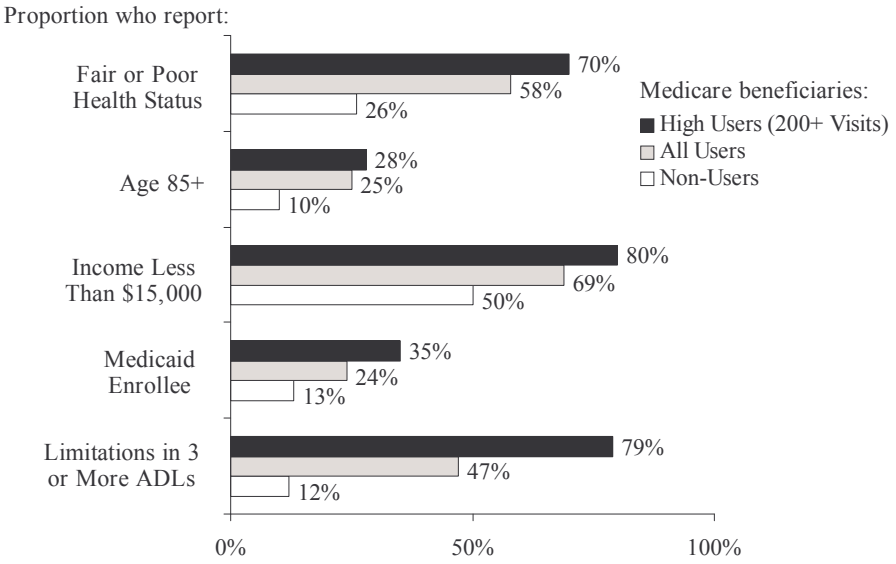
The PPS is scheduled to replace this interim system for agencies' cost-reporting periods beginning on or after October 1, 1999. The BBA provides some guidelines for the PPS, but leaves the specific details of the new system—such as the unit of service for the prospective rates and a patient classification system—to be developed over the next two years. However, the BBA specifies that initial payment rates under the PPS be set so that projected total payments in fiscal year 2000 are equal to what payments would be if the PPS were not in effect and instead the cost and beneficiary limits in place at the end of the previous fiscal year were lowered by 15 percent. (If the PPS is delayed, the payment caps under interim system are to be cut by 15 percent.)

BENEFICIARIES MOST AFFECTED BY THE CHANGES

While the new policy aims to promote an efficient mix of services and eliminate inappropriate care, it may adversely affect access to or quality of home health care, especially for those beneficiaries who use the most care. The highest users of home health care—the 10 percent with 200 or more visits during the year—accounted for 43 percent of Medicare's home health costs in 1994 and 60 percent of the growth in home health spending over the 1991-1994 period.

Relative to other beneficiaries using home health care, high home health users are not only more likely to be older, in poor or fair health, and have lower incomes, but also to have long-term care needs. More than nine in ten high home health users have limitations in activities of daily living (ADLs), and 79 percent have limitations in three or more ADLs.

Demographic Characteristics of High Home Health Users, All Home Health Users, and Non-Users, 1994



Source: Georgetown University Institute for Health Care Research and Policy, based on data from Joel Leon, Patricia Neuman, and Stephen Parente, "Understanding the Growth in Medicare's Home Health Expenditures," Henry J. Kaiser Family Foundation, June 1997.

Although the prevalence of long-term care needs among users suggests that the home health benefit is providing some long-term personal care, further examination of patterns of care shows that a need for long-term care does not by itself explain high use of home health care. More than half the Medicare beneficiaries with long-term care needs who were not in nursing homes used no home health care in 1996. Only about 16 percent of home health users with severe limitations (that is, limitations in at least three ADLs) were high users in 1994. Furthermore, most high home health users appear to have multiple, often complex, medical needs requiring a range of acute as well as long-term care services. One study found, for example, that about two-thirds of high home health users experienced acute illness, frequently involving one or more hospitalizations.

Overall, Medicare's home health benefit cannot be characterized as simply providing even high users either acute or long-term care. Rather, for a majority of high users, it appears to be providing both types of services to people who need both.

RISKS CHANGES POSE FOR BENEFICIARIES

Both the interim system and the PPS may potentially restrict access to care, especially for high users, rather than simply eliminate unnecessary services or care considered beyond Medicare's scope. Under the interim system, each agency's per beneficiary cap does not vary with changes in the agency's mix of patients. Thus, agencies that have shifted toward more costly patients since the base year will encounter financial pressure to reduce services per user. They might respond by lowering the number of visits per person, shifting the mix of visits toward less costly ones, or avoiding the most costly beneficiaries.

Although the PPS will adjust payment rates to reflect each agency's patient mix, risks to access remain a concern. Methods of adjusting payments for patients' needs and other factors related to costs should be developed. If payments do not adequately reflect costs, reductions in care may not be confined to inappropriate or excess services. In addition, the sizable spending cut in fiscal year 2000—and the opportunity to profit from reduced services—may create strong incentives for agencies to avoid the most costly patients or to reduce the quality or the amount per person of the services they deliver.

To avoid arbitrary service restriction, it will be necessary to implement the home health payment changes in the BBA with caution, continuously monitoring their effects. If developing the refinements needed to make the PPS effective takes longer than is assumed by the BBA, it may be necessary to loosen or adapt the interim limits. If developing the refinements is more difficult than anticipated, then it may be necessary to reassess how best to balance incentives in updating the home health payment system.

Finally, even with cautious implementation, expenditure control in Medicare's home health benefit is likely to reduce services, particularly for beneficiaries with complex medical

problems and long-term care needs. In some states, Medicaid may pick up some of the slack. As Medicare's home health spending is curtailed, however, more federal support may be needed to fill service gaps.

INTRODUCTION

The Balanced Budget Act of 1997 (BBA) will significantly modify Medicare's home health care benefit. The policy changes are aimed at controlling the costs of the benefit, which is one of the fastest-growing parts of the Medicare program, and at giving home health agencies incentives to deliver care more efficiently. The main strategy is to change how Medicare pays these agencies. The BBA will replace cost-based reimbursement with a prospective payment system (PPS) under which Medicare will pay agencies a predetermined amount per unit of service. The specific details of the PPS, which is to become effective on October 1, 1999, have yet to be designed. In the meantime, beginning October 1, 1997, the BBA tightens the limits on payments to home health agencies to slow spending and encourage agencies to control service volume.

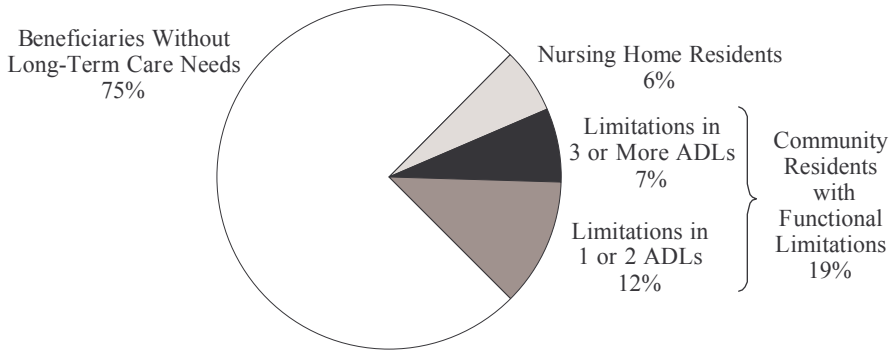
A PPS for home health potentially could both control spending and promote efficient delivery of appropriate services. By using preset prices, a PPS could enable the Medicare program to gain more control over total spending for home health than under cost-based reimbursement. Moreover, because agencies will be at risk of losses if their costs exceed payments, but will earn profits if their costs are lower, a PPS could encourage more efficient practices and mix of services. At the same time, however, the PPS—and the reduced payment limits in effect before its implementation—could result in restrictions on access to home health care, or reduced care, especially for beneficiaries who use the greatest amounts of such care.

