

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Medicare Beneficiary Experiences with
Home Health Care**



Inspector General

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EXECUTIVE SUMMARY

PURPOSE

To examine the experiences of Medicare beneficiaries with accessing and receiving home health care.

BACKGROUND

This inspection is part of a current series of four Office of Inspector General inspections about Medicare home health care. *Access to Home Health Care After Hospital Discharge 2001, OEI-02-01-00180*, assesses the effects of the prospective payment system on access to home health care for Medicare beneficiaries who are discharged from the hospital. *Medicare Home Health Care - Beneficiaries from the Community, OEI-02-01-00070*, looks at access to home health care for Medicare beneficiaries who have not recently been in the hospital. We are also conducting a study that examines physician practices in prescribing, certifying, and monitoring Medicare home health services.

Home health services consist of skilled nursing, physical, occupational, and speech therapy, as well as social work and home health aide services, all furnished in a patient's home. Medicare will pay for home health care only if the service is ordered by a physician and is reasonable and necessary for the treatment of a homebound patient's illness or injury.

After a history of increases in the early 1990's, Medicare home health expenditures have dropped since 1998. A number of factors have contributed to the decrease including the new payment system created by the Balanced Budget Act of 1997, which changed home health agency payment from a cost-based method to a prospective payment system of fixed, predetermined rates.

We combined two methods for this inspection: a beneficiary mail survey of 713 Medicare home health beneficiaries who began a new episode of home health care in January 2001 and follow-up telephone interviews with a sub-sample of 30 beneficiaries.

FINDINGS

Beneficiaries are positive about their Medicare home health care

Virtually all Medicare beneficiaries (93 percent) who began receiving home health care in January 2001 are satisfied with their care. Satisfaction levels are high among all groups of Medicare recipients. Levels do not differ among beneficiaries with different

diagnoses nor between those living in urban and rural locations. Also, Medicare beneficiaries generally report a positive relationship with their home health caregivers. Most believe their caregivers treat them well and say they are not concerned for their safety when workers are in their homes. Just a few beneficiaries (four percent) report concerns about the quality or adequacy of their home health care. They report such problems as missed appointments or a lack of consistency among home health workers.

Medicare beneficiaries report almost no difficulty gaining access to care

Almost none of the Medicare beneficiaries who began a new episode of home health care in January 2001 experienced problems accessing care. In fact, only 13 of 501 respondents report any access problems. Nearly all of these 13 respondents were not in the hospital immediately before beginning home health care. About half of them had difficulty finding a home health agency and the other half report that they were refused by an agency. Our study, however, only includes those Medicare beneficiaries who successfully obtained home health care. We are not able to report on the experiences of those who were unable to obtain any home health services.

Although only a few had access problems, almost half of all beneficiaries say that they did not have multiple agencies to choose from. They also report that their personal involvement in planning for their own care is limited. They say it is their doctor who makes most of the decisions about their care.

Some beneficiaries would like more services

Twenty percent of beneficiaries believe they are not receiving all of the services they need. They fall into three categories: 1) those who are no longer receiving any home health services but believe they still need care; 2) those who want more of a specific service they are already receiving; and 3) those who want a specific service they are not currently receiving. These beneficiaries most often request home health aide services or physical therapy.

Not all of the home health services beneficiaries want are covered by Medicare. For example, beneficiaries are not eligible for Medicare home health aide services unless they are also receiving a skilled service, such as skilled nursing or physical therapy. Some beneficiaries request more aide services to help with bathing, feeding, or household chores. If this is their only care need, they are not eligible for aide services under the Medicare benefit. Also, Medicare only covers home health care when the service is medically necessary. Therefore, beneficiaries such as one woman who wants more physical therapy for palliative care may not be eligible for Medicare coverage of the therapy.

