

## Beneficiary Copayments: The Right Answer for Home Health?

As total national health expenditures grow as a percentage of gross domestic product, public policymakers seek effective means to address rising health care costs. Over the last 30 years, legislators have proposed and implemented various legislative measures, demonstration projects and investigations, seeking to slow cost growth. In addition to designing innovative health care delivery models and implementing broad scale reform measures, private insurers and the Federal government have instituted various cost sharing mechanisms to deter utilization of services and rein in costs. Many parts of the Medicare program employ copayments, a flat dollar amount that is charged directly to patients when they receive medical treatment, or coinsurance, a percentage of the Medicare-approved amount that patients must pay. Both types of cost sharing are an attempt to reduce Medicare program costs. This strategy is predicated on the theory that the more services cost patients, the less patients will use them. Inpatient hospital services, outpatient care, skilled nursing facilities (“SNFs”) and Medicare Part D drug coverage all utilize a type of copayment or coinsurance in an effort to contain costs. Nevertheless, cost in these sectors has risen dramatically over the last ten years.<sup>1</sup>

To date, Medicare has not required a copayment or coinsurance for home health due to the following significant considerations:

- **Researchers have found that home health care is cost-effective, and Medicare should accordingly incentivize, rather than discourage, the use of home health services;**
- **Requiring a home health copayment would have an adverse impact on vulnerable populations; and**
- **Many recognize that a home health copayment would be an insufficient tool to address fraud and abuse.**

### Home Health is Cost-Effective

Home health beneficiaries who are homebound require intermittent or part-time

care in the form of skilled nursing care, physical therapy, occupational therapy, speech-language pathology services or social services.<sup>2</sup> Medicare pays Medicare-certified home health agencies (“HHAs”) a bundled

payment for covered services provided to a beneficiary during a 60-day period (also known as an episode). In 2009, beneficiaries who used home health services averaged 21.5 visits, or encounters with a home health care provider, per episode.<sup>3</sup>

Relative to institutionalized care, such as inpatient hospitals, Medicare pays far less for beneficiaries to use skilled home health care than for many other post-acute services. The comparison of Medicare charges on a per day or per visit basis for different care environments is depicted in Figure 1 below. The chart illustrates the comparatively low cost of home health services.

In fact, research shows that the early use of home health care services can prevent costly rehospitalizations. Avalere Health LLC studied Medicare claims data from 2005 and 2006 for Medicare beneficiaries with a primary or secondary diagnosis of diabetes, chronic obstructive pulmonary disease or congestive heart failure – chronic medical conditions that represent large costs to the Medicare system.

The Avalere study found that:<sup>4</sup>

- Early home health care use saved Medicare \$1.71 billion in 2005-2006;

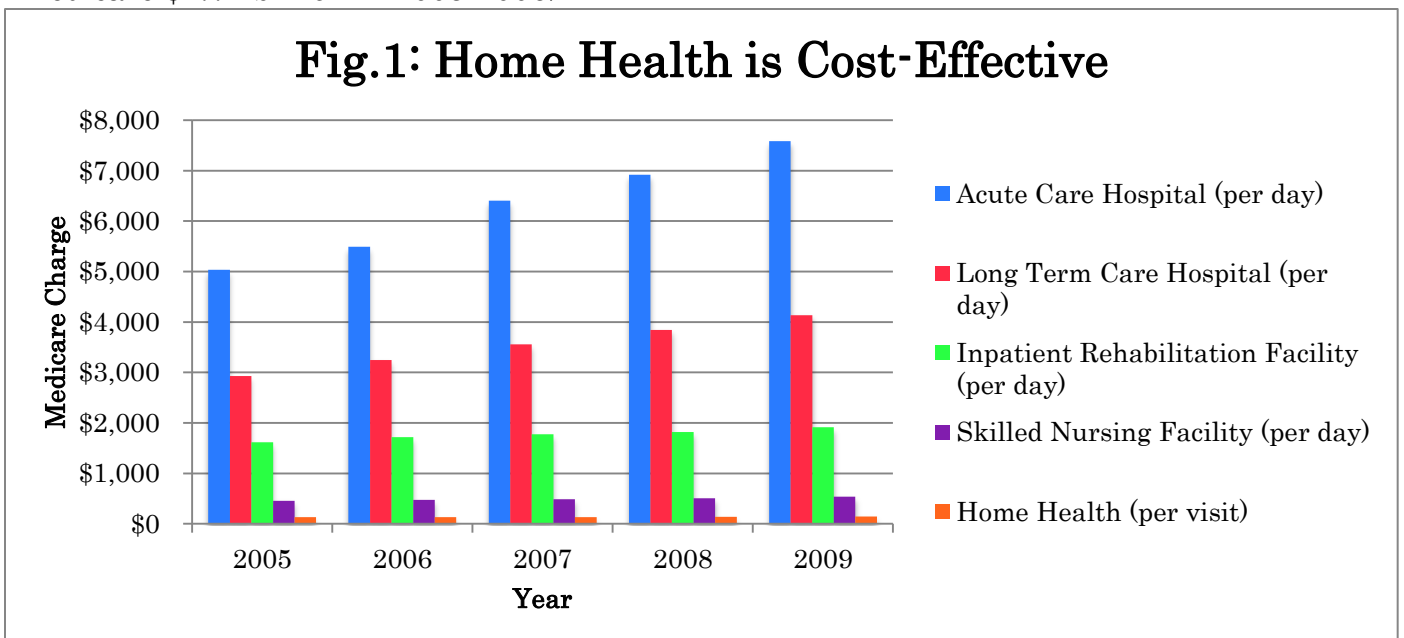
- An additional \$1.77 billion in the same period would have been saved if all Medicare beneficiaries with similar chronic diseases had accessed home health care services; and,
- Approximately \$216 million (about 12.7 percent) of the savings is attributable to as many as 24,000 fewer hospital readmissions.

“ Between 1998 and 2008, mean [hospital] lengths of stay decreased 4.1%...this was entirely due to the increase in the fraction of hospital patients discharged to home health care, from 6.4% to 9.9% in 2008. ”

~Frank R. Lichtenberg, Columbia University, Graduate School of Business

Moreover, research has shown that home health care is associated with decreasing inpatient hospital lengths of stay and lower overall health care costs. Frank Lichtenberg of Columbia University and the National Bureau of Economic Research found that, between 1998 and 2008, mean hospital length of stay decreased 4.1 percent

**Fig.1: Home Health is Cost-Effective**



due to a 50 percent increase in the share of hospital patients discharged to home health care.<sup>5</sup> Research has also shown that reducing hospital lengths of stay leads to Medicare cost savings.<sup>6</sup> Therefore, Professor Lichtenberg’s study attributing reduced lengths of hospital stay to home health also suggests significant cost savings for the Medicare program.

Home health care often offers a safer care setting as compared to inpatient care. Extended tenure in a hospital exposes patients to the risk of obtaining a healthcare-associated infection (“HAI”). A 2007 analysis provided by the Centers for Disease Control and Prevention (“CDC”) revealed that 1.7 million HAIs occurred in U.S. hospitals in 2002. As a result, approximately 99,000 individuals lost their lives.<sup>7</sup> In a study published in the *Annals of Internal Medicine*, Medicare beneficiaries who received care at home had lower rates of consultations, procedures, and use of devices than their hospital counterparts but demonstrated comparable or better clinical outcomes.<sup>8</sup>

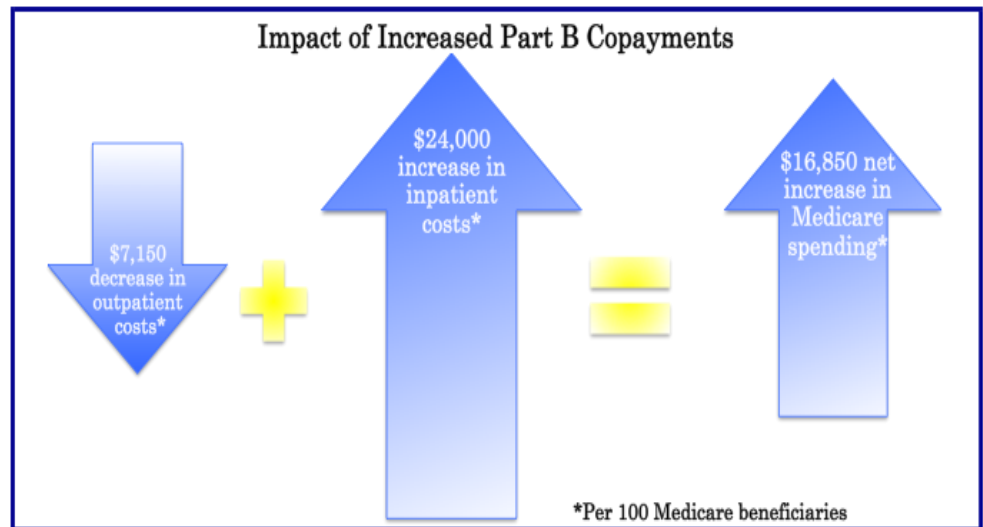
Recognizing that home-based care is a beneficial and cost-effective part of the American health care system, many decision-makers and expert observers have recommended policies that would facilitate patient access to skilled home health services. By contrast, instituting copayments for home health care would discourage the beneficial utilization of these services.

## Adverse Effects of Copayments

In light of the fact that home health presents a cost-efficient alternative to other

care settings, imposing a home health copayment could yield significant unintended fiscal consequences. A study conducted by the Alpert Medical School of Brown University in conjunction with the Providence VA Medical Center examined the cost tradeoff that occurs between outpatient care and more costly inpatient care when beneficiaries are faced with increased Medicare Part B copayments. The study, illustrated below, concluded that while increased Medicare Part B copayments would lead to \$7,150 in Part B savings for every 100 enrollees, inpatient expenditures would increase by \$24,000 for every 100 enrollees in the year copayments were increased.<sup>9</sup> Essentially, increasing cost barriers to preventive and stabilizing cost-efficient care eventually leads to the use of more expensive inpatient care and an increase in overall Medicare program costs.

The imposition of a home health



copayment could have other deleterious effects, as well. For example, increased cost sharing can prompt individuals to reduce their utilization of necessary medical services, thereby having a negative impact on health outcomes.<sup>10</sup> In addition, 35 percent of home health users have both Medicare and Medicaid coverage (dual-eligible).<sup>11</sup> Dual-eligible beneficiaries are

## Spending Concerns Not Addressed By Copayments

more likely than non-dual beneficiaries to be of poorer health status; dual-eligible beneficiaries have higher rates of diabetes, pulmonary disease, stroke, and Alzheimer's disease.<sup>12</sup> Meanwhile, nearly 60 percent of the remaining beneficiaries have incomes below 200 percent of the federal poverty line ("FPL").<sup>13</sup> Accordingly, individuals with yearly incomes of \$21,780 or less and couples with annual incomes of \$29,420 or less would still be burdened with a copayment.<sup>14</sup> Instituting home health copayments can therefore be seen as a regressive policy, having a disproportionate impact on poorer and sicker individuals.

Various forms of cost-sharing, such as copayments, have differential effects on diverse demographics and tend to have a negative impact on vulnerable individuals. The Brown University study also noted that beneficiaries living in low-income areas, African-American enrollees, and enrollees with hypertension, diabetes or a history of acute myocardial infarction were particularly sensitive to increased outpatient copayments as compared with the entire study cohort<sup>15</sup>. What's more, patients who forgo home health care in the face of rising out-of-pockets costs may suffer declining health to an extent that forces them to obtain more-costly inpatient care.

Some might assume that Medicare Supplemental Insurance ("Medigap") or Medicaid, in the case of dual-eligibles, would cover a home health copayment for some beneficiaries. However, most Medigap plans today would not cover supplementary home health costs. While Medicaid would in fact cover the cost of copayments for dual eligible individuals, requiring States to do so in fiscally stringent times would amount to an unfunded mandate on already strained State budgets.

The application of a home health copayment erroneously assumes that utilization of home health occurs at a uniform rate across the country and that patients are the impetus behind this growth. Instead, high provider and reimbursement growth is concentrated in only a few regions across the country. The map below depicts the "MedPAC-25 Counties" - counties identified by the Medicare Payment Advisory Commission ("MedPAC") with particularly high home health utilization rates. In these counties, an average of 26 percent of fee-for-service ("FFS") beneficiaries utilized home health services compared with 9.4 percent nationally in 2008. In other words, high home health utilization is isolated and concentrated in just a few areas of the country.

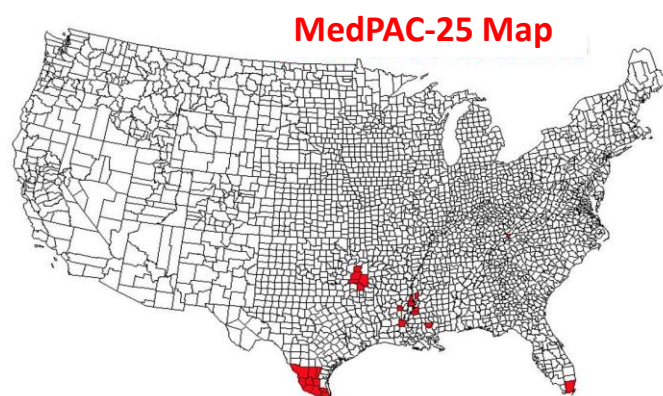




Table 1 illustrates the extent to which provider and reimbursement growth in a portion of the 25 MedPAC Counties from 2005 to 2009 dramatically outpaces the national average.

<b>Region</b>	<b>Reimbursement Growth 2005-2009</b>
National	47%
Duval, TX	113.1%
Webb, TX	128.3%
Jim Wells, TX	140.8%
Starr, TX	161.6%
Hancock, TN	220.1%
Jefferson, MS	233.4%
Miami-Dade, FL	240.8%
Red River, TX	243.1%

MedPAC has noted that the “number of agencies has increased dramatically in California, Texas, and Florida—states that have experienced program integrity concerns in the past.”<sup>18</sup> The amalgamation of this data suggests that high home health margins are the product of potentially fraudulent providers in specific regions of the country. Forcing beneficiaries to pay a copayment would not alter the behavior of fraudulent providers, nor would such a strategy selectively address high utilization regions of the country that demand a targeted approach. Furthermore, the imposition of a home health copayment represents a policy disconnect as the practice improperly punishes beneficiaries for the misdeeds of

fraudulent providers in a minority of U.S. communities.

“ The number of [home health] agencies has increased dramatically in California, Texas, and Florida—states that have experienced program integrity concerns in the past. ”

~Medicare Payment Advisory Commission

## Conclusion

As policymakers consider mechanisms to cut costs in the health care sector, they must understand the distinctive features of home health in the overall health care delivery system. Beneficiary cost-sharing in home health could actually increase total health expenditures, harm at-risk populations and divert attention away from true cost-saving solutions. This Trend Report presents three important observations unique to the field of home health. First, home health provides a cost-effective alternative to expensive inpatient services. Second, the implementation of a home health copayment would adversely impact vulnerable beneficiaries. Finally, efforts to contain costs and improve the home health sector should focus on curtailing fraud and abuse practices, rather than discouraging the beneficial use of home-based care.

*The Alliance for Home Health Quality and Innovation (the Alliance) was formed in 2008 by leading home health community members committed to sponsoring research and educating the public and policymakers on the benefits that home health care can bring to chronic, acute and prevention-based health care initiatives. AHHQI has pledged to drive quality home health care through clinical excellence, innovative practices and strong compliance standards.*

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- <sup>1</sup> United States. Department of Health and Human Services. Center for Medicare and Medicaid Services, MedPAR data files.
- <sup>2</sup> United States. Department of Health and Human Services. Center for Medicare and Medicaid Services. *Medicare and Home Health Care*. Washington, DC, 2010. Print.
- <sup>3</sup> *Medicare Payment Policy*. Rep. Medicare Payment Advisory Commission, Mar. 2011. Pg. 192. Web. <[http://www.medpac.gov/documents/Mar11\\_EntireReport.pdf](http://www.medpac.gov/documents/Mar11_EntireReport.pdf)>.
- <sup>4</sup> "The Effects of Early Home Health Use." Avalere, 2010.
- <sup>5</sup> Lichtenberg, Frank R. *Is Home Health Care a Substitute for Hospital Care?* Rep. 28 Oct. 2010. Web. <[http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1744090](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1744090)>.
- <sup>6</sup> Cleverley, William O. *Essentials of Health Care Finance*. Gaithersburg, MD: Aspen, 1997. Print.
- <sup>7</sup> Klevens, R. M. "Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002." *Public Health Reports* 122 (2007): 160-66.
- <sup>8</sup> Leff, Bruce, Lynda Burton, and Bruce Naughton. "Hospital at Home: Improving Patient Care." *Annals of Internal Medicine* 143.11 (2005): 798-808. Print.
- <sup>9</sup> Trivedi, Amal N., Husein Moloo, and Vincent Mor. "Increased Ambulatory Care Copayments and Hospitalizations among the Elderly." *The New England Journal of Medicine* 362.4 (2011): 320-28. Web.
- <sup>10</sup> Ibid.
- <sup>11</sup> MedPAC's Proposed Home Health Copayment: Affected Beneficiaries and Potential Impacts. Avalere, 2011.
- <sup>12</sup> *Health Care Spending and the Medicare Program*. Medicare Payment Advisory Commission, June 2011. Pg. 35. Web. <<http://www.medpac.gov/documents/jun10databookentirereport.pdf>>
- <sup>13</sup> MedPAC's Proposed Home Health Copayment: Affected Beneficiaries and Potential Impacts. Avalere, 2011.
- <sup>14</sup> *Federal Register*, Vol. 76, No. 13, January 20, 2011, pp. 3637-3638.
- <sup>15</sup> Trivedi, Amal N., Husein Moloo, and Vincent Mor. "Increased Ambulatory Care Copayments and Hospitalizations among the Elderly." *The New England Journal of Medicine* 362.4 (2011): 320-28. Web.
- <sup>16</sup> *Medicare Payment Policy*. Rep. Medicare Payment Advisory Commission, Mar. 2011. Web. <[http://www.medpac.gov/documents/Mar11\\_EntireReport.pdf](http://www.medpac.gov/documents/Mar11_EntireReport.pdf)>.
- <sup>17</sup> United States. Department of Health and Human Services. Center for Medicare and Medicaid Services, MedPAR data files.
- <sup>18</sup> *Medicare Payment Policy*. Rep. Medicare Payment Advisory Commission, Mar. 2011. Web. <[http://www.medpac.gov/documents/Mar11\\_EntireReport.pdf](http://www.medpac.gov/documents/Mar11_EntireReport.pdf)>.