Commentary

Medicare Home Health Utilization in Context

Eliot Z. Fishman, Joan D. Penrod, and Bruce C. Vladeck

HOME HEALTH IN HISTORICAL CONTEXT

Medicare's home health benefit has gone through two major boom and bust cycles since 1980, largely because there is so much confusion and ambivalence about just what the benefit is supposed to do. Home care was included in the Medicare benefits package in 1965 as a means to shorten inpatient hospital stays, but for the first 15 years of Medicare's history, demand for home care grew faster than supply as inpatient utilization by the elderly skyrocketed, while many traditional providers of home care were unwilling or unable to expand.

In response, in 1980 Congress opened up the program to full participation by for-profit providers, eliminated the requirement for prior hospitalization as a condition for receiving benefits, and removed the limit on the number of visits per episode. These measures produced a rapid expansion in utilization of Medicare home health care; expenditures increased 111 percent between 1980 and 1983. The Reagan Administration, attempting to rein in the effects of the legislative loosening of requirements for Medicare home care, initiated the first clampdown on the benefit, largely successfully: Medicare home care grew only 10 percent between 1985 and 1988. (Health Care Financing Review 1998, Table 46).

Three elements then combined to drive a second boom in Medicare home health utilization and expenses. First, partly in response to the mid-1980s administrative efforts to hold down home health costs, in 1988 Federal Judge Stanley Sporkin ruled in *Duggan v. Bowen* that the Health Care Financing Administration (HCFA) had abused its authority and acted counter to Congressional intent in its administration of the home care benefit, and shortly after HCFA agreed to largely abandon the administrative controls it had developed in the earlier part of that decade (Stone 2000). Second, the introduction of the Prospective Payment System for inpatient hospital care

under Medicare in 1983 substantially altered the incentives for hospitals concerning timely discharge of inpatients, and substantially increased the demand for home care or other “post-acute” services to facilitate shorter, and presumably more profitable, lengths of stay. Third, the federal government and the states both began backing away from the massive, open-ended commitments they had made in the previous decade to expanding Medicaid-financed home- and community-based services for the frail elderly as an alternative to nursing home care, but the states continued, through Certificate-of-Need laws and other measures, to tightly constrain the supply of nursing home beds. As a result, the continuing growth in the population of frail elderly people with limited financial means in need of long-term care services left a considerable reservoir of unmet need in many communities.

Thus, during the years in which HCFA was trying to restrain Medicare home health spending in the mid-1980s, demand for such services was growing rapidly. When the consent decree in *Duggan* took effect toward the end of the decade, Medicare spending on home health care took off, from less than \$3 billion in 1986 to more than \$18 billion in 1996, a compound annual growth rate in excess of 25 percent per year. Increases in per-visit costs (which were subject to regulatory ceilings) accounted for a relatively small proportion of this growth. Instead, the number of beneficiaries receiving services each year more than doubled, while the number of visits per beneficiary receiving services more than tripled.

In April 1997, the Trustees of the Hospital Insurance Trust Fund, which encompasses Part A of Medicare (covering inpatient hospital care, skilled nursing facilities, hospice, and home health), reported that, in the absence of legislative action, the fund would be insolvent by sometime in 2001. The explosive growth in home health expenses was clearly a major part of the problem; home health care, which as recently as 1989 had accounted for barely 2.5 percent of all Part A expenditures, exceeded 15 percent of the total in 1996, and was growing rapidly (Trustees of the Hospital Insurance Trust Fund 1997). Insuring the solvency of the Trust Fund all but required doing something about home health care. Thus the second clampdown on the home health benefit ensued with the Balanced Budget Act of 1997 (BBA).

Address correspondence to Eliot Z. Fishman, Ph.D., Senior Research Associate, Institute for Medicare Practice, Mount Sinai School of Medicine, 1200 Fifth Ave., Box 1062, NY, NY 10029. Both at Mount Sinai School of Medicine, Joan D. Penrod, Ph.D., is Assistant Professor, Department of Geriatrics and Adult Development, and Bruce C. Vladeck, Ph.D., is Professor, Institute for Medicare Practice.

