CHAPTER 6

Access to home health services

RECOMMENDATIONS

6A The Secretary should speed the development of regulations that outline home health care coverage and eligibility criteria based on clinical characteristics of beneficiaries. The Secretary should report to the Congress recommending the legislation needed to accomplish the implementation of these regulations.

6B The Secretary should use criteria based on clinical characteristics of beneficiaries to monitor use of home health services.

6C If the Congress is not confident that the Secretary can implement a prospective payment system for home health services by 2000, then it should explore the feasibility of establishing a process for agencies to exclude a small share of their patients from the aggregate per-beneficiary limits. Such a policy should be implemented in a budget-neutral manner.

6D The Secretary should establish a nationally uniform process to ensure that fiscal intermediaries have the training and ability to provide timely and accurate coverage and payment information to home health agencies.

6E The Secretary should improve the applicability of the Medicare fee-for-service appeals process for home health users and establish a mechanism for informing beneficiaries about their rights to appeal determinations of noncoverage by home health agencies.

CHAPTER 6

Access to home health services

In this chapter

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- Monitoring access to home health services

In response to a decade of rapidly rising spending for Medicare home health services, the Balanced Budget Act of 1997 modified home health care payments. The Congress intended the interim payment system to be a temporary mechanism to control home health spending until a prospective payment system was developed. Beneficiary advocates and home health industry representatives contend that these Medicare payment limits restrict beneficiaries' access to home health care. In response, the Congress directed the Medicare Payment Advisory Commission to examine the impact of the interim payment system on access to home health services. Preliminary data suggest that fewer Medicare beneficiaries are receiving home health care than in the recent past, the number of visits per user has decreased, and the number of agencies has declined. Some agencies report that they no longer accept or are likely to discharge earlier certain types of patients because of the payment changes. Beneficiary representatives indicate that some beneficiaries are having more difficulty obtaining services to which they believe they are entitled under Medicare's benefit. However, the degree to which this can be attributed to the payment system cannot be ascertained because concurrent policy changes and other factors in the home health market also have contributed to the changes. Moreover, a lack of clinically based standards for home health use makes it impossible to assess the degree to which these changes are appropriate.

The Balanced Budget Act of 1997 (BBA) required the Health Care Financing Administration (HCFA) to carry out new payment policies aimed at controlling Medicare spending for home health services, then one of the fastest growing parts of the Medicare program. The BBA modified Medicare's payment policies by requiring that the existing cost-based system be replaced with a prospective payment system (PPS) beginning in October 1999.[1] To slow spending until the prospective payment system is in place, the BBA also modified the payment limits for home health services. This interim payment system (IPS) became effective for cost-reporting periods beginning October 1, 1997.

In response to concerns that the IPS was reducing agencies' ability to provide care to Medicare beneficiaries, the Congress modestly increased the payment limits beginning October 1998. It also directed the Medicare Payment Advisory Commission (MedPAC) to examine the impact of the interim payment system on access to care. In this chapter, the Commission describes the IPS and factors that may affect access to care, including the number of providers and responses of home health agencies' to the interim payment system. We also describe some of the access barriers reported by individuals familiar with beneficiaries using home health services. The Commission makes recommendations throughout the chapter on ways to ameliorate concerns raised.

Home health payment policy

Medicare payments for home health services rose to about $17 billion in 1996 from about $2 billion in 1988, an average annual increase of 31 percent (MedPAC 1998). This resulted from both an increase in the number of beneficiaries who received home health services and an increase in the number of visits they received. During this period, the number of home health users doubled; by 1996, one in ten beneficiaries used Medicare home health care. For those who received services, annual visits increased from 23 to 79 between 1988 and 1996 (see Table 6-1). While payments per visit remained relatively stable during this period—increasing less than 2 percent annually—payments per user increased about 18 percent annually.

To some extent, Medicare's previous payment system fostered growth in spending because the program paid home health agencies their costs, up to a limit. These payment limits, applied in aggregate, encouraged home health agencies to boost their revenues by providing more services and keeping their average costs per visit below the national limits.

The Congress mandated the IPS to reduce overall home health spending by controlling both spending per user and spending per visit. The IPS controls spending per user through an aggregate limit on agency spending. This limit, termed the aggregate per-beneficiary limit, is based on a blend of historical per-user costs for the agency and agencies in the region. Reducing the per-visit limits, which limited home health agency payments previously, continues to control spending per visit. (See text box on this page for a detailed explanation of how the IPS limits are calculated.)

Calculating the interim payment system limits

Before the BBA, Medicare paid home health agencies their actual costs up to an aggregate limit based on their per-visit costs. An agency's aggregate limit was calculated by multiplying the national per-visit limit for each of the six types of visits by the number of visits of each type the agency furnished. The national limit was set at 112 percent of the mean cost for each type of visit.

For example, assume an agency treated two Medicare beneficiaries during a cost-reporting period. Further assume that the agency provided one skilled nursing visit and one physical therapy visit to Beneficiary A and ten skilled nursing visits and five physical therapy visits to Beneficiary B. Finally, assume the applicable per-visit limits for skilled nursing visits and physical therapy visits are $100 and $150, respectively. The first table below shows the aggregate per-visit cost limit for the agency would be $2,000. Thus, the agency would receive the lower of its actual costs or $2,000.

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TABLE 6-A **Calculating aggregate per-visit limits**

Beneficiary	Number of visits: Skilled nursing	Number of visits: Physical therapy	Per-visit limit	Contribution to aggregate per-visit limit
A	1		$100	$100
A		1	150	150
B	10		100	1,000
B		5	150	750
Aggregate per-visit cost limit				$2,000

Note: Payments are the lower of actual costs, the aggregate per-beneficiary limit, or the aggregate per-visit limit.

1 The Omnibus Consolidated and Emergency Supplemental Appropriations Act (P.L. 105-277) delayed the implementation of the prospective payment system until October 1, 2000.

Calculating the interim payment system limits

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The BBA changed Medicare's home health payment method in two ways. First, it added an average per-beneficiary cost limit. This new limit was based on 98 percent of the average per-beneficiary patient costs for each agency in fiscal year 1994 (adjusted for price inflation for 1996-1998) and the average per-patient cost for agencies in the region. Seventy-five percent of an agency's historical costs are blended with 25 percent of the median costs of agencies in the same region. The average per-beneficiary limit for agencies that became Medicare certified after fiscal year 1994 was set at the national median of the limits for established agencies.

Second, the BBA decreased the per-visit cost limits from 112 percent of the national mean cost per visit to 105 percent of the national median. Because the medians were less than the means, this reduction was greater than 7 percent. For cost-reporting periods starting in fiscal year 1998, Medicare pays home health agencies the lower of their actual costs, the aggregate per-beneficiary limit, or the aggregate per-visit limit.

Using the same simplified example and adding the assumptions that per-visit limits were 10 percent lower and the agency's per-beneficiary cap is $850, Table 6-B shows the effect of the BBA policy. The aggregate per-visit limit for the agency would be $1,800. The aggregate per-beneficiary limit is the number of beneficiaries multiplied by $850—or in the case of this agency treating two beneficiaries, $1,700. Thus, the agency would receive the lower of its actual costs or $1,700.

In October 1998, the Congress made minor adjustments to the IPS for fiscal year 1999. It increased the per-visit limits to 106 percent of median costs per visit. The legislation also increased the per-beneficiary limits for established agencies that were under the national average by one-third of the difference between their limit under the original BBA formula and the national average. Per-beneficiary limits for agencies established between 1994 and 1998 will be based on 100 percent of the national rate instead of 98 percent. To discourage entry of new agencies into the market, agencies established in fiscal year 1999 or later will have their per-beneficiary limits set at 75 percent of the national median for established agencies, based on 98 percent of the national rate. ■

TABLE 6-B

Calculating aggregate per-visit limits (assuming a 10 percent reduction)

Beneficiary	Number of visits: Skilled nursing	Number of visits: Physical therapy	Per-visit limit	Contribution to aggregate per-visit limit
A	1		$90	$90
A		1	135	135
B	10		90	900
B		5	135	675
Aggregate per-visit cost limit				$1,800

Note: Payments are the lower of actual costs, the aggregate per-beneficiary limit, or aggregate per-visit limit.

The per-beneficiary limits quickly became the most controversial element of the IPS. Because these limits are based on historical practice and expense patterns, many agencies may exceed their limits unless they reduce average costs. Last year, HCFA estimated that about 65 percent of freestanding home health agencies and about 40 percent of hospital-based agencies would exceed their aggregate per-beneficiary limits in 1998. HCFA also expected that these agencies' costs would exceed their limits on average by 11 percent and 6 percent, respectively (HCFA 1998). Some agencies may have kept their average costs below their limits by reducing the number of visits or by accepting new patients who need less expensive care. Some agencies whose case mix became more costly, however, may have difficulty reducing their costs sufficiently without eliminating appropriate services covered under the Medicare benefit.

Monitoring access to home health services

To analyze access to services, the Commission examined Medicare home health claims data, surveyed home health agencies, and convened a panel discussion with individuals familiar with beneficiaries' access problems. (Details of our study design are found in the box on the next page.)

We believe the home health environment has changed considerably in the past two years. For example, the number of home health agencies has decreased substantially compared with the number in the period immediately before the IPS. Some home health agencies said they avoid patients whose care they expect or find to be expensive. Some agencies also said they provide fewer services per user than in the past. Participants in our panel said that some beneficiaries have been unable to receive the services to which they believe they are entitled under Medicare. Panelists also indicated that once patients are identified as having

Access to home health services: study design

The following sections describe MedPAC's survey of Medicare home health agencies and the panel of individuals knowledgeable about beneficiaries' access concerns.

Survey of Medicare-certified home health agencies

To learn about the impact of the IPS payment limits on the behavior of home health agencies, MedPAC contracted with Abt Associates Inc., a social science research firm based in Cambridge, MA, to survey by telephone about 1,000 home health agencies. The goal of the survey was to gather information about agencies' understanding of the IPS and whether the payment policies influenced how they provided home health services to Medicare beneficiaries.

Using a September 1998 extract of HCFA's Online Survey, Certification, and Reporting System (OSCAR), augmented by information about closures identified through January 1999, Abt selected a random sample of Medicare-certified home health agencies, stratified by census region and home health agency size. The number of Medicare patients served during 1997 defined agency size, and agencies that served a larger number of patients were slightly more likely to be chosen for the sample.

About a week before the telephone survey, MedPAC sent letters to home health agency administrators to explain the purpose of the survey and to encourage participation. To facilitate completion of the survey, MedPAC asked administrators to identify the individuals most knowledgeable about Medicare policies and tell them to expect a call.

To improve the reliability of the survey instrument, Abt trained interviewers and field-tested the instrument before implementing it.

Abt also sought to increase the survey response rate. Interviewers used phone numbers listed in the OSCAR to contact agencies in the sample, but if the OSCAR phone number had been disconnected, they consulted other sources. They also left messages on answering machines indicating that someone would call back. If the agency employee who was most knowledgable about Medicare was unable to participate in the interview at the time of the initial call but agreed to participate in the survey, Abt scheduled an appointment at a time convenient for the employee.

Abt conducted the survey between February 23 and March 24, 1999. The response rate was approximately 80 percent, with 1,054 completed interviews.

Panel of individuals knowledgeable about beneficiaries' access concerns

To learn about beneficiary perspectives on access to home health services, MedPAC contracted with Abt Associates Inc. to convene a panel of individuals familiar with beneficiaries' access problems. The purpose of the panel was to learn more about the nature of home health access problems, not the extent to which they exist. Abt asked the panel to address the following questions:

- How have changes in Medicare payment policy affected beneficiary access to home health care?
- What happens to beneficiaries who have difficulty accessing home health services?

MedPAC intended panelists to have direct experience with Medicare beneficiaries having difficulty obtaining home health care. The panel was recruited using a "snowball" sampling technique. First, Abt compiled a list of about 10 individuals and organizations considered to be informed about the IPS and Medicare beneficiaries' concerns. Next, Abt contacted these individuals and organizations to discuss their insights into the effects of the IPS on access to home care and to obtain names and contact information for other individuals and organizations knowledgeable on the issue. MedPAC concentrated on identifying individuals and organizations in areas where home health agencies reportedly had closed. But because of the extensive geographic variation in home health use, MedPAC also sought a national representation for the panel memebership. In total, Abt contacted about 80 individuals as potential panelists.

From these potential participants, MedPAC selected 14 panel members. The goal was to obtain representation of a range of professionals from different geographic areas who are in contact with different types of Medicare beneficiaries who might use home health care (for example, those with specific diseases, frail elders, individuals with disabilities, minorities, and low-income beneficiaries).

The panel included three physicians (two geriatricians), one nurse, and one social worker. It also included four attorneys, two health and aging advocates, and one state government official who worked for a Medicaid home and community-based services program. The panelists represented seven of the nine census divisions and came from the District of Columbia and 12 states—Arkansas, California, Connecticut, Georgia, Indiana, Maryland, Massachusetts, Michigan, New York, Tennessee, Texas, and Virginia. Five of the panelists indicated they have direct experience and concern about home health care in rural areas. ■

TABLE 6-1 **Medicare home health use, 1988–1996**

Year	Number of beneficiaries receiving home health services (in thousands)	Number of visits (in thousands)	Visits per user	Payments per user
1988	1,582	37,130	23	1,287
1989	1,685	46,297	27	1,500
1990	1,940	69,389	36	1,986
1991	2,226	98,650	44	2,487
1992	2,523	132,494	53	3,061
1993	2,868	168,029	59	3,556
1994	3,175	220,495	69	4,179
1995	3,457	266,261	77	4,621
1996	3,583	283,939	79	4,819

Source: Health Care Financing Administration, Office of the Actuary, April 1999.

expensive care needs, agencies may discontinue their care abruptly and these patients may have difficulty obtaining care from other agencies. In effect, some home health agencies are making coverage decisions based on payment considerations.

Although these findings are suggestive, concurrent changes in the home health environment prevent us from drawing conclusions about the direct effect of the IPS on access to care. Other factors that may explain decreases in use include antifraud initiatives targeting home health care, the removal of venipuncture as a qualifying service for home health eligibility, more stringent Medicare claims review and sequential billing policies, and market forces affecting the supply of home health agency employees. Agencies also may be modifying their behavior, anticipating a prospective payment system.

Moreover, it is impossible to determine the degree to which the changes in use of home health services that have occurred in the past two years are appropriate. It is difficult in part because Medicare's standards for eligibility and coverage are too loosely defined.

RECOMMENDATION 6A

The Secretary should speed the development of regulations that outline home health care coverage and eligibility criteria based on clinical characteristics of beneficiaries. The Secretary should report to the Congress recommending the legislation needed to accomplish the implementation of these regulations.

Medicare's current eligibility and coverage policies do not consider clinical characteristics of home health users. Current policy defines eligibility vaguely, and beneficiaries may be eligible for home care if they are homebound and need skilled services. Beneficiaries are considered homebound if they are normally unable to leave home, if leaving home requires a considerable and taxing effort, and if absences from the home are infrequent and relatively short. However, fiscal intermediaries apply considerable discretion in interpreting and applying the homebound definition (GAO 1996). As the BBA requires, the Secretary recently issued a report on the homebound requirement and its application. While the Secretary did not recommend adopting a new definition, improving homebound determinations may be possible in the future, using patient-level data from the Outcomes and Assessment Information Set (OASIS).

Medicare's coverage standards allow for providing services part time or intermittently. Beneficiaries may receive services any number of days per week but for fewer than 8 hours each day and for 28 or fewer hours each week (or, subject to case-by-case review, for fewer than 8 hours each day and for 35 or fewer hours per week).

These guidelines, however, do not suggest appropriate levels of care. As the BBA requires, the Secretary is in the early stages of developing coverage standards for home health care use based on patient characteristics and need. The Commission believes that separate standards should be developed for patients with chronic care and those with acute care needs. Because the Secretary faced lawsuits regarding home health coverage and eligibility rules in the past, she should report to the Congress any legislative changes that would be helpful in implementing the new coverage standards.

RECOMMENDATION 6B

The Secretary should use criteria based on clinical characteristics of beneficiaries to monitor use of home health services.

Once HCFA establishes clinically based coverage standards for use of home health services, the agency also should use these standards to monitor access to home health care and appropriate use of services. HCFA could monitor these aspects of use through contracts with Medicare's quality improvement organizations as it is doing to monitor access and quality in skilled nursing facilities.[2]

2 The organizations now prefer to be called quality improvement organizations because they believe this title denotes the scope and orientation of their current responsibilities better than does peer review organizations, the term used in statute and by HCFA.

Ensuring beneficiaries have access to appropriate services

Provider supply is one of many aspects of measuring access to care. While a certain number of providers is necessary to furnish care, it is difficult to determine the appropriate number—enough so that care is available but not so many that care is furnished inefficiently. Moreover, supply relates to both the number of agencies and their capacity to provide care. Examination of certification data offers information on the number of agencies, and our survey of agencies furnished some insight into changes in agency capacity.

During most of the 1990s, the number of Medicare-certified home health agencies grew about 9 percent annually. Analysis of agency counts by MedPAC and by the General Accounting Office (GAO 1998) as well as findings from the Commission's survey of agencies suggest a consistent trend—a roughly 10 percent decline in the number of agencies in the year following implementation of the IPS, and even another 5 percent to 10 percent decline so far in fiscal year 1999.