This paper focuses on how the new PPS and the interim payment system might affect beneficiaries who need long-term care. These are beneficiaries who, due to chronic illness or disability, need personal assistance with basic routine tasks of life. Although difficult to measure precisely, the prevalence of long-term care needs is often approximated by the rate of functional limitations typically associated with the need for personal assistance. In 1993, about one-fourth of Medicare beneficiaries needed long-term care (Figure 1). Approximately 6 percent lived in a nursing home or other institution. Another 19 percent were community residents who needed personal assistance with at least one of six activities of daily living (ADLs)—bathing, getting in and out of a bed or chair, using the toilet, dressing, eating, and walking.[1] Compared with elderly beneficiaries, a greater proportion of beneficiaries under age 65 and disabled (about 13 percent of total beneficiaries in 1997) have long-term care

[1] Because surveys and researchers vary in their definitions of functional limitations and the specific ADLs and instrumental activities of daily living (IADLs) they use, estimates of the rate of functional limitations often differ among studies. See, for example: Joshua M. Wiener et al., "Measuring the Activities of Daily Living: Comparisons Across National Surveys," *Journal of Gerontology: Social Sciences* 45(6): S229-S237, 1990; and Joshua M. Wiener and Catherine M. Sullivan, "Long-Term Care for the Younger Populations: A Policy Synthesis, in Joshua M. Wiener, Steven B. Clauser, and David L. Kennell, eds., *Persons with Disabilities: Issues in Health Care Financing and Service Delivery* (Washington, D.C.: The Brookings Institution, 1995).

needs. In 1992, about one-third of these beneficiaries lived in the community and had ADL limitations, and another 7 percent lived in long-term care facilities.[2] Still, 84 percent of beneficiaries with long-term care needs in 1992 were elderly.

Figure 1
Distribution of Medicare Beneficiaries, by Long-Term Care Needs, 1993



Total Medicare Beneficiaries = 37.6 million

Source: Judith Feder and Jeanne Lambrew, "Why Medicare Matters to People Who Need Long-Term Care," *Health Care Financing Review* 18(2):99-112, Winter 1996 (data from Health Care Financing Administration, Office of the Actuary, analysis of the Medicare Current Beneficiary Survey).

Beneficiaries with long-term care needs are of particular concern for several reasons. First, because they are relatively more likely than other beneficiaries to use home health care—and to use more care, on average, when they do—they may be significantly affected by the policy changes. Second, these changes may especially affect users with the longest episodes of care, most of whom have long-term care needs. Third, since beneficiaries with long-term care needs have considerably poorer health status and lower incomes than other beneficiaries, they may be particularly vulnerable to any adverse effects of the policy changes on access to needed care.

[2] Mary A. Laschober and Gary L. Olin, *Health & Health Care of the Medicare Population: Data from the 1992 Medicare Current Beneficiary Survey* (Rockville, MD: Westat, Inc., November 1996).

MEDICARE'S HOME HEALTH CARE BENEFIT: WHY CHANGE IT?

Although Medicare primarily covers acute medical care furnished by hospitals, physicians, and other providers, it also covers some services often referred to as post-acute care, including home health care, and skilled nursing facility and rehabilitation services. The post-acute care benefits are designed to provide skilled services and therapies, especially following acute medical care, for people who do not need the more intensive level of care offered in hospitals. In recent years, Medicare's spending for home health care—its largest area of post-acute care spending—has climbed rapidly. By 1996, home health accounted for 9.2 percent of total Medicare spending, up from 3.6 percent in 1990.[3] The changes in home health policy in the BBA are largely in response to concerns about this rapid rate of growth and its sources.

THE HOME HEALTH BENEFIT

Medicare's home health benefit does not cover long-term care for people who need such care exclusively, but for people who qualify, the types of care it covers overlap substantially with the types that constitute long-term care. Specifically, the home health benefit covers some personal assistance with basic activities—that is, long-term care type services—along with skilled, post-acute services to beneficiaries who need both.

Medicare pays for home health care for homebound enrollees who need intermittent skilled-nursing care, or physical or speech therapy.[4,5] For those who meet the eligibility criteria, Medicare will pay for part-time or intermittent skilled nursing and home health aide services; physical, speech and occupational therapy; and medical social services. Beneficiaries can receive an unlimited number of visits and do not pay a deductible or coinsurance for home health visits. A physician must initially certify the need for home health care and establish a treatment plan, recertifying the need for services at least every two months. Services must be provided by, or arranged by, a Medicare-certified home health agency. In addition to home health visits, durable medical equipment—such as walkers and oxygen equipment—and most medical supplies furnished by home health agencies are also covered. (Beneficiaries must pay 20 percent coinsurance for covered durable medical equipment.)

While people eligible for home health care may receive some assistance with basic tasks of daily living from home health aides, the coverage of such services is limited. Medicare does not cover personal care (such as assistance with bathing or eating) or household services (such as meal preparation or housework) if these are the only services a beneficiary needs.

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[3] Based on data from the Health Care Financing Administration, Office of the Actuary, 1997.

[4] Although the need for occupational therapy cannot be used to establish eligibility initially, Medicare will continue to cover home care for beneficiaries who require occupational therapy after they no longer need one of the qualifying services.

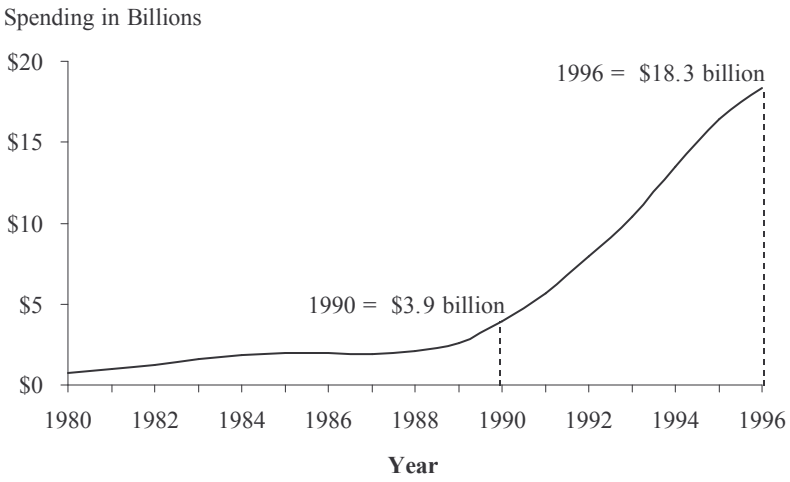
[5] Health Care Financing Administration, Department of Health and Human Services, *Medicare Home Health Agency Manual: Transmittal No. 222*, April 1989.

Home health aide visits must be prescribed by a physician for the purpose of providing personal care or other services that are needed to maintain the beneficiary's health or facilitate treatment.[6] However, home health aides are permitted to provide a small amount of incidental personal or household services at the time they are administering covered care. Due to the broad eligibility and coverage criteria, the benefit covers a wide range of patients, from those needing one or a few visits, to those needing extensive care, and from those needing only skilled nursing care or therapy to those needing a mix of services.

GROWTH IN HOME HEALTH SPENDING AND CONTRIBUTING FACTORS

During the past several years, home health has been one of the most rapidly growing parts of the Medicare program. From 1990 to 1996, spending rose from $3.9 billion to $18.3 billion, an average annual rate of 29 percent (Figure 2).[7] In comparison, total Medicare spending increased, on average, by 11 percent annually. Estimated fiscal year 1997 spending for home health care is $19.0 billion.[8]

Figure 2
Medicare Spending for Home Health Care, 1980-1996



Source: Georgetown University Institute for Health Care Research and Policy, based on data from the Health Care Financing Administration, Office of the Actuary, May 1997.

Trends in Use

The largest component of the recent growth of spending has been the increase in average number of visits per home health user. From 1990 to 1996, this average more than

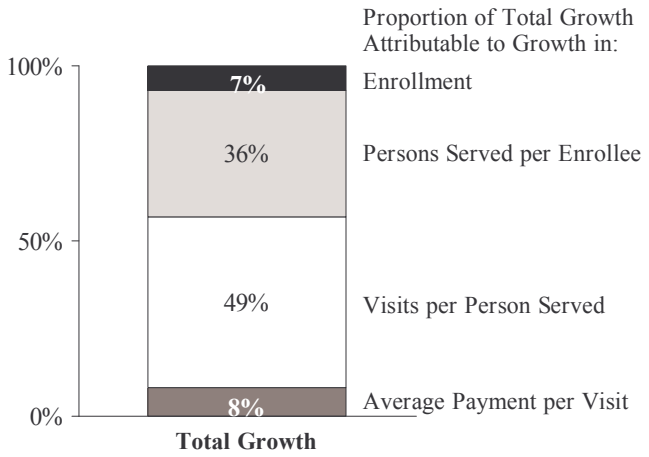
[6] Home health aides are trained to provide health assistance, such as changing bandages or dressings, and other care that is supportive of skilled nursing or therapy. They typically have more training than personal care aides and perform tasks requiring more skill. Walter Feldesman, *Dictionary of Eldercare Terminology* (Washington, D.C.: United Seniors Health Cooperative, 1997).

[7] Authors' calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1997. Only the hospice benefit--which accounted for just 1 percent of Medicare spending in 1996--has risen faster than home health, averaging 33 percent annual growth between 1990 and 1996.

[8] The $19.0 billion excludes spending on home health care for beneficiaries enrolled in Medicare-contract health maintenance organizations. Congressional Budget Office, Medicare Baseline, January 1997.

doubled from 36 visits to 77 visits, accounting for 49 percent of the total increase in home health spending over the period (Figure 3). The proportion of beneficiaries using home health has also grown rapidly, from 5.6 percent in 1990 to 9.8 percent in 1996, accounting for 36 percent of home health spending growth. In contrast, average payments per visit have risen slowly, accounting for only 8 percent of total growth in spending for this benefit. Average payments per visit rose only 2.2 percent annually, less than the rate of general inflation. This relatively slow growth reflects in part a shift in the mix of visits over time, with an increasing proportion consisting of lower-cost home health aide visits.

Figure 3
Sources of Growth in Medicare Spending for Home Health Care, 1990-1996



Source: Georgetown University Institute for Health Care Research and Policy, based on data from the Health Care Financing Administration, Office of the Actuary, 1997, and the Prospective Payment Assessment Commission, 1997.

Factors Influencing Growth

A number of factors have influenced recent growth in the use of home health care. The most important of these is probably the expansion in eligibility and coverage criteria in 1989. Other contributing factors include decreased regulatory oversight of the industry, changing medical practices, and incentives of Medicare's payment system and the benefit design.

Expansions in eligibility and coverage criteria. As has been widely noted, regulatory changes that broadened home health benefit eligibility and coverage rules were an important factor in the recent expansion of home health spending.[9] In 1989, as part of an

[9] See, for example: General Accounting Office (GAO), *Medicare: Home Health Utilization Expands While Program Controls Deteriorate,* GAO/HEHS-96-16, March 1996; Genevieve Kenney and Marilyn Moon, "Reining In the Growth in Home Health Services Under Medicare," The Urban Institute, February 1997; and Christine Bishop and Kathleen Carley Skwara, "Recent Growth Of Medicare Home Health," *Health Affairs* 12(3):95-110, Fall 1993.

agreement reached in a lawsuit, Duggan v. Bowen, the Health Care Financing Administration (HCFA) revised the Medicare payment manual to clarify the eligibility and coverage standards for home health care.[10] The revisions effectively made a wider range of beneficiaries eligible for home health and allowed them to receive a greater number—and more frequent—visits than under prior practices. The revisions clarified that care:[11]

- Eligibility based on needing "intermittent" skilled nursing care requires the beneficiary to have a medically predictable, recurring need for skilled nursing services. This criterion can usually be met if the person needs skilled nursing services at least once every 60 days, and can also be met if the person has a less frequent, but recurring, predictable need for such care.

- Skilled nursing services used to establish eligibility include observation, and management and evaluation of patient care (as well as direct services).

- Beneficiaries who are in stable condition or need chronic skilled care can be eligible for home health care. (Previous eligibility standards had been interpreted as requiring that a recipient's condition be improving.)

The revisions also clarified that Medicare would cover skilled nursing and home health aide visits if they were "part-time *or* intermittent." In contrast, Medicare's fiscal intermediaries had, in practice, required visits to be "part time *and* intermittent." The revised regulations specified that beneficiaries could get, on a weekly basis, up to 28 hours of skilled nursing and home health aide services combined (and up to 35 hours subject to review on a case-by-case basis). The revisions also permitted beneficiaries to receive full-time care (that is, 8 hours per day) for up to 21 consecutive days, or longer in exceptional cases where the need for care was finite and predictable.

Less regulatory oversight. Changes in regulatory practices and a loosening of regulatory oversight appear to have further contributed to higher home health spending.[12] The 1989 changes in the payment manual made it more difficult for Medicare's intermediaries to deny home health claims by prohibiting denials to be made solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on general utilization data. Instead, the revision required that the need for care be evaluated based on review of the patient's medical condition. This change made it costlier for intermediaries to determine whether a claim should be denied, thereby resulting in fewer denials. In addition, because of

[10] Duggan v. Bowen, U.S. District Court for the District of Columbia, Number 87-0383, August 1, 1988.

[11] GAO, 1996; Richard Price, "Medicare's Home Health Benefit," Congressional Research Service, 95-1009 EPW, March 11, 1996; and Health Care Financing Administration, 1989.

[12] GAO, 1996.

significant budget reductions in Medicare's funding for contractor medical reviews, the proportion of claims intermediaries must review declined. Also because of funding cuts, Medicare in 1995 dropped a requirement that audits of home health agencies include visiting beneficiaries' homes (although the option of doing so remains).

Changing environment and medical practices. The greater availability of home health following the 1989 changes helped the benefit adapt to changing medical practices. These include the shortening of hospital stays in response to Medicare's PPS for inpatient hospital services, as well as medical advances. For example, medical innovations have enabled some patients to be treated at home or through a combination of outpatient and home health care, thereby avoiding—or receiving shorter—hospital stays.

Increased access to home health care also may have allowed some beneficiaries to remain at home rather than receive care in a nursing home. During the past decade, both nursing home residency and average lengths of stay in nursing homes have declined among the elderly. From 1985 to 1995, the proportion of elderly people living in nursing homes and similar institutions fell from 4.6 percent to 4.1 percent, and their average stay went down by 18 percent, from 1,026 to 838 days.[13] These drops may be linked to greater availability of care at home.[14]

Incentives of the payment system and benefit design. At the same time, however, the incentives created by the payment system and benefit structure may have resulted in more home health care being provided than was needed for appropriate care. Home health is one of the few remaining areas of Medicare in which providers are reimbursed on the basis of costs. Medicare pays home health agencies based on allowable costs, subject to a specified limit on the agency's total payments for all covered home health visits.

Prior to the BBA's changes in the limits (which are effective for agencies' cost-reporting periods beginning on or after October 1, 1997), each agency's payment limit was calculated as the sum across visit types of the per visit limit for each of six visit types multiplied by the number of visits of that type provided by the agency. The visit types are skilled nursing care, physical therapy, speech therapy, occupational therapy, home health aide services, and medical social services. Thus, an agency could avoid hitting its payment limit by offsetting above-average costs per visit for one type of service with below-average costs for another type. The limit for each visit type was set at 112 percent of the national average cost per visit incurred by free-standing home health agencies for that service type,

[13] Genevieve W. Strahan, *An Overview of Nursing Homes and their Current Residents: Data from the 1995 National Nursing Home Survey*, Advance Data from Vital and Health Statistics, No. 280 (Hyattsville, MD: National Center for Health Statistics, 1997); and Achintya N. Dey, *Characteristics of Elderly Nursing Home Residents: Data from the 1995 National Nursing Home Survey*, Advance Data from Vital and Health Statistics, No. 289 (Hyattsville, MD: National Center for Health Statistics, 1997).

[14] Dey, 1997.

with adjustments for urban or rural location and for differences in wage rates among geographic areas.

The main shortcoming of the old payment system was that it provided little incentive for agencies to deliver an efficient amount or mix of home health services. Although agencies' payments were subject to limits, it is difficult to assess the extent to which those limits have affected average costs per visit. While the limits do not appear to have been binding for most agencies, this may be because they slowed cost growth to keep from exceeding their limits. For example, in 1994, only 29 percent of agencies had costs exceeding their limits.[15] However, since an agency's payment limit increased with the number of visits it delivered, it had no reason to curb volume as long as the average cost per visit did not exceed the average limit. In fact, because the limits were based on national averages, agencies had an incentive to provide numerous, relatively low-cost visits within each visit type. At the same time, because Medicare covers unlimited visits with no copayments, beneficiaries are likely to consider services as desirable, even if their value is minimal.

Other factors. The rapid growth in the number of Medicare-certified home health agencies, particularly for-profit ones, suggests that the payment policies have been attractive. From 1990 to 1995, the number climbed by 60 percent, from 5,695 agencies to 9,120.[16] Free-standing, for-profit agencies accounted for 60 percent of the growth. They increased from 33 percent of all certified agencies in 1990 to 43 percent in 1995.

In addition to the attractive incentives, the ease of obtaining and keeping Medicare certification may have contributed to this trend: Medicare certifies nearly all home health agencies that apply, and agencies generally retain their certification, even after being repeatedly cited for substandard care.[17]

The incentives created by Medicare's policies with respect to other services besides home health care may also have indirectly affected home health use. By promoting shorter hospital stays, for instance, Medicare's PPS for inpatient hospital care probably drove up the demand for home health following hospitalization. The financial pressures created by the hospital PPS also motivated hospitals to seek additional sources of revenue beyond inpatient care, and therefore may have encouraged some to establish and refer patients to hospital-based home health agencies. For example, one study found that patients treated in hospitals that own a post-acute provider (such as a home health agency or skilled nursing facility) were

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[15] Prospective Payment Assessment Commission (ProPAC), *Medicare and the American Health Care System: Report to the Congress* (Washington, D.C.: ProPAC, June 1997).

[16] National Association for Home Care, *Basic Statistics About Home Care 1996* (Washington, D.C.: National Association for Home Care, October 1996).

[17] General Accounting Office, *Medicare Home Health Agencies: Certification Process Is Ineffective in Excluding Problem Agencies*, testimony by Leslie G. Aronovitz before the Senate Special Committee on Aging, GAO/T-HEHS-97-180, July 28, 1997.

somewhat more likely to receive post-acute care immediately after hospitalization than patients with similar diagnoses treated in other hospitals.[18]

[18] Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (Washington, D.C.: ProPAC, June 1996).

THE BALANCED BUDGET ACT'S CHANGES IN HOME HEALTH POLICY

The Balanced Budget Act of 1997 makes a number of changes in Medicare's home health care policy, the most important of which will affect Medicare's method of paying for home health.[19] The aim of these proposals is not simply to control the price of home health services but to constrain volume per person served.

INTERIM SYSTEM OF PAYMENT LIMITS

During the next two years, Medicare will continue to pay home health agencies on the basis of costs, subject to modified and tighter limits. For cost-reporting periods beginning on or after October 1, 1997, home health agencies' payments will be subject to the lower of two limits.[20] The first is a *cost limit* on the agency's total reimbursable costs, computed using a method that is similar to the current cost limit (although reduced by certain modifications). The modifications base the per visit limits on 105 percent of median national costs for each type of visit, instead of 112 percent of the mean as under the previous method. Additionally, they lower the limits to recapture the savings from a two-year freeze on updates that ended in July 1996. The second caps how much each agency can receive per beneficiary it serves. This *per beneficiary* limit is a blended amount based on 75 percent of the agency's costs per beneficiary and 25 percent of the average cost per beneficiary for agencies in its census region, using 98 percent of a base year's costs (cost-reporting period ending during fiscal year 1994). The amount is updated by the home health market basket, a national index of growth in input costs of home health agencies, such as wages and utility expenses.[21]

PROSPECTIVE PAYMENT SYSTEM

The BBA requires that a PPS for Medicare home health services be established for cost reporting periods beginning on or after October 1, 1999. The Act leaves most specific details of the system to be developed by the Secretary of the Department of Health and Human Services. For example, the Secretary is to determine the unit of service on which prospective payments will be based, the standard prospective payment amount (or amounts), and the adjustments used to rates to account for difference in factors related to costs. Specifically, the BBA requires payment rates to account for differences in patients' needs (case mix) and geographic variations in wage levels. It gives the Secretary the option of incorporating regional or urban differences, or both. The Secretary has the further option of providing

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[19] *Balanced Budget Act of 1997: Conference Report to Accompany H.R. 2015*, U.S. House of Representatives, Report 105-217, July 30, 1997.

[20] The legislation also delays the annual update in payment limits for certain agencies. Specifically, agencies with cost-reporting periods beginning from July 1, 1997, to September 30, 1997, did not receive an update in 1997. Instead, such an agency will receive its next update effective for its cost-reporting period beginning in 1998, at which time it will also shift to limits computed under the new interim system.

[21] The updates to costs for computing per beneficiary limits will include the two-year freeze that began on July 1, 1994, which also affects the cost limits.

additional payments or adjustments for outliers (cases requiring an unusual amount or type of care) not to exceed 5 percent of total PPS payments in a fiscal year.

Initially, rates under the PPS are to be set so that projected total payments in fiscal year 2000 will be equal to what they would be under a 15 percent reduction in agencies' cost and per beneficiary limits. If the PPS is not ready to be implemented on October 1, 1999, the cost and per beneficiary limits are to be reduced by 15 percent instead.

OTHER CHANGES IN PAYMENTS

The BBA makes other, more minor, changes in home health payment policy. It requires that, beginning October 1, 1997, payment limits for home health agencies will be based on where services are provided, rather than where the home health agency's billing office is located. The BBA also eliminates periodic interim payments to home health agencies after fiscal year 1999.

CHANGES IN ELIGIBILITY AND COVERAGE CRITERIA

Besides changes in payments, the BBA contains several provisions affecting (or potentially affecting) Medicare's eligibility and coverage rules. First, the Act narrows the eligibility criteria for home health by requiring that a need for skilled nursing care not be based solely on requiring venipuncture for drawing a blood sample; this provision becomes effective February 5, 1998 (6 months after enactment). Information from a National Association for Home Care (NAHC) survey (with about 250 respondents) suggests that this change may affect numerous beneficiaries. Home health episodes may be shortened, for example, for some patients who start out with substantial needs for skilled care but who become ineligible once those needs taper off and venipuncture is the only skilled service they require.

Second, the BBA defines "intermittent" skilled nursing care for determining eligibility and "part-time or intermittent" skilled nursing and home health aide care for determining coverage, effective for services provided on or after October 1, 1997. The new definitions differ somewhat from the previous regulatory definitions and practices:

- "Intermittent" skilled nursing care for purposes of eligibility is defined by the BBA as skilled nursing care needed on fewer than 7 days each week or less than 8 hours each day for periods of up to 21 days (or longer in exceptional circumstances when the need for additional care is finite and predictable). In contrast, the previous definition was generally interpreted as requiring that care be needed on fewer than 5 days each week (for periods of any length), or up to 7 days per week for periods of two to three weeks (with exceptions where the need for care was finite and predictable).[22] Thus, the main effect of this change is to expand eligibility by now including people who need care on 5 or 6 days per week for a period of more than 3 weeks.

[22] Health Care Financing Administration, Division of Post-Acute Care, 1997.

- "Part-time or intermittent" skilled nursing and home health aide care, for coverage purposes, is defined by the BBA as care provided for less than 8 hours each day and 28 or fewer hours each week (or less than 8 hours each day and 35 or fewer hours each week subject to review on a case-by-case basis). This represents a narrowing of coverage. Under the previous rules, Medicare also covered full-time care (that is, 8 hours per day) for up to 21 consecutive days (or longer, in cases where the need for care was finite and predictable), and therefore permitted up to 56 hours per week of skilled nursing and home health aide visits. Under the previous rules, Medicare also covered care provided for 8 or more hours per day as long as it was intermittent (that is, not daily) and did not exceed 28 hours per week (or 35 hours under case-by-case review).

Third, the Act permits the Secretary to establish standards for the frequency and duration of covered home health services, effective October 1, 1997. Medicare will not pay for visits that exceed such standards. However, neither how these standards would be defined nor what, if any, impact they might have, is clear. For these reasons, the Congressional Budget Office (CBO) has not projected any Medicare savings from this policy.

Finally, although the law does not change the definition of "homebound," as applied in determining eligibility, it recognizes the recent concerns over this standard by compelling the Secretary to study the criteria used to meet this requirement, including the circumstances under which a person can leave home and still qualify. The Secretary is to send recommendations to Congress by October 1, 1998.

OTHER CHANGES

A provision in the BBA affecting hospital payments may also influence home health use by reducing the financial advantage for hospitals of discharging certain types of patients to home health after relatively short stays. Beginning October 1, 1998, hospital patients in ten diagnosis-related groups (DRGs) who are discharged to post-acute care, including home health, will be treated as transfers for purposes of determining hospital payment. (The Secretary is to choose these DRGs based on high volume and use of post-acute care.) In such cases, if the hospital stay were relatively short, payment would be less than the full per patient DRG rate.

Supplementing the BBA, recent regulatory changes in home health policy seek to slow growth by reducing fraud in the program. Specifically, these changes place a moratorium on certification of any new home health agencies for approximately six months as of September 15, 1997.[23] They also require existing agencies to reapply every 3 years for

[23] Health Care Financing Administration, Office of Legislation, 1997; and Amy Goldstein, "President Acts to Curb Home Health Care Fraud," *The Washington Post*, September 16, 1997, p. A4.

continued certification. Additionally, they increase the numbers of audits of home health agencies and reviews of home health claims conducted by the government.

BUDGETARY EFFECT

The CBO estimates that the BBA's home health care provisions will lower Medicare spending on this benefit by $16.2 million, or 12.8 percent, during the five-year period from fiscal year 1998 through fiscal year 2002, compared with what it would have been without a change in policy.[24] As a result, a significant slowing of Medicare's home health spending is projected. Based on CBO's projections, spending is expected to rise on average by 5.8 percent annually during this period, from $19.0 billion in fiscal year 1997 to $25.2 billion in fiscal year 2002.[25] Absent policy change, CBO had projected 9.5 percent annual growth for this period.

[24] Based on CBO, Estimated Budgetary Impact of H.R. 2015 (Public Law 105-33), The Balanced Budget Act of 1997, August 12, 1997; and CBO, Medicare Baseline, January 1997.

[25] CBO's projections for home health spending are for Medicare's fee-for-service benefits; they do not include home health care provided to beneficiaries enrolled in health maintenance organizations or in other types of health plans receiving capitation payments from Medicare.

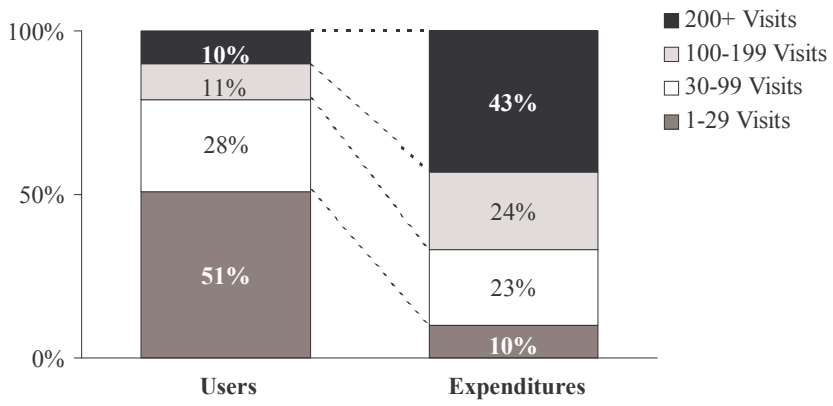
WHO WILL THE CHANGES AFFECT MOST? CHARACTERISTICS OF HOME HEALTH USERS

As the new payment limits and then the PPS become effective, home health agencies will encounter financial pressure to constrain cost growth. Beneficiaries with the highest levels of use are likely to be affected the most by the changes in the delivery of home health. They will be especially affected not only because home health services play a large role in their health care, but also because policy changes (both the interim system and the PPS) will create incentives for agencies to reduce high volume episodes.

PATTERNS OF USE

In 1996, about 10 percent of Medicare beneficiaries used home health care. However, a relatively small share of beneficiaries accounted for a disproportionately large share of home health spending. In 1994, only 10 percent of users (1 percent of the Medicare population) had 200 or more visits during the year, yet they accounted for 43 percent of all home health spending (Figure 4). Most users did not have many visits: 51 percent of users in 1994 had fewer than 30 visits, while 23 percent had fewer than 10.[26]

Figure 4
Distribution of Medicare Home Health Users and Expenditures, by Number of Visits, 1994



Source: Joel Leon, Patricia Neuman, and Stephen Parente, "Understanding the Growth in Medicare's Home Health Expenditures," Henry J. Kaiser Family Foundation, June 1997.

Both the percentage of users with numerous visits and their share of spending have been expanding. From 1991 to 1994, for instance, the share of users with 200 or more annual

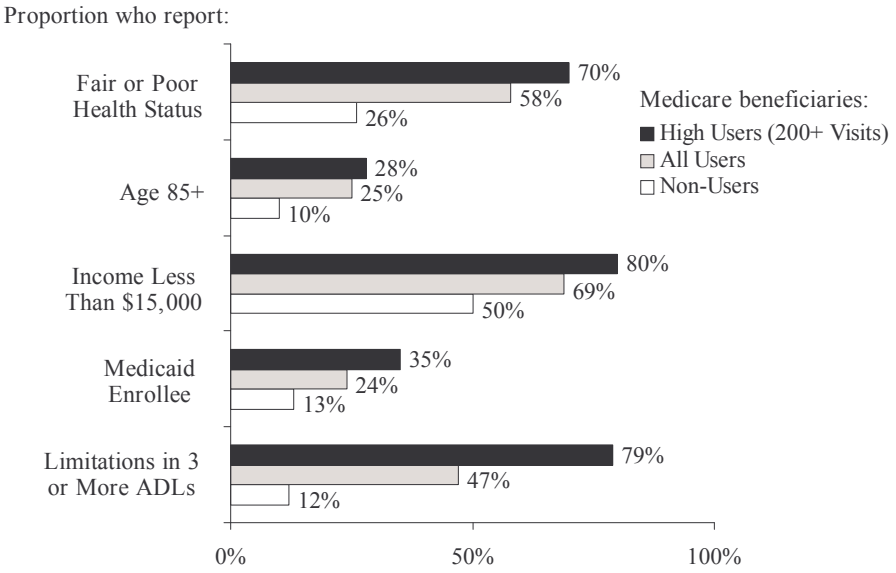
[26] ProPAC, June 1997.

visits rose from 4 percent to 10 percent.[27] Spending on their care grew from 20 percent of total home health spending in 1991 to 43 percent in 1994. Consequently, these high users accounted for 60 percent of the total growth in home health spending over the three-year period.[28]

CHARACTERISTICS OF USERS

In general, compared with other beneficiaries, home health users are more likely to report fair or poor health, be 85 or older, have low incomes, and be enrolled in Medicaid (Figure 5). Most home health users require the type of personal assistance with ADLs associated with long-term care, and many have substantial needs, as indicated by multiple limitations. In 1994, three-quarters of home health users reported limitations in at least one ADL, while 47 percent reported limitations in three or more ADLs (Figures 5 and 6).[29] In comparison, only 12 percent of non-users reported limitations in three or more ADLs.

Figure 5
Demographic Characteristics of High Home Health Users, All Home Health Users, and Non-Users, 1994



Source: Georgetown University Institute for Health Care Research and Policy, based on data from Joel Leon, Patricia Neuman, and Stephen Parente, "Understanding the Growth in Medicare's Home Health Expenditures," Henry J. Kaiser Family Foundation, June 1997.

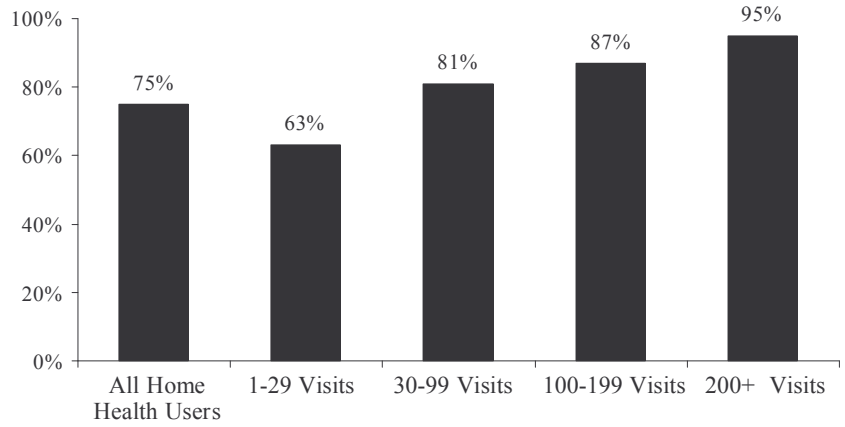
[27] Joel Leon and Steve Parente, *Understanding the Growth in Medicare Home Health Utilization and Expenditure: Technical Report*, Center for Health Affairs, Project HOPE, August 1997.

[28] Authors' estimate using data on 1991 and 1994 distributions by visit groups from Leon and Parente, 1997, and data on total expenditures from Health Care Financing Administration, Office of the Actuary, 1997.

[29] Based on the following six ADLs: bathing or showering, dressing, getting into and out of bed or chair, using the toilet, eating, and walking.

The highest users of home health care are even more likely to have significant health care needs and low incomes. In 1994, 70 percent of users with 200 or more visits reported fair or poor health status, compared with 58 percent of all home health users and 26 percent of non-users (Figure 5). A large proportion of high home health users have long-term care needs. Of beneficiaries with 200 or more visits, 95 percent had at least one ADL limitation and 79 percent reported limitations in three or more ADLs (Figures 5 and 6). Also, among high home health users, 80 percent had incomes below $15,000, compared with 69 percent of all home health users, and 50 percent of non-users.

Figure 6
Proportion of Home Health Users with Functional Limitations in One or More Activities of Daily Living, by Number of Visits, 1994



Source: Georgetown University Institute for Health Care Research and Policy, based on data from Joel Leon and Stephen Parente, *Understanding the Growth in Medicare Home Health Utilization and Expenditures: Technical Report*, Project HOPE, August 20, 1997.