EVALUATING THE BBA

The provisions that have caused the most concern in the home care community since the BBA was enacted were largely uncontroversial within the legislative process, and indeed emerged to a considerable degree from a cooperative partnership between legislative staff of both parties, representatives of the executive branch, and representatives of the industry itself. The Interim Payment System, the rapid movement to prospective payment, the tightening of requirements for agencies, and the disincentives for hospital ownership of home care agencies were all the result of protracted discussion, interchange, and even some agreement.

The surprisingly dramatic impact of these changes was a 52 percent drop in home health expenditures in the following two years; the percentage of Medicare beneficiaries receiving skilled home health services declined about 20 percent and use among users declined 39 percent (McCall et al. 2001). McCall and her colleagues disaggregate these impressive figures in a variety of ways, most of which suggest a more pronounced decline in personal care (assistance with bathing, feeding, dressing, toileting, and walking) for the chronically ill and those in need of nonmedical assistance than in shorter term post-acute medical services. In particular, while all types of visits declined (except for speech therapy, which inexplicably increased), the largest decline, 59 percent, was for home health aides, the least medicalized of the home health provider types.

Is this decline in utilization a good or a bad thing? What we can learn from looking at changes in utilization before and after a reimbursement change is inherently limited without also looking at the appropriateness of the services being utilized. Analysis by RAND of DRG payment for acute services published 12 years ago is a notable model (Kahn et al. 1990). But that standard limitation on the interpretation of utilization changes is greatly complicated in the case of home health because its purposes are not well defined as a matter of either principle or practice.

THE HOME HEALTH BENEFIT IN STATUTE

In order to be eligible for Medicare-covered home care services, beneficiaries must be “homebound,” and must require “skilled” services on an “intermittent” basis. These terms, which date back to the early days of the Medicare home care benefit—from a period, in other words, in which the

practice of sophisticated home care for the elderly was very limited and at an early developmental stage—have limited utility in capturing either the clinical needs of contemporary beneficiaries or the circumstances under which home care is most effectively provided. But they remain in force because of the unavailability of alternatives.

THE HOME HEALTH BENEFIT AS POST-ACUTE SERVICE

The obsession with reductions in inpatient lengths of stay as a means of reducing costs contributed to a boom in “post-acute” care in the early and mid-1990s of which home care was only one part. Medicare payments to skilled nursing facilities quadrupled in six years, from \$2.5 billion in 1990 to \$10.3 billion in 1995, and overall, post-acute care grew from less than 6 percent of Part A spending in 1986 to 27 percent in 1996 (Prospective Payment Assessment Commission 1997). By 1997, one in four hospitalized Medicare beneficiaries was discharged into post-acute care (Liu et al. 1999). Even as health economists increasingly questioned the economic benefit of further reductions in length of stay (Reinhardt 1996), HCFA focused, primarily through the BBA, on tightening both eligibility and payment for post-acute providers, as well as cutting payment to hospitals when short inpatient stays were followed by a transfer to post-acute care.

THE HOME HEALTH BENEFIT AS ALTERNATIVE MODEL FOR PERSONAL ASSISTANCE

As McCall and colleagues note, “the intent behind the BBA legislation was to rein in use of the Medicare home health benefit for more chronic long-term personal home health services.” But while the Medicare home health benefit was clearly not designed originally as a source of long-term personal assistance for beneficiaries with severe functional limitations, in many communities there may be no alternative.

Public policy toward long-term home care for the elderly remains confused and contradictory. Arguments that expansions in home care will save money by substituting for nursing homes or inpatient hospital care no longer command much credence in the expert community, though they are often still believed by politicians and the public (Weissert and Hedrick 1994; Doty 2000; Abt Associates 1999). But there is little dispute that demographic

forces will substantially increase the need for long-term chronic care, and that the overwhelming preference of consumers and their families is to receive such services at home (Kane 2001; Simon-Rusinowitz and Hoffland 1993).