Several factors in addition to the IPS are likely associated with declines in agency supply. For example, greater oversight of home health providers may have slowed agencies' entry into the market in the past two years. The Secretary imposed a four-month moratorium on the certification of new home health agencies in early 1998. Several months after she lifted this moratorium, the Omnibus Consolidated and Emergency Supplemental Appropriations Act (P.L. 105-277) required that new home health agencies (those certified on or after October 1, 1998), have per-beneficiary limits equal to 75 percent of the median for existing agencies. This new limit was intended to discourage the entry of agencies into the Medicare program.

Regardless of the causes, it is too early to assess the appropriateness of declines in agency supply. The Commission views some decline as an appropriate response to the rapid increase in home health agencies and service use during the 1990s.

MedPAC also examined whether changes in Medicare payment limits induced agencies to change how they deliver care to beneficiaries. The Commission expected that agencies would reduce their costs in response to the IPS in several ways. Because spending growth results in part from increases in the number of visits per user, we expected agencies to reduce the number of visits per person served. Agencies might attempt to lower average costs per person by eliminating discretionary visits, by substituting less costly visits for expensive care, or by providing a few specialized visits rather than a larger number of unspecialized visits. Because per-beneficiary limits are based on average costs, home health agencies need not reduce their costs for all patients uniformly. By averaging costs, the payment limits allow inexpensive patients to balance out the more expensive ones. With this in mind, home health agencies might attempt to attract more inexpensive patients or avoid patients with expensive needs.

Findings from an analysis of Medicare claims data suggest that home health agencies indeed have changed their practice patterns since the IPS was implemented. Claims data reveal that fewer Medicare beneficiaries received home health care in the first three months of calendar year 1998, compared with the number in the same quarter of the previous year.[3] Once admitted to home care, beneficiaries use fewer services. In particular, the number of more discretionary visits, such as those by home health aides, declined. We cannot determine the magnitude of this change, but discussions with Medicare's fiscal intermediaries confirm that the number of users and the number of visits per user have declined. Because current data limitations make it difficult to determine the extent to which home health use has changed, the Commission will reexamine the use of home health services when better data are available.

Results from MedPAC's survey of home health agencies also follow this general trend (Table 6-2). The home health agencies that we surveyed report their Medicare caseload has decreased. They also provide fewer visits per user, fewer aide visits, and they have adopted more stringent admission and discharge practices because of the IPS. Because agencies worry about operating under the per-beneficiary limits, they report avoiding high-cost or seemingly high-cost patients. Nearly 40 percent of agencies surveyed responded that because of the IPS, they no longer admit all Medicare patients whom they would have admitted previously, and about 30 percent of agencies reported discharging certain Medicare patients because of the IPS. A recent study concerning costs of home health care found that patients using care for a long time were more costly than others (Gage 1999). Indeed, agencies most frequently identified long-term or chronic care patients as those they no longer admitted or have discharged as a result of the IPS.

RECOMMENDATION 6C

If the Congress is not confident that the Secretary can implement a prospective payment system for home health services by 2000, then it should explore the feasibility of establishing a process for agencies to exclude a small share of their patients from the aggregate per-beneficiary limits. Such a policy should be implemented in a budget-neutral manner.

3 While we are confident that the data characterize general trends in home health use, we are reluctant to publish specific results because HCFA is concerned that the data may be flawed. The agency maintains that problems in the way it administered the BBA-required shift of some home health services to Medicare Part B may have resulted in underreported use during the period studied. HCFA is verifying its home health data and correcting them as needed.

TABLE 6-2

Medicare caseload, patient visits, admissions, and discharges of home health agencies

Survey question	Percent
Since your agency became subject to IPS, has the number of Medicare home health patients you serve…	
Increased	16%
Decreased	56
Remained the same	28
Since the Medicare interim payment system was implemented, has the total number of visits per patient that your agency provides to Medicare beneficiaries…	
Increased	2
Decreased	71
Remained the same	27
Are there patients whom you would previously have admitted for Medicare home health services who you no longer admit due to IPS?	
Yes	39
No	61
Have you discharged any Medicare patients due to IPS?	
Yes	31
No	69

Source: MedPAC survey of Medicare-certified home health agencies, conducted by Abt Associates Inc. February-March 1999.

The case-mix adjusted PPS being developed will not take effect before October 2000. In the meantime, an exclusion policy for very expensive patients could be implemented. The Commission suggests allowing agencies to exclude a small portion of their patients from the aggregate per-beneficiary payment limits to ensure that these beneficiaries will have access to needed services. Medicare would reimburse care for excluded patients based on the lesser of actual costs or the aggregate per-visit limits. Because the excluded patients would receive a disproportionate amount of services, HCFA may want to have medical reviewers focus their efforts on these high-use cases.