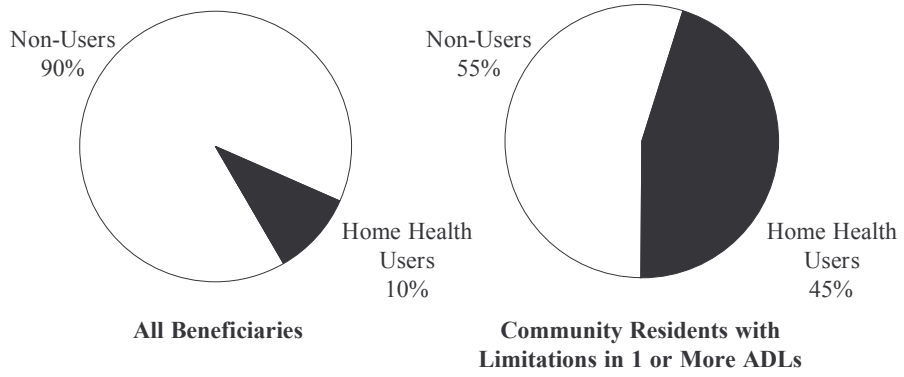
The prevalence of long-term care needs and the relatively long periods of care suggest that beneficiaries with the longest episodes of home health are using the benefit to help them cope with chronic conditions. Beneficiaries with the longest episodes of care also use a mix of visit types that includes relatively more home health aide visits and fewer skilled nursing care visits than users with shorter episodes of care. For example, using 1993-1994 data, the Prospective Payment Assessment Commission (ProPAC) estimated that for episodes lasting 166 days or longer, 50 percent of visits were home health aide visits, 42 percent were skilled nursing visits and 8 percent were physical therapy or other types of visits. In comparison, for episodes lasting 30 or fewer days, only 21 percent of visits were home health aide visits, while 60 percent of visits were skilled nursing visits and 19 percent were physical therapy or other types of visits.[30]

[30] Prospective Payment Assessment Commission, *Report and Recommendations to the Congress* (Washington, D.C.: ProPAC, March 1, 1996).

These trends have raised questions about the extent to which the benefit may be providing predominantly long-term care services, in contrast to the post-acute skilled nursing and therapy services on which the benefit was originally intended to focus. However, other evidence suggests that long-term care needs may not be the primary factor influencing long episodes of home health.

First, long-term care needs by themselves do not predict high home health use. While this group is notably more likely to use home health care compared with other beneficiaries, over half of beneficiaries with long-term care needs who are not in nursing homes do not use the home health benefit. In 1996, roughly 55 percent of beneficiaries living in the community with one or more ADL limitations did not use home health care (Figure 7). Further, even among beneficiaries with substantial long-term care needs who use home health, most are not high users. In 1994, only 16 percent of home health users with limitations in three or more ADLs received 200 or more visits (Figure 8).

Figure 7
Proportion of Beneficiaries Using Home Health Care, by Functional Status, 1996



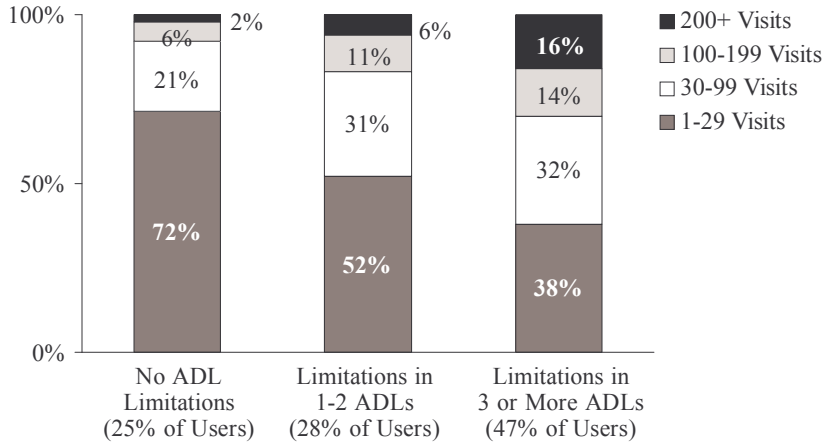
Note: The proportion of home health users among community residents with functional limitations was approximated using 1992 data for elderly beneficiaries adjusted to reflect growth between 1992 and 1996 in the proportion of total beneficiaries using home health.

Source: Georgetown University Institute for Health Care Research and Policy, based on data from the Medicare Current Beneficiary Survey, 1992, and the Health Care Financing Administration, Office of the Actuary, 1997.

Moreover, evidence on the health care needs of high home health users suggests that they often have substantial acute as well as long-term care needs. In a study of home health patients with episodes lasting six months or longer (about 12 percent of all episodes), the researchers found that 82 percent had multiple illnesses and about one-half had an acute illness or acute exacerbation of a chronic illness.[31] Further, the primary diagnoses at admission to home health for users with long episodes were similar to those for home health patients in general. The authors concluded that it is incorrect to identify short-stay home

health patients as those with acute illnesses and long-stay patients as those with chronic illnesses.

Figure 8
Distribution of Medicare Home Health Users, by Functional Status and Number of Visits, 1994



Source: Georgetown University Institute for Health Care Research and Policy, based on data from Joel Leon, Patricia Neuman, and Stephen Parente, "Understanding the Growth in Medicare's Home Health Expenditures," Henry J. Kaiser Family Foundation, June 1997.

Similarly, another study found that most high home health users have acute medical conditions, as evidenced by their use of acute and other post-acute services. About two-thirds of users with 200 or more visits in 1994 had either used home health as part of an acute episode (typically, after a hospital stay) or had "medically complex" patterns of care during the year, often including multiple hospitalizations followed by post-acute care.[32] The other one-third of high users had begun home health use without prior hospital or skilled nursing facility use.

Based on the evidence from these studies, most high home health users do not appear to be using Medicare's home health benefit solely or predominantly for long-term care. Rather, most appear to have multiple—often complex—medical needs, requiring a range of acute and long-term care services. Many are in and out of the hospital, often several times in a year, and therefore typically use home health in conjunction with acute and other post-acute services. Thus, for heavy users, Medicare's home health care benefit appears mainly to provide both skilled post-acute care and long-term care services to those who need both.

[31] Barbara R. Phillips and Amy Zambrowski, *A Profile of Very-Long-Stay Medicare Home Health Patients: Characteristics and Care*, Mathematica Policy Research, Draft, July 30, 1995.

[32] Joel Leon, Patricia Neuman, and Stephen Parente, "Understanding the Growth in Medicare's Home Health Expenditures," The Henry J. Kaiser Family Foundation, June 1997.

ISSUES IN LIMITING PAYMENTS FOR HOME HEALTH: HOW MIGHT BENEFICIARIES BE AFFECTED?

Both the interim payment system and the PPS are likely to have their greatest impact on high home health users because of the incentives they will create for agencies to limit the number of visits they provide per user. Under the PPS, the specific details of the payment method will determine how powerful the incentives will be.

INTERIM SYSTEM OF LIMITS ON AGENCIES' PAYMENTS

Establishing a per beneficiary limit for each home health agency will for the first time give agencies an incentive to restrict the number (as well as cost) of visits they provide to each patient. An agency's per beneficiary limit will depend on a blend of agency-specific and regional costs in the base year. Although the base year costs are updated to reflect average growth in agencies' input costs, the per beneficiary limits do not incorporate changes in the number or mix of visits per person served. Because the average number of visits (and corresponding spending) per user has been increasing, holding agencies to their 1994 per beneficiary costs is likely to constrain most agencies. Furthermore, the per beneficiary limit will probably be more restrictive than the cost limit for most agencies, because an agency's cost limit rises with the number of visits it provides (which the per beneficiary cap does not). Still, for some agencies with particularly high per visit costs relative to national averages, the cost limit could be the tighter constraint. The Health Care Financing Administration estimates that, in fiscal year 1998, about 70 percent of agencies would be affected by the lower cost limits alone, compared with 31 percent that would have been affected under the pre-BBA method of computing limits.[33] Even more agencies will probably be affected by either the cost or per beneficiary limits.

The agencies most affected by the tightened limits will not necessarily be the most inefficient ones (such as those providing more care than medically necessary). The per beneficiary limits will have the greatest effects on agencies in two circumstances. First, those whose patterns of care have, since the base year, shifted significantly toward a costlier amount or mix of services per person are likely to be affected by the per beneficiary limit. For some, that shift may reflect inefficient practices, such as providing more care than medically necessary. But for others, it may indicate a change in patient characteristics resulting in greater needs for care. The per beneficiary cap may significantly hamper the ability of such agencies to provide appropriate care, especially over time. In contrast, agencies with shifts toward less costly patients are likely to have looser per beneficiary limits, relative to their costs, than other agencies. In fact, the per beneficiary limits will provide an incentive for agencies to seek new, relatively low-cost patients. Still, reduced cost limits will constrain

[33] Health Care Financing Administration, Office of the Actuary, 1997.

even agencies with shifts toward less-costly patients more than they would have been under the former payment policy.