Nonetheless, in many communities (including those with the most rapid growth in the number of Medicare home health agencies as well as services provided) Medicare's home health benefit has been the *only* public source of in-home personal assistance not rationed by ostensible risk of institutionalization (or by income), despite the fact that it is also a relatively expensive way to deliver unskilled personal assistance services, and one whose eligibility standards are vague and anachronistic.

CONCLUSION

Some portion of the growth in use of the Medicare home health benefit during the 1988–1996 boom was clearly wasteful, the result of a gold-rush (particularly in Arkansas, Louisiana, Oklahoma, and Texas) that fed off low requirements to qualify as a provider, limited scrutiny of the appropriateness of claims, and outright fraud, although fraud turned out not to be as large a part of the phenomenon as many anticipated (Office of the Inspector General 1997). Industry surveys, as well as the absence of broad access problems since 1997, suggest that many of the agencies that closed in the aftermath of BBA were redundant, and the introduction of prospective payment together with uniform assessment should provide a more stable and rigorous platform for the industry going forward (Medicare Payment Advisory Committee 2000; U.S. Congress 1999). But a lot of the growth in 1988–1996 was driven by underlying demand created by declining inpatient hospital use and a growing frail elderly and disabled population with a clear preference for care at home. The Medicare home health benefit may not have been an appropriate response to the needs of that population, but no other systematic response has yet emerged.

REFERENCES

- Abt Associates. 1999. "The Impact of PACE on Participant Outcomes." Cambridge, MA.
- Doty, P. 2000. "Cost-Effectiveness of Home and Community-Based Long-Term Care Services." Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

- Health Care Financing Review*. Statistical Supplement. 1998.
- Kahn, K. L., L. V. Rubenstein, D. Draper, J. Kosecoff, W. H. Rogers, E. B. Keeler, and R. H. Brook. 1990. "The Effects of the DRG-based Prospective Payment System on the Quality of Care for Hospitalized Medicare Patients." *Journal of the American Medical Association* 264 (15): 1953-5.
- Kane, R. 2001. "Long-term Care and a Good Quality of Life: Bringing Them Closer Together." *Gerontologist* 41 (3): 293-304.
- Liu, K., B. Gage, J. Harvell, D. Stevenson, and N. Brennan. 1999. "Medicare's Post-Acute Care Benefit: Background, Trends, and Issues to Be Faced." Urban Institute. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, January 1999.
- McCall, N., H. Komisar, A. Petersons, and S. Moore. 2001. "Medicare Home Health before and after the BBA." *Health Affairs* 20 (3): 189-98.
- Medicare Payment Advisory Committee. 2000. "Report to the Congress: Selected Medicare Issues." Washington, DC.
- Office of the Inspector General. 1997. "Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York, and Texas." Washington, DC: U.S. Department of Health and Human Services.
- Prospective Payment Assessment Commission. 1997. "Medicare and the American Health Care System: Report to the Congress." Washington, DC.
- Reinhardt, U. 1996. "Spending More through 'Cost-Control': Our Obsessive Quest to Gut the Hospital." *Health Affairs* 15 (2): 145-54.
- Simon-Rusinowitz, L., and B. Hofland. 1993. "Adopting a Disability Approach to Home Care Services for Older Adults." *Gerontologist* 33 (2): 159-67.
- Stone, D. 2000. "Reframing Home Health Care Policy." Cambridge, MA: Radcliffe Public Policy Center.
- U.S. Congress. 1999. "Medicare Home Health Agencies: Closures Continue, with Little Evidence Beneficiary Access Is Impaired." Washington, DC: U.S. General Accounting Office.
- Weissert, W., and S. Hedrick. 1994. "Lessons Learned from Research on Effects of Community-Based Long-Term Care." *Journal of the American Geriatrics Society* 42 (3): 348-53.