Providing timely information to agencies and beneficiaries

Agencies might inadvertently restrict services because of misunderstandings about antifraud initiatives, coverage rules, and the mechanics of the IPS. In particular, discussions with home health agency representatives revealed they did not always know their per-beneficiary limits or understand that the limits apply to average costs for all patients served. Some agencies had interpreted the limits as absolute caps on the amount they could spend on each beneficiary. This misunderstanding may have led some providers to unnecessarily reduce the services they furnish or to avoid certain patients.

RECOMMENDATION 6D

The Secretary should establish a nationally uniform process to ensure that fiscal intermediaries have the training and ability to provide timely and accurate coverage and payment information to home health agencies.

In the months prior to implementing the IPS, HCFA published a detailed description of the system in a program memorandum and in proposed and final rules implementing the new policy. The BBA allowed fiscal intermediaries several months to calculate and notify home health agencies of their payment limits under the IPS, though some fiscal intermediaries were late to comply with this requirement. By the time many agencies learned their individual limits, they were well into their fiscal year 1998 cost-reporting periods. As a result, they had to anticipate their limits for a portion of the year and, upon notification, adjust their practice patterns accordingly. This late notification caused confusion among agencies.

Anecdotal evidence also suggests that information provided by fiscal intermediaries and HCFA regional offices was confusing and inconsistent at times. Some agencies and physicians reported they received misleading information concerning Medicare eligibility, coverage, and payment for home health services. Because confusion about the payment system will also be a concern as HCFA implements a PPS for home health services, the Commission urges the Secretary to minimize misunderstanding so that agencies' responses do not threaten access to care.

Such an effort might include special notices to home health providers similar to the memorandum the HCFA Administrator sent to agencies to explain the IPS payment limits and agencies' responsibilities as Medicare providers. Under Medicare's conditions of participation, home health agencies must not discriminate against Medicare patients—if agencies provide care to non-

Medicare patients with health problems of a certain level of severity, they also must serve Medicare patients with the same severity of health problems. (DeParle 1998).

Pressures brought on by the IPS also have highlighted the importance of the Medicare appeals process and beneficiaries' understanding of it.

In Medicare's traditional program, beneficiaries may initiate an appeal for payment for home health services only after the agency submits a bill on their behalf and Medicare's fiscal intermediary rejects it. When agencies bar beneficiaries from admission, they cannot appeal the decision.

Even when beneficiaries are admitted to home health agencies, the current appeals process may not help them. Medicare requires home health agencies to inform beneficiaries when they believe Medicare no longer will cover the cost of their care. When agencies anticipate they will be financially liable for a patient's care and decide to discharge patients or reduce their services, beneficiaries have the right to "demand bill" Medicare. That is, beneficiaries can demand that the home health agencies submit bills on their behalf to determine if the service will be covered. In the meantime, however, beneficiaries are responsible for the cost of the care the agency provides.

RECOMMENDATION 6E

The Secretary should improve the applicability of the Medicare fee-for-service appeals process for home health users and establish a mechanism for informing beneficiaries about their rights to appeal determinations of noncoverage by home health agencies.

According to the panelists, beneficiaries often do not know about the appeals process or their right to demand bill. When the PPS for hospitals took effect, beneficiaries were given the right to appeal decisions to discharge them, although the hospitals did not always inform them of their rights to appeal (ProPAC 1986). A similar situation could be avoided by requiring home health agencies to inform beneficiaries of their rights upon admission. HCFA also could require agencies to use a standard form explaining the reasons for restricting or terminating services and listing steps for beneficiaries to follow to get a formal decision from the Medicare fiscal intermediary about coverage and eligibility. In the long term, peer review organizations could review discharges from home health agencies as they do for hospital discharges.

HCFA is working to improve its appeals process for home health users. The agency is in the early stages of developing regulations to make the Part A and Part B appeals processes consistent. These regulations will not address the denials described above. In response to litigation on this issue, the agency also is considering distributing new notification letters to beneficiaries to explain their appeal rights. However, limits on computer systems stemming from the year 2000 problem may be the deciding factor in determining whether this policy is implemented.

The Commission believes an improved appeals process is an important measure to protect rights of beneficiaries to home health services. Combined with the other recommendations in this chapter, it will help to ensure that Medicare beneficiaries have access to appropriate home health services. ■

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