CONCLUSION

As the Office of Inspector General continues to monitor the Medicare home health care program after the implementation of the prospective payment system, it is noteworthy that Medicare beneficiaries are pleased with their care. Beneficiaries who entered care in January 2001 report positive experiences both accessing and receiving Medicare home health services. As noted earlier we are currently preparing three other reports that examine beneficiary access to care and the role of the physician in home health care.

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INTRODUCTION

PURPOSE

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BACKGROUND

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Medicare Home Health Care

Home health services consist of part-time or intermittent skilled nursing, physical, occupational, and speech therapy, and certain related services, including social work and home health aide services, all furnished in a patient's home. Services are typically provided by registered nurses, therapists, social workers, or home health aides employed by or under contract with a home health agency. These agencies can be freestanding or hospital-based and are classified as not-for-profit, proprietary, or governmental.

Medicare will pay for home health care only if the service and the beneficiary meet certain criteria. The services must be ordered by a physician and be reasonable and necessary for the treatment of the patient's illness or injury. Further, the beneficiary must be eligible for Medicare coverage of home health services. In order to be eligible, a beneficiary must be homebound, under the care of a physician who has established a plan of care, and need at least one of the following intermittent skilled services: skilled nursing care, physical therapy, speech language pathology, or continued occupational therapy. At the start of care occupational therapy alone does not constitute a skilled need; however, after care has begun and other skilled services are discontinued, continued occupational therapy is a skilled need. There are no specific limits on the number of visits or length of coverage and no co-payments or deductibles.

A beneficiary is considered homebound when leaving home requires a considerable and taxing effort. The Benefits Improvement and Protection Act of 2000 (BIPA) clarified the definition, stating that a person can leave his or her home for certain purposes such as attending adult day care activities or religious services and still qualify for Medicare home health services.

Trends in Medicare Home Health Care

After a history of increases, Medicare home health expenditures have dropped since 1998. Between fiscal years 1991 and 1997, home health care annual expenditures rose from \$4.7 billion¹ to \$17.6 billion.² This was due to an increase in both number of beneficiaries receiving home health services and the number of visits they received. In 1998, however, spending for home health services began to drop and in fiscal year 1999 was \$8.7 billion.³

A number of factors have contributed to the recent decrease in Medicare home health spending. These include the prospective payment limits created by the Balanced Budget Act of 1997 (BBA) as well as several initiatives that were implemented in response to concerns about fraud and abuse. Specifically, the Health Insurance Portability and Accountability Act substantially increased financial support to control fraud and abuse by home health agencies.

Prospective Payment System

The Balanced Budget Act of 1997 changed the way Medicare pays for home health care. The law requires a payment change from a cost-based method to a prospective payment system (PPS) of fixed, predetermined rates for home health services. The new prospective payment system went into effect nationally on October 1, 2000. Before PPS was implemented home health agencies were reimbursed under an interim payment system (IPS) beginning in October 1997.

Under PPS, home health agency payments are based on a 60-day episode that is adjusted according to case-mix. The case-mix is based on data elements from the patient's medical assessment (Outcome and Assessment Information Set) and the projected number of therapy hours. The data elements capture information about the patient's clinical severity, functional severity and service utilization.

Generally, agencies will receive two payments for each episode. They receive the first payment at the beginning of the episode, after they submit a Request for Anticipated

¹ **1992 HCFA Statistics**, U.S. Department of Health and Human Services

² **1998 HCFA Statistics**, U.S. Department of Health and Human Services

³ Health Care Financing Administration, U.S. Department of Health and Human Services

Payment (RAP), and the second payment when they submit a claim at the end of the episode. The RAP contains a code that represents the payment category, or Home Health Resource Group (HHRG), of the beneficiary's episode. The claim includes line-item detailing of the services the agency provided.

METHODOLOGY

We combined two methods for this inspection: a beneficiary mail survey and follow-up telephone interviews.

Sample Selection

Using the Health Care Financing Administration National Claims History File, we selected a simple random sample of 713 Medicare home health beneficiaries. Thirteen of these were not useable because of bad addresses. Our universe included all Medicare beneficiaries who:

- C started a new episode of home health care between January 7 and January 13, 2001 and
- C had a RAP submitted to HCFA by January 31, 2001.

We excluded from the universe beneficiaries who were deceased or resided in Guam and Puerto Rico. We defined a new home health episode as any episode where the date of the admission on the RAP was the same as the first date of service. This does not include episodes that renew services for the same diagnosis. The sample includes beneficiaries with a hospital stay immediately prior to starting home health care and those coming from the community without a hospital stay.

Beneficiary Mail Survey

We sent a self-administered mail questionnaire to the 700 sample beneficiaries with a usable address. We also sent pre-notification letters, follow-up postcards, and, to non-respondents, a second questionnaire. We encouraged our sample beneficiaries to ask for the assistance of a family member or friend in filling out the questionnaire. Six beneficiaries completed the survey over the telephone with OIG staff.

Beneficiaries responded to the questionnaire during March and April, 2001. Approximately two-thirds of the respondents had completed their most recent home health episode at the time of the survey.

We received 530 responses, for a response rate of 74 percent. Of the 530:

- C 501 beneficiaries completed the survey and indicated that they had received home health care;

C 29 indicated that they had not received any home health care since January 1, 2001.

We did not consider these 29 in our analysis of the survey data. We plan to follow-up with these beneficiaries after the final claims for this time period are available.

Follow-up Telephone Interviews

In addition, we conducted follow-up telephone interviews with a purposive sub-sample of 30 beneficiaries. These 30 beneficiaries were selected because their responses to the questionnaire indicated some problems with the care they received. Specifically, they either had difficulty accessing or receiving care. During the follow-up interviews we spoke to either the beneficiaries or family members about their concerns.

Limitations

There are two limitations to our methodology. First, we pulled our sample from RAPs rather than final claims in order to minimize the length of time between when the beneficiary started care and completed the survey. However, a RAP requests anticipated payment for services the agency plans to provide in the future. It is not a claim for services already provided. Consequently, our sample may have included some beneficiaries who did not actually receive home health services in January. Second, our sample included only beneficiaries who were accepted as a patient by a home health agency. Therefore, we are not able to report on the experiences of beneficiaries who were never able to obtain home health care.

This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

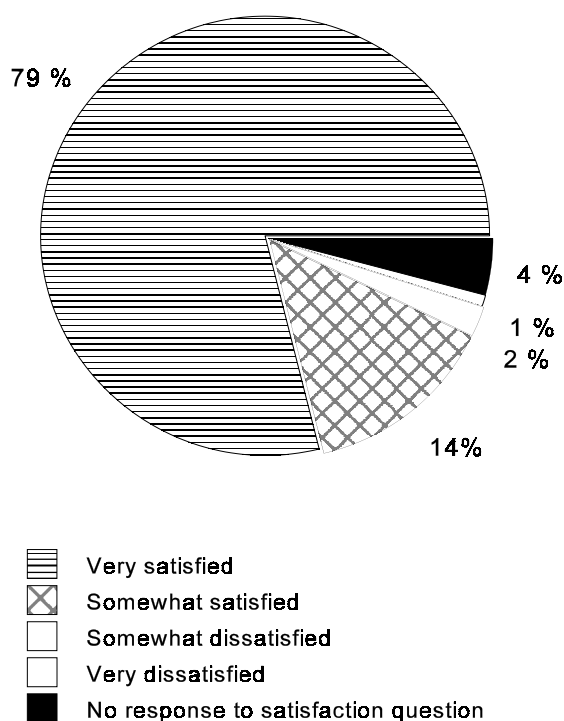
FINDINGS

Beneficiaries are positive about their Medicare home health care

Ninety-three percent are satisfied with their home health care

Virtually all Medicare beneficiaries (93 percent) who began receiving home health care in January 2001 are satisfied with their care. In fact, 79 percent are very satisfied. (See Graph 1 below.)

