Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

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To cite this article: Joy Stair (1998) Holding up Home Care and Hospice, Oncology Issues, 13:5, 48-48, DOI: 10.1080/10463356.1998.11904783

To link to this article: https://doi.org/10.1080/10463356.1998.11904783

Published online: 18 Oct 2017.

Holding Up Home Care and Hospice

by Joy Stair, M.S., R.N.

During the course of last year's federal budget debate, the home health care benefit came under a relentless barrage of negative publicity, including flawed government studies and media reports alleging massive fraud and abuse and overutilization. It is true that some providers have abused the Medicare home health program; unfortunately, this small minority provided a measure of legitimacy to HCFA's exaggerated charges of fraud and abuse and the benefit changes contained in the Balanced Budget Act (BBA) of 1997. The budget debate on the home health benefit, however, was never about older and disabled Americans and the value of the home health benefit in their lives—it was all about controlling providers. The Congressional Budget Office (CBO) scored the home health provisions at $16.1 billion in savings over fiscal years 1998-2002, starting with $1.5 billion in 1998.

Some of the more problematic changes in the home health benefit for the home health/hospice industry and, consequently, patients, include:

- Reimbursement for home care services (skilled nursing and therapies) is still cost based. The BBA introduces an Interim Payment System (IPS), which requires complex changes to the payment system and in essence reduces Medicare reimbursement to 1993 levels for many agencies. Of major importance is the fact that the annual aggregate per visit cost limits are reduced approximately 21 percent, and there will be an additional 15 percent reduction in cost limits effective October 1, 1999. Consequently, providers are finding that they have to take drastic measures to bring their operations within their aggregate per patient limit.
- Venipuncture is eliminated as a qualified service (effective February 1998). A patient may have home blood draws if that service is provided in conjunction with skilled nursing care; however, those patients not requiring services other than venipuncture will need to pay privately or travel to an outpatient setting for their lab draws. Beneficiaries who require home venipuncture are often the oldest and most disabled Medicare patients and tend to reside in rural areas.
- The BBA imposed a phased-in 30 percent fee cut for home oxygen, with a 25 percent reduction in 1998 and another 5 percent in 1999. Although this cut does not directly impact the patient, suppliers of home oxygen have had to alter their operations to accommodate this cut; in many cases, the number of suppliers has been reduced and service delivery has suffered as associated clