Spotlight

Understanding Medicare's Home Health Benefit

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This *Spotlight* describes Medicare rules for coverage of home health care services—which are complicated and often misunderstood. Recent changes to Medicare criteria for coverage of rehabilitation therapy and skilled nursing care have expanded the availability of home health services to people with chronic debilitating conditions. At the same time, reductions in Medicare payments may be limiting access to such services. Proposals to impose a copayment for services could further discourage their use.

Background

Medicare is the federal health insurance program available to most people ages 65 and older, as well as those under 65 with disabilities[1] or end-stage renal disease. Home health services may offer a less expensive, less disruptive option than care in a hospital or skilled nursing facility. Medicare's home health benefit can also reduce the length of time individuals spend in a hospital or skilled nursing facility, as they can continue to receive skilled care in their homes when they no longer need higher levels of care delivered by institutional providers.

In 2015, 3.5 million Medicare beneficiaries received skilled home health services from over 12,300 home health agencies.[2] The demand for Medicare home health services among the older population will likely increase as the number and share of older Americans grows. By 2060, demographers project that the number of Americans ages 65 and older will double.[3] Research indicates that the majority of older Americans want to stay in their home as they age,[4] and Medicare's home health care benefit can help

many homebound older adults meet their needs for skilled care while remaining in their homes.

What Services Does the Medicare Home Health Benefit Cover?

Medicare covers part-time or intermittent home health services, such as skilled nursing care, physical therapy, speech-language pathology, continuing occupational therapy, medical social services, and home health aide services. Medicare also covers medical supplies and durable medical equipment (e.g., wheelchairs and walkers) for use in the home if a physician certifies that they are medically necessary. Services that the Medicare home health benefit does *not* cover include most drugs, transportation, and housekeeping services.

A Medicare-certified agency must deliver Medicare home health services. Beneficiaries and their family caregivers can find information about the Medicare home health benefit, identify certified home health agencies in their area, and obtain information about the quality of care these agencies deliver on Medicare's official website (www.Medicare.gov).

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Who Is Eligible for the Medicare Home Health Benefit?

Eligibility rules for coverage of home health services are complicated and often misunderstood. In order to get Medicare home health care, beneficiaries must meet the following criteria:

1. **Beneficiaries must be under a physician's care, and they must be receiving services under a plan of care certified by the physician.** A physician must order and certify a plan that explains the primary reasons the beneficiary requires home health care as well as the types of skilled services required, such as skilled nursing care, physical therapy, speech therapy, or occupational therapy. Only a physician—not a nurse practitioner or physician assistant—can order and certify a plan of care.

2. **Beneficiaries must have a face-to-face visit.** Within 90 days prior to or 30 days after the start of home health services, the person must have a face-to-face visit with a physician, nurse practitioner, or physician assistant so that they can assess the need for home health services.

Issues with the Face-to-Face Visit

Medicare pays somewhat more for house calls (home visits) than office visits,[5] so, in some cases, a physician or nurse practitioner will visit beneficiaries in their homes.[6] However, the face-to-face visit requirement creates a conundrum for those who must be effectively homebound (described below) but must still visit the physician's office to be certified for the home health care they need. Increasingly, nurse practitioners make the largest number of house calls to homebound elders[7] and can conduct the required face-to-face visit, but nurse practitioners are not able to certify the home health plan of care.[8] Only a physician can certify the medical necessity of home health services. Medicare does not pay separately for this physician certification which Medicare considers the physician's responsibility as part of overseeing the plan of care.[9] While providers can conduct the face-to-face visit remotely using telehealth services in rural areas, these services must originate in a physician's office or other designated site (e.g., a hospital) in order to qualify for remote consultations.

Unfortunately, homebound beneficiaries in rural areas are likely to have trouble getting out of the house to an approved site. Thus, Medicare's coverage restrictions limit the utility of the telehealth option.

3. **Beneficiaries must be deemed *homebound* by a physician.** To receive Medicare services in the home, beneficiaries must be "homebound," meaning they are unable to leave their home without "considerable and taxing effort."[10] In addition, individuals must either

   a. need the help of another person or medical equipment (such as crutches or a wheelchair) to leave their home, **OR**
   b. have a condition for which leaving the home would be against medical advice.

   Under Medicare rules, a *home* may include an assisted living facility or nursing home. Medicare considers beneficiaries homebound if they are only able to leave their home for medical treatment or other short and infrequent trips for nonmedical reasons, such as attending church, a funeral, or a graduation.

Exceptions to the Homebound Requirement

Under Medicare's bundled payment initiative for hip and knee replacement surgery, Medicare beneficiaries who do **not** qualify as homebound are still able to get limited home health visits after they leave the hospital.

4. **Beneficiaries must need part-time (intermittent) skilled services.** Skilled services include physical therapy, speech therapy, and skilled nursing care. Beneficiaries who require full-time skilled care are not eligible for home health care under Medicare.

Improvement Standard

Until a few years ago, Medicare limited home health coverage to individuals who showed potential for improvement, referred to as the **improvement standard**. However, following settlement of a lawsuit in 2013,[11] Medicare dropped the improvement requirement and now covers rehabilitation therapy and skilled nursing services that help beneficiaries maintain

their current condition and prevent deterioration. To be eligible, a beneficiary must have either:

    a. a skilled therapist who can create a maintenance program or do maintenance therapy for the condition, **OR**

    b. a condition that will presumably improve within a "reasonable" and "generally predictable" amount of time.

5. **Beneficiaries must be recertified every 60 days.** Medicare authorizes home health agencies to provide care for an "episode of care" that lasts 60 days. For those who need additional care, a physician must recertify the person's plan of care and eligibility status. There is no limit on the number of home health episodes a physician may recertify, as long as the person continues to meet the eligibility criteria described above.
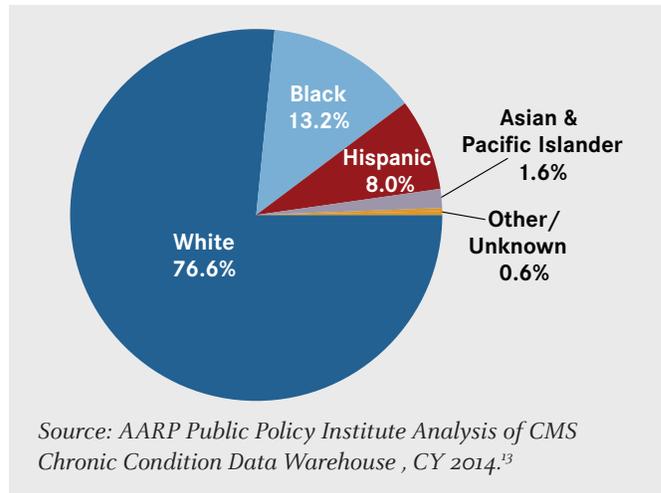
Who Uses Medicare Home Health Services?

In 2014, about 3.5 million people used Medicare home health services. The majority of Medicare home health beneficiaries are White (77 percent, figure 1) and female (62percent, figure 2). About a third of home health beneficiaries were *dual-eligibles*—that is, low-income beneficiaries who were eligible for both Medicare and Medicaid—who often had high-cost health care needs (figure 3). Medicare home health beneficiaries include a substantially higher share of those who are dually eligible than the overall fee-for-service Medicare population, which includes about 20 percent of beneficiaries who are dually eligible.[12]
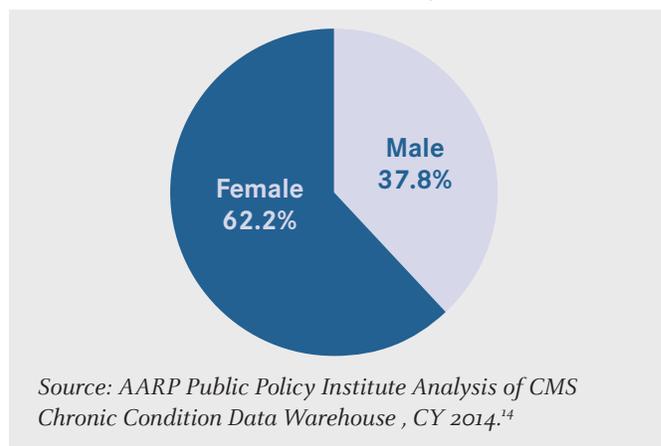
How Does Medicare Pay for Home Health Services?

Since 2001, Medicare has paid for home health services based on a prospective payment system that pays home health agencies a predetermined fixed rate for covered services during a 60-day episode of care. Medicare adjusts the base rate for case mix (i.e., individual characteristics and resources required) and geographic area. Medicare also adjusts the payment annually based on changes in market prices of goods and services that home health agencies purchase.
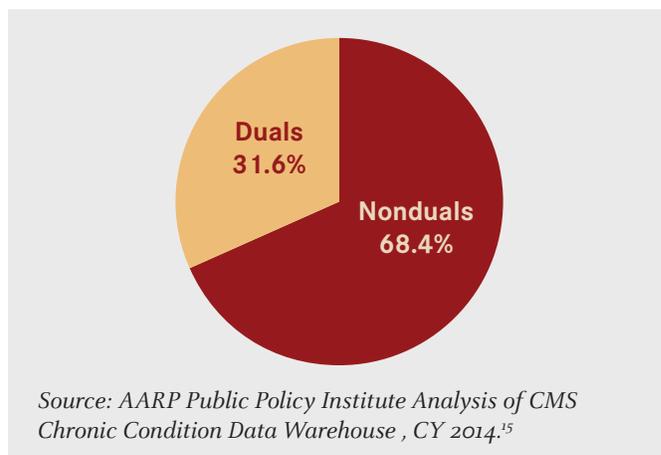
FIGURE 1
Home Health Beneficiaries by Race/Ethnicity, 2014

Source: AARP Public Policy Institute Analysis of CMS Chronic Condition Data Warehouse , CY 2014.[13]

FIGURE 2
Home Health Beneficiaries by Sex, 2014

Source: AARP Public Policy Institute Analysis of CMS Chronic Condition Data Warehouse , CY 2014.[14]

FIGURE 3
Home Health Beneficiaries by Dual Eligibility Status, 2014

Source: AARP Public Policy Institute Analysis of CMS Chronic Condition Data Warehouse , CY 2014.[15]

Since adoption of the prospective payment system in 2001, Medicare spending for home health services has doubled to over $18 billion.[16] Although the increase in spending is likely attributable to an increase in use of home health services among a growing aging population, some observers are concerned that agencies are overpaid and have proposed reducing Medicare payments.

Proposed Changes

The Medicare Payment Advisory Commission (MedPAC), an independent congressional agency that advises Congress on Medicare issues, has found that home Medicare payment rates consistently exceed the cost of home health services. In 2009 and 2011, MedPAC recommended that:

- the payment rate be rebased to better reflect actual use and cost of home health services (see text box)[17];

- the number of therapy visits not be factored into the payment rate, as it gives providers a financial incentive to increase therapy visits[18]; and

- a beneficiary copayment of $150 be imposed for home health episodes that do not follow a hospitalization—an approach that is intended to reduce overutilization but may limit access to care[19] (see textbox).

Rebasing Payments

In response to a congressional mandate in the Affordable Care Act, Medicare has reduced its payment for home health episodes to more closely reflect agencies' costs for these services.[20] These changes, referred to as **payment rebasing**, have reduced Medicare payments by 14 percent over four years, ending in 2017. In addition, a number of other legislative and regulatory changes have resulted in as much as a 22 percent reduction in Medicare payments for home health services from 2011 to 2020.[21] Home health agencies argue that rebasing Medicare payments has limited access to home health care for beneficiaries with complex needs and high health care costs. MedPAC continues to believe that, on average, Medicare overpays for home health services.[22]

Proposed Copayment

Several policymakers have proposed adding a copayment for Medicare home health services.[23,24] Proposals for Medicare home health copayments, also referred to as **cost sharing**, have varied from $100 to $600 per 60-day episode. Cost sharing proposals aim to reduce Medicare spending and encourage more appropriate use of home health services. However, Medicare beneficiaries who use home health services tend to be older and sicker than other Medicare beneficiaries. Imposing beneficiary cost sharing for home health care could discourage many individuals from using home health services and force them to seek care in higher-cost settings like hospitals and nursing homes, leading to higher Medicare costs. Previous experience led Congress to repeal Medicare home health copayments decades ago—due both to the burden they placed on seniors and to the tendency of copayments to shift care to more costly settings.[25]

Fraud and Abuse

Medicare faces ongoing challenges of fraud and abuse in home health care. In general, most home health agencies are honest and use correct billing information. However, investigations have found that some home health agencies commit fraud. Over the years, the US Department of Health and Human Services Office of Inspector General (HHS OIG) has reported numerous cases of fraud by individual home health agencies.[26] Authorities have recovered millions of dollars of fraudulent spending through enforcement actions against home health agencies, but some reports suggest that fraudulent activities tend to remain concentrated in certain areas.[27]

The Center for Medicare & Medicaid Services (CMS) has taken a number of steps to curb improper payments and fraudulent home health services, such as imposing a moratorium on the enrollment of new agencies in areas believed to have a high fraud rate.[28] In a demonstration, CMS imposed a pre-claim review and prior authorization process as a condition for delivery of home health services in order to ensure their medical necessity.[29] According to some reports, this demonstration substantially reduced use of Medicare home health services in some areas.[30]

Conclusion

The Medicare home health benefit serves millions of people and plays a key role in the US health care system. Any future changes to this benefit must ensure appropriate access to and affordability of home health services for older Americans. Policymakers, health care organizations, and advocates should work together to ensure that Medicare beneficiaries and their family caregivers have up-to-date information about any changes in eligibility criteria or costs for services and that they have the resources they need to make informed decisions about their health care.

1 Medicare imposes a two-year waiting period before covering people with disabilities, except for those with amyotrophic lateral sclerosis, also known as Lou Gehrig's disease.