Graph 1
**Medicare Beneficiary Satisfaction
with Home Health Care**



Source: Home health beneficiary survey, 2001

Satisfaction is high among all groups of Medicare home health recipients. Satisfaction levels do not differ among beneficiaries with different diagnoses nor between those living in urban and rural locations. Also, beneficiaries discharged from the hospital prior to starting home health care and those directly coming from the community are equally satisfied, as are beneficiaries both with and without a prior home health experience.

Most beneficiaries report the care they are receiving in 2001 compares favorably to care they have received in past years. More than half of beneficiaries had Medicare home health care prior to their current episode. Most (85 percent) rate their current services about the same or better than their prior services.

Furthermore, many beneficiaries report being grateful for the services they receive. Almost one quarter volunteer complementary comments about their home health care. One beneficiary writes, “I sincerely appreciate the help that I received from this Medicare program.” Another comments, “I could never have managed without the home health care, since I live alone.”

Beneficiaries generally have good relationships with their caregivers

Medicare beneficiaries generally report a positive relationship with their home health caregivers. Most (95 percent) believe that their home health workers treat them well, and just as many say they have no concern for their personal safety or for the safety of their property when these workers are in their home. Also, several beneficiaries praise the caring attitude and skill of their caregivers. One beneficiary’s family member writes, “We have only the highest regard for the persons who visited our father. Each person was professional, friendly, helpful and sympathetic to our needs.” Another writes that “the therapist taught me to do my therapy. She helps me and makes sure I do it correctly. [She is] pleasant, personable, and professional.”

Just a few report concerns about the quality or adequacy of their care

Four percent of beneficiaries are concerned about the quality or adequacy of their home health care. These few respondents express various concerns. Most commonly, they report that their home health worker either misses or is late for appointments. Others in this group say that the agency is not providing the services that were ordered. Lastly, a few say that their Medicare home health services stopped abruptly while they believe they still needed care. During follow-up telephone interviews, one says, “The doctor said I needed [care] for four months and I only got it for one.”

Several beneficiaries also express concern about the lack of consistency among their home health workers. For example, the wife of one beneficiary says that it is physically taxing for her to train each new home health worker about her husband’s special needs and “every other week it was someone different.” In fact, about one third of all beneficiaries receiving skilled nursing care say that the same nurse does not usually visit each time. Similarly, twenty percent say the same about their home health aides.

A small number of beneficiaries (four percent) report having made formal complaints in the past about their concerns. They made almost half of these complaints to their home health agency. Most complaints were specifically about their home health workers. Only about one third of these beneficiaries report that they are satisfied with the way their complaint was resolved.

Finally, a small number of beneficiaries (five percent) with prior home health experience say the care they are receiving now is worse than past care; they cite problems with the quality or frequency of services. Some say that their home health caregivers did a better job in past years, while others report that in the past they obtained more home health services, such as a greater number of nursing and aide visits.

Medicare beneficiaries report almost no difficulty gaining access to care

Very few beneficiaries report access problems

Almost none of the Medicare beneficiaries who began a new episode of home health care in January 2001 experienced problems accessing care. In fact, only 13 of 501 respondents, most of whom did not have a hospital stay before beginning care, report any access problems. About half of these 13 say they had difficulty finding an agency. The other half say they were refused by an agency. Some of these problems appear to be related to the complexity of the patient's care. For example, one writes that her "care is complicated and most agencies don't want me." Beneficiaries also attribute access problems to inadequate agency staffing levels. In a telephone interview, another says she had access difficulty because "the agency did not have the staff to do wound care."

Although very few are having difficulty finding a home health agency, almost half of all beneficiaries report that they do not have more than one agency to choose from. In fact, only one third of beneficiaries discharged from the hospital had a choice of agency. Nevertheless, almost all of those who were able to choose an agency are receiving care from their first choice. Medicare requires that hospitals provide all beneficiaries with a choice of home health agencies; we do not know if these beneficiaries do not report a choice because they were not given one, there is only one agency in their area, or for some other reason .