Second, by blending in a regional component, the per beneficiary limit will apply greater pressure on agencies with above-average per beneficiary costs in their region. Some of these agencies may be inefficient, but others are likely to have high costs because their patients have more intense needs, or are located in areas with relatively high home health use for other reasons.

Agencies facing financial pressure under the new payment rules will have strong incentives to change their behavior toward high users. They may try to limit their costs by reducing visits per person (for example, by discontinuing patients' visits sooner than they otherwise would) or shifting the mix of visits toward less costly ones. They might also seek to avoid beneficiaries whose care was expected to be especially costly. Similarly, agencies will have an incentive to avoid re-admitting a beneficiary who had already received home health care that year, since the per beneficiary limit is based on the number of individuals served during the year. (If a person is treated by multiple agencies during the year, the per beneficiary limits are to be prorated among the agencies.)

The potential effect of restricted numbers of visits on beneficiaries is uncertain. Relatively little is known about the effects of varying amounts and types of home health care on patient outcomes. Two recent studies, however, suggest that better outcomes are associated with greater Medicare home health use. One study of post-hospital home health use by Medicare beneficiaries found that for patients with similar characteristics, greater home health use was associated with reductions in the numbers of limitations in activities of living (ADLs) and instrumental activities of daily living (IADLs) beneficiaries' experienced, and with an increase in the likelihood that beneficiaries reported an improvement in general health status.[34] Another study, comparing home health use by beneficiaries in health maintenance organizations (HMOs) and fee-for-service settings, found that elderly beneficiaries in HMOs received fewer home health visits and had worse outcomes, after adjusting for differences in functional limitations, health condition and other factors.[35] The evidence from these studies calls for caution in assuming that reductions in service would be improvements in efficiency rather than lower quality care.

PROSPECTIVE PAYMENT SYSTEM

After two years, the interim system of payment limits is to be replaced by a more sophisticated PPS, with the potential capacity to adjust payments for patients' needs and

[34] Jack Hadley et al., "Use of Home Health Care, Post-Hospital Medicare Spending, and Changes in Health Status" Institute for Health Care Research and Policy, Georgetown University, draft, September 1997.

thereby offset the incentives to reduce care inappropriately. However, in the first year of the PPS, fiscal year 2000, in addition to the new system, agencies will also encounter a reduction of about 15 percent in aggregate home health payments relative to what they would have been under the previous year's payment limits. Ideally, agencies will respond to the new incentives and financial constraint by improving the efficiency and effectiveness of the care they provide—for example, by eliminating unnecessary visits and improving the content of visits so fewer would be needed. However, the new system and spending cuts could create even more powerful incentives for agencies to avoid the most costly patients, or to reduce or alter the services they provide in ways that diminish quality of care. Not only will aggregate payments be lowered by the 15 percent cut, but the PPS will introduce a profit incentive. Specifically, agencies that keep their costs below the PPS rates will earn profits, while under the interim system, agencies with costs below the limits will be reimbursed their costs, but not more.

The specific components of the PPS will be of critical importance to how the new system affects spending, access, and quality, especially for high users. These elements include the definition of the unit of service for the prospective rates, a patient classification system, adjustments for other factors related to costs, and a method of computing base payment rates.

Unit of Service and Patient Classification

The BBA leaves the definition of the unit of service to be developed, but implies that it will be some type of episode of care, generally consisting of multiple visits. Specifically, the Act states that in defining the unit of service, "the Secretary shall consider an appropriate unit of service and the number, type and duration of visits provided within that unit...." In an episode-based system, a home health agency will receive a fixed, predetermined payment for all the services it provides during that episode. Thus, the episode definition determines the period over which agencies will be expected to manage the patient's treatment for a given price.

In defining an episode, the key decisions are how to define when the episode begins and what services or time period it covers. An episode of home health care could, for example, be defined as all covered services received during a period that is both preceded and followed by periods (such as 45 days or 60 days) during which the person receives no covered care. Under this definition, an agency would usually receive one fixed payment for the entire episode, regardless of its length. Another option would be to define an episode in a similar way but limited by a specified maximum time period or number of visits. Under this option, one alternative is that services received after reaching the limit could be considered a new episode, with the agency receiving a payment for each episode. Another alternative

[35] Robert E. Schlenker, Peter W. Shaughnessy, and David F. Hittle, "Patient-Level Cost of Home Health Care Under Capitated and Fee-for-Service Payment," *Inquiry* 32: 252-270, Fall 1995.

would be to use an outliers or exceptions policy for the visits occurring after the limit, with the agency receiving an additional payment. (A variant of this option would be to treat an entire episode exceeding the limit—rather than only the visits beyond the limit—under an outlier or exceptions policy.)

In setting rates for an episode of care, the goal is to encourage delivery of an appropriate amount and quality of care in an efficient manner. As with the per beneficiary limits, rates that failed to consider patient characteristics would discourage appropriate treatment of costly patients. An episode-based PPS should therefore vary rates among different types of patients or episodes. The BBA requires the PPS to include such a case mix adjustment to its payment rates. Ideally, rates will vary to reflect important differences in patients' needs so that all patients retain equal access to care. Prospective payment systems also usually adjust payments to reflect differences in costs of providers that are considered to be beyond their control, such as differences in local wage levels, in order to provide equitable payments among providers.

Currently, the lack of a good case mix adjustor for home health care is a major hurdle for a PPS. Ideally, a case mix adjustor would not depend on service actually received, but instead on patient characteristics (such as medical condition and functional status) to classify patients by expected home health needs. Although Medicare developed a case mix classification system for use in a demonstration project on home health payment, that system was not intended for use as a case mix adjustor in a national system. Furthermore, it has been found to account for only a small portion of the variation in home health agencies' costs.[36]

The BBA requires research into a case mix adjustor and permits the collection of data from home health agencies to facilitate the development of one. However, it is not clear whether a good adjustor could be developed before the PPS is scheduled to become effective. Without good case mix adjustment, quality of care might be adversely affected, since some agencies that were providing appropriate amounts of care might not be able to cover the associated costs, while less efficient ones might profit. In addition, a poor case mix adjustor might give agencies an incentive to avoid certain types of patients for whom they expected the costs of care to exceed Medicare's payment.

Even with good case mix adjustment, another potential difficulty in defining home health episodes and setting appropriate rates is the immense variation in the length of home health episodes, which range from one day to several years. If a patient classification system were developed that sufficiently accounted for legitimate differences in the duration of home health needs, then the large variation might not be a problem. However, if high variation

[36] Henry B. Goldberg, "Implications of Alternative Home Health Payment Proposals," and Lewin-VHI, "Comparison of the Congressional Conference Agreement and an Alternative Proposal for the Medicare Home Health Care Benefit," in National Association for Home Care, *Analyses of The Republican Congressional and Democratic Medicare Home Health Payment Plans* (Washington, D.C.: National Association for Home Care, December 1995).

occurs within the patient categories used for rates, then agencies may face strong pressure to shorten episodes.

A related issue is how to define and adjust for outlier cases. The purpose of an outlier adjustment is to compensate agencies for unusually expensive cases and thereby to avoid discouraging them from accepting costly patients or from providing them with appropriate care. Under the BBA, total payments for outlier cases are to account for up to 5 percent of total home health payments. (A similar proportion of payments under Medicare's PPS for inpatient hospital care is devoted to outlier payments.)

Given the wide variation in episode lengths, 5 percent of payments would probably cover only a small proportion of care currently received by high home health users. For example, a Congressional proposal in 1995 would have set a maximum episode length of 165 days, with visits beyond that period subject to a different payment method than visits falling within that episode length. This definition would have meant that a large share of visits would probably have fallen outside the 165-day maximum. Analysis of 1993-1994 data by the Prospective Payment Assessment Commission (ProPAC), for instance, indicates that 20 percent of episodes exceeded 165 days and accounted for 61 percent of all visits, with 24 percent of all visits occurring after the 165th day.[37] Although visits after the 165th day may have had lower costs, on average, than other visits because a great proportion were home health aide visits, they probably accounted for well over 5 percent of total visit costs. Without adequate outlier payments, agencies may seek to limit the costs of treating the people needing the most care—for example, by cutting off their visits to end the episode, or by providing fewer visits or less costly visits during the episode.

Geographic Variation and Blended Rates

The large geographic variation in home health use poses another difficult issue for the design of a prospective system. For example, in 1995, the average number of visits per home health user was more than twice as high in the West South Central region as in the Middle Atlantic states—120 visits compared with 46 (Table 1). Although these rates do not adjust for variations in patients' needs, researchers have found that geographic differences persisted even after controlling for differences in selected patient characteristics.