2 MedPAC, "Report to the Congress: Medicare Payment Policy" (March 2017), http://www.medpac.gov/docs/default-source/reports/mar17_entirereport.pdf?sfvrsn=0.

3 Administration on Aging; Administration for Community Living, US Department of Health and Human Services, "A Profile of Older Americans: 2016" (2016), https://www.giaging.org/documents/A_Profile_of_Older_Americans__2016.pdf.

4 Rodney Harrell, Jana Lynott, and Shannon Guzman, "What Is Livable? Community Preferences of Older Adults" AARP Public Policy Institute, 2014), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/liv_com/2014/what-is-livable-report-AARP-ppi-liv-com.pdf.

5 Compare Medicare payments for Healthcare Common Procedure Coding System (HCPCS) codes for office visits (99201–99205 and 99211–99215) to home visits (99341–99345 and 99347–99359).

6 Nengliang Yao, Karen Rose, Virginia LeBaron, et al. "Increasing Role of Nurse Practitioners in House Call Programs." *J. Am. Geriatric Soc.* 65:847-852 (April 2017).

7 Yao, et al. "Increasing Role of Nurse Practitioners in House Call Programs."

8 Andrea Brassard, "Removing Barriers to Advanced Practice Registered Nurse Care: Home Health and Hospice Services." AARP Public Policy Institute, *Insight on the Issues* 66 (July 2012), http://www.aarp.org/health/medicare-insurance/info-07-2012/removing-barriers-to-advanced-practice-registered-nurse-care-home-health-hospice-AARP-ppi-health.html.

9 Centers for Medicare & Medicaid Services, "Medicare Home Health Benefit", Medicare Learning Network ICN 908143 (March 2017), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Home-Health-Benefit-Fact-Sheet-ICN908143.pdf.

10 Hillary Loeffler and Crystal Simpson, "Certifying Patients for the Medicare Home Health Benefit" (Centers for Medicare & Medicaid Services, January 2015), https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-12-16-HHBenefit-HL.pdf.

11 Centers for Medicare & Medicaid Services, "*Jimmo v. Sebelius* Settlement Agreement Fact Sheet" (2013), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf.

12 MedPAC and Medicaid and CHIP Payment and Access Commission, "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid," (January 2017), http://www.medpac.gov/docs/default-source/publications/jan17_medpac_macpac_duals databook.pdf?sfvrsn=0.

13 For each home health agency, calculations exclude individuals in a racial/ethnic group with fewer than 11 individuals. Calculations also exclude home health agencies that serve fewer than 11 beneficiaries during the year.

14 Calculations exclude home health agencies that serve fewer than 11 beneficiaries during the year.

15 Calculations exclude home health agencies that serve fewer than 11 beneficiaries during the year.

16 MedPAC, "Report to the Congress: Medicare Payment Policy" (March 2009). http://www.medpac.gov/docs/default-source/reports/Mar09_Ch02E.pdf?sfvrsn=0 .

17 MedPAC, "Report to the Congress: Medicare Payment Policy" (March 2011), http://www.medpac.gov/docs/default-source/reports/Mar11_Ch08.pdf?sfvrsn=0.

18 MedPAC, "Report to the Congress" (March 2011).

19 MedPAC, "Report to the Congress: Medicare Payment Policy" (March 2017), http://www.medpac.gov/docs/default-source/reports/mar17_entirereport.pdf?sfvrsn=0.

20 MedPAC, "Report to the Congress: Impact of Home Health Payment Rebasing on Beneficiary Access to and Quality of Care" (December 2014), http://www.medpac.gov/docs/default-source/reports/december-2014-report-to-the-congress-impact-of-home-health-payment-rebasing-on-beneficiary-access-to.pdf?sfvrsn=0.

21 Partnership for Quality Home Healthcare, "Medicare Home Health Rebasing" (2013), http://homehealth4america.org/media-center/attach/160-2.pdf.

22 MedPAC, "Report to the Congress" (March 2009).

23 Office of Management and Budget, "President's Budget for FY 2013" (February 2012).

24 MedPAC, "Report to the Congress" (March 2017).

25 Partnership for Quality Home Healthcare, "Why Congress Repealed the Medicare Home Health Copayment" (2013) http://www.homehealth4america.org/images/pdf/why-congress-repealed-copayment.pdf.

26 HHS OIG, "Semi-Annual Report to Congress, October 1, 2015–March 31, 2016" (2016), https://oig.hhs.gov/reports-and-publications/semiannual/index.asp.

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28 Centers for Medicare & Medicaid Services, "Provider Enrollment Moratorium" (2017), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/ProviderEnrollmentMoratorium.html.

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30 Center for Medicare Advocacy, "An Open Letter to CMS About Fraud," (September 2016), http://www.medicareadvocacy.org/an-open-letter-to-cms-about-fraud/.

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