Beneficiaries' involvement in planning for care is limited

Beneficiaries receive help in planning for their home health care. Over one quarter report not being involved at all in the planning for their home health care, and about 40 percent say they were only somewhat involved. Only one in ten report that they were able to find and choose a home health agency without help.

Most beneficiaries report that it is their doctor who makes most of the decisions about their care. In fact, 79 percent say that it is their doctor, rather than their family or social worker, who decided when they needed home health care. Most beneficiaries (54 percent) also find out about their home health agency from their doctor, rather than from someone they know or the hospital discharge planner. In addition, when beneficiaries have to choose between two or more agencies, they most commonly get help from their doctor.

Some beneficiaries would like more services

Twenty percent of beneficiaries believe they are not receiving all of the services they need

Beneficiaries who believe they are not getting all of the home health care that they need fall into three categories: 1) those who are no longer receiving any home health services but believe they still need care; 2) those who want more of a specific service they are already receiving; and 3) those who want a specific service they are not currently receiving. Overall, these beneficiaries request home health aide services most frequently, followed by physical therapy. Some beneficiaries report needing specific care, such as a nurse to check blood sugar levels or additional weeks of physical therapy. Other beneficiaries' needs are more general, such as needing more help for activities like bathing or household chores.

However, not all of these services are covered by Medicare

Not all of the home health aide services beneficiaries want are covered by Medicare. Medicare only covers an aide when the patient is also receiving a skilled service, such as skilled nursing or physical therapy. Without one of these needs, Medicare does not cover an aide to help with personal care. In several of our telephone interviews, beneficiaries request more aide services to help with bathing, feeding, or household chores. If this is their only care need, they are not eligible for aide services under the Medicare benefit.

Further, Medicare only covers home health care when the service is medically necessary. For example, physical therapy is considered medically necessary only when the therapist is either teaching the patient a maintenance program or the patient has rehabilitation goals that can be reached in a predictable period of time. Therefore, beneficiaries such as one woman who wants more physical therapy for palliative care because she is still in pain may not be eligible for Medicare coverage of the therapy.

A few beneficiaries express discontent with the Medicare home health benefit. For example, the daughter of one beneficiary writes, "because a patient has Alzheimer's Disease but no other health conditions that require skilled nursing, does not mean that home health aides are not necessary." Another says that she needed more physical therapy but it had stopped because she "wasn't progressing the way (she) should." Several other beneficiaries comment that they need help to pay for their medications and other personal products, such as incontinent pads, neither of which are covered by Medicare.

CONCLUSION

As the Office of Inspector General continues to monitor the Medicare home health care program after the implementation of the prospective payment system, it is noteworthy that Medicare beneficiaries are pleased with their care. Beneficiaries who entered care in January 2001 report positive experiences both accessing and receiving Medicare home health services. As noted earlier we are currently preparing three other reports that examine beneficiary access to care and the role of the physician in home health care.

Recent Office of Inspector General Home Health Inspections

Office of Inspector General, US Department of Health and Human Services, “Medicare Beneficiary Access to Home Health Agencies: 2000,” OEI-02-00-00320, September 2000.

Office of Inspector General, US Department of Health and Human Services, “Adequacy of Home Health Services: Hospital Readmission and Emergency Room Visits,” OEI-02-99-00531, September 2000.

Office of Inspector General, US Department of Health and Human Services, “ Medicare Home Health Agency Survey and Certification Deficiencies,” OEI-02-99-00532, September 2000.

Office of Inspector General, US Department of Health and Human Services, “Medicare Beneficiary Access to Home Health Agencies,” OEI-02-99-00530, October 1999.

Confidence Intervals for Key Variables

We calculated confidence intervals for nine key variables. The point estimate and 95% confidence interval are given for each of the following:

Key Variables	Point Estimate	
Medicare home health beneficiaries who are satisfied with their care Very satisfied Somewhat satisfied	79% 14%	+/- 3.5 +/- 3.1
Beneficiaries who believe that their home health workers treat them well	95%	+/- 1.9
Beneficiaries who are concerned about the quality of their home health care	4%	+/- 1.9
Beneficiaries who say that they had no difficulty finding an agency to accept them as a patient.	93%	+/- 1.9
Beneficiaries who report they were not refused by an agency	85%	+/-3.1
Beneficiaries who do not have more than one agency to choose from	46%	+/- 4.4
Beneficiaries who report that their doctor decided they needed home health care	81%	+/- 3.5
Beneficiaries who report not being involved in the planning for their home health care	29%	+/- 4.0
Beneficiaries who believe they are not getting all of the home health care that they need	20%	+/- 3.5

Non-Respondent Analysis

We tested for the presence of any non-response bias in our survey results. For this inspection, the non-respondents are the 183 sample beneficiaries from whom we did not receive a completed questionnaire. From our sample of 713, we received a total of 530 responses. Of these, 501 beneficiaries indicated they had received services. We consider these beneficiaries respondents. The other 29 beneficiaries indicated that they had not received services. We excluded these 29 from this analysis.

We used a Chi-Square test to compare our respondents and non-respondents on key demographic variables. These variables were gender, race⁴, and urban/rural location.⁵ In order for the results to be statistically significant at the 95 percent confidence level, the Chi-square value must be higher than 3.84 with 1 degree of freedom. The results of the Chi-square analysis are presented in Tables A, B, and C.

Table A shows no statistically significant differences between respondents and non-respondents for gender. The table also includes the response rates for both males and females.

Table B, however, show a statistically significant difference between respondents and non-respondents for race. In order to test whether this difference introduced bias, we conducted further analysis on the difference between the race variable for two key survey questions. Assuming the non-respondents and respondents from the same group of beneficiaries responded to the two key questions at the same rate, we calculated a hypothetical point estimate for these two questions for all beneficiaries. This calculation gave hypothetical point estimates that were the same as the estimates reported. Seventy-nine percent of beneficiaries said they are very satisfied with their home health care, and 20 percent say they are not getting all the services they need.

Table C shows a statistically significant difference between respondents and non-respondents for urban and rural location. We conducted the same analysis as described above for the urban/rural variable. The estimate for the percentage of beneficiaries who are very satisfied with their care is slightly lower - 78 percent as opposed to 79 percent. The new estimate on the percentage who say they are not getting all the services they

⁴ We divided race into two categories, white and non-white, in order to assure that the numbers in each cell would large enough for meaningful comparisons.

⁵ We assigned beneficiaries' urban/rural status based on the zip code of their mailing address and the 1990 Census data.

need is higher - 21 percent rather than 20 percent. These differences are not statistically significant.

Given the results of this analysis, we believe that the inspection findings accurately represent the experiences of the Medicare beneficiaries in our sample. We therefore believe that our survey findings can be generalized to the universe of beneficiaries who began receiving Medicare home health services in January, 2001.

Table A
GENDER BY RESPONSE

	Respondents	Non-respondents	Total	Response rate
Male	194 (39%)	56 (31%)	250	77%
Female	307 (61%)	127 (69%)	434	71%
Total	501	183	684	73%
Chi-square = 3.8123				
Degree of freedom = 1				

Table B
RACE BY RESPONSE

	Respondents	Non-respondents	Total*	Response rate
White	438 (88%)	142 (77%)	580	76%
Other	60 (12%)	40 (23%)	100	60%
Total	498	182	680	73%
Chi-square = 10.4777				
Degree of freedom = 1				
* No race reported for 4 beneficiaries				

Table C
URBAN/RURAL BY RESPONSE

	Respondents	Non-respondents	Total*	Response rate
Rural	143 (30%)	32 (21%)	162	88%
Urban	328 (70%)	130 (79%)	471	70%
Total	471	162	633	74%
Chi-square = 6.7810				
Degree of freedom = 1				
*No urban/rural designation for 51				