Table 1
Average Number of Medicare Home Health Visits and Average Medicare Payments per Home Health User, by Region and State, 1995

	Average Visits per User		Average Payments per User	
		State	Payments	State

[37] Authors' calculations from results reported in ProPAC, March 1996.

Area of Residence	Number	Ranking[a]	(in dollars)	Ranking[a]
Total U.S.	**72.3**		**4,473**	
New England	**82.8**		**4,400**	
Connecticut	80.1	12	4,770	11
Maine	70.2	15	3,717	25
Massachusetts	94.3	9	4,730	13
New Hampshire	60.8	24	3,057	40
Rhode Island	63.1	23	4,037	22
Vermont	67.1	21	3,030	42
Middle Atlantic	**46.2**		**3,284**	
New Jersey	42.8	45	2,997	44
New York	48.5	38	3,569	31
Pennsylvania	45.7	41	3,155	37
East North Central	**55.5**		**3,580**	
Illinois	54.5	29	3,648	29
Indiana	78.9	14	4,431	17
Michigan	49.9	36	3,713	26
Ohio	53.8	31	3,232	35
Wisconsin	43.7	44	2,797	46
West North Central	**50.8**		**3,108**	
Iowa	49.3	37	2,467	51
Kansas	59.9	25	3,700	28
Minnesota	42.5	47	2,746	47
Missouri	54.1	30	3,466	33
Nebraska	42.4	48	2,678	48
North Dakota	46.2	40	2,535	50
South Dakota	42.5	46	2,556	49
South Atlantic	**72.3**		**4,383**	
Delaware	48.1	39	2,874	45
District of Columbia	45.4	42	3,708	27
Florida	80.7	11	5,105	9
Georgia	107.9	7	5,567	8
Maryland	38.3	50	3,023	43
North Carolina	56.3	27	3,358	34
South Carolina	68.5	16	3,939	23
Virginia	53.4	34	3,472	32
West Virginia	55.8	28	3,118	38
East South Central	**112.3**		**5,800**	
Alabama	121.7	4	5,675	7
Kentucky	67.6	19	3,595	30
Mississippi	127.6	2	6,205	6
Tennessee	121.1	5	6,886	4
West South Central	**119.8**		**7,016**	
Arkansas	80.7	10	3,870	24
Louisiana	144.2	1	7,867	1

Area of Residence	Average Visits per User		Average Payments per User	
	Number	State Ranking[a]	Payments (in dollars)	State Ranking[a]
Oklahoma	127.0	3	7,358	2
Texas	116.8	6	7,217	3
Mountain	**70.1**		**4,619**	
Arizona	59.4	26	4,366	18
Colorado	67.6	20	4,688	14
Idaho	65.6	22	4,192	20
Montana	53.5	33	3,228	36
Nevada	68.0	18	4,874	10
New Mexico	68.0	17	4,136	21
Utah	105.9	8	6,283	5
Wyoming	79.4	13	4,559	16
Pacific	**50.2**		**4,366**	
Alaska	45.3	43	4,568	15
California	53.5	32	4,735	12
Hawaii	51.7	35	4,235	19
Oregon	38.2	51	3,116	39
Washington	38.7	49	3,055	41

[a] Ranking of 1 indicates state (including the District of Columbia) with the highest value.

Source: Georgetown University Institute for Health Care Research and Policy, based on data from *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 1997.*

The BBA partially recognizes the geographic variation in utilization patterns in two ways. First, it permits a four-year transition period during which an agency's payments can be partially based on agency-specific costs. Second, after the transition period, it allows the prospective rates to permanently reflect regional differences in costs, rather than requiring fully national rates. Even within regions, however, use varies widely. Among states in the West South Central Region, for example, the average number of visits per user in 1995 ranged from 81 in Arkansas to 144 in Louisiana, or from 33 percent below to 20 percent above the regional average of 120, respectively.

The desirability of using regional or national averages to set rates would depend largely on the reasons for the variation. For example, using such averages may be more desirable if the variation is primarily because of differences in efficiency, but less desirable if they are related to differences in beneficiaries' needs beyond those reflected through case mix adjustments. Researchers have found a number of factors to be associated with state or regional variation in home health utilization. These include the availability of nursing home

beds, state Medicaid policies, and the proportion of patients served by for-profit agencies, as well as patients' demographic and health characteristics.[38]

This research suggests that there are currently two significant difficulties in determining appropriate geographic adjustments for a home health PPS. First, the sources of geographic variation in home health use are not fully understood. Although several studies have identified a number of factors that appear to influence home health use, the full range of sources and their roles is not completely known—for example, a lack of case mix information has meant that studies have generally been limited in their the ability to control for differences in patients' needs among geographic areas or agencies. Second, several of the factors found to influence home health are beyond an agency's control and unrelated to efficiency—in particular, state Medicaid policies and other state-level factors appear to influence Medicare home health use. For example, one study found that higher home health use among states was associated with lower Medicaid expenditures on home health, the lack of a state personal care program, and fewer long-term care facilities.[39] One implication is that agencies in locations with relatively high Medicare home health use may face especially strong incentives under national, or even regional rates, to restrict the amount of care they provide.

[38] See, for example: Marc A. Cohen and Anne Tumlinson, "Understanding State Variation in Medicare Home Health Care: The Impact of Medicaid Program Characteristics, State Policy, and Provider Attributes," *Medical Care* 35(6):618-633, 1997; Jennifer Schore, "Regional Variation in the Use of Medicare Home Health Services," in Joshua M. Wiener, Steven B. Clauser, and David L. Kennell, eds., *Persons with Disabilities: Issues in Health Care Financing and Service Delivery* (Washington, D.C.: Brookings Institution, 1995); and Genevieve M. Kenney and Lisa C. Dubay, "Explaining Area Variation in the Use of Medicare Home Health Services," *Medical Care* 30(1):43-57, 1992.

[39] Cohen and Tumlinson, 1997. See also: Genevieve Kenney, Shruti Rajan, and Stephanie Soscia, "Interactions Between the Medicare and Medicaid Home Care Programs: Insights from States," Urban Institute, #6523-003, November 1996.

CONCLUSION

The Balanced Budget Act will make major changes in the way Medicare pays home health agencies. By establishing first a per beneficiary payment limit and then an episode-based PPS, along with a cut of about 15 percent in total home health payments in fiscal year 2000, the new policies will give agencies powerful incentives to reduce their volume of care per patient. As a result, high-use beneficiaries are likely to be affected the most by agencies' responses to the new incentives. Ideally, agencies will be able to adapt by becoming more efficient—for example, by finding ways to reduce the number of visits or improve the content of visits while maintaining quality of care. However, the tightening of payments and the new incentives created by the changes in payment methods may lead to adverse effects on access to care, or quality of care.

The interim system will tighten the limits agencies face on the amount of their costs Medicare will reimburse. Because per beneficiary limits fail to account for changes in beneficiaries' needs, keeping them in place too long could jeopardize appropriate care.

Under the PPS, Medicare will pay for home health using per episode rates designed to reflect variation in patient case mix, along with other sources of variations in costs. In this way, the PPS could improve on the interim payment system's per beneficiary limits. It may be difficult, however, to develop a good case mix system before October 1, 1999, when the PPS is scheduled to take effect. Furthermore, imposing a reduction in total payments, with or without such a system, gives priority to savings over the objective of assuring payment that adequately reflects the greater care needs of some patients.

The risks of imposing an inadequate PPS system, like retaining a rigid interim system, are enormous for high home health users. Virtually all of these users require long-term care. But assumptions that payment constraints will limit only long-term care services may be overly simplistic. Evidence that high home health users experience a mix of acute and long-term care needs suggests that financial pressure to restrict service cannot be easily justified as focusing Medicare's home health benefit on acute rather than long-term care. Rather, such pressure penalizes beneficiaries with complex needs for multiple kinds of service.

To avoid arbitrary service restriction, it will be necessary to implement the home health payment changes in the BBA with caution, continuously monitoring their effects. If developing the refinements needed to make the PPS effective takes longer than is assumed by the BBA, it may be necessary to loosen or adapt the interim limits. If developing the refinements is more difficult than anticipated, then it may be necessary to reassess how best to balance incentives in updating the home health payment system.

Finally, even with cautious implementation, expenditure control in Medicare's home health benefit is likely to reduce service, particularly for beneficiaries with complex medical problems and long-term care needs. In some states, Medicaid may pick up some of the slack. As Medicare's home health spending is curtailed, however, more federal support may be needed to fill service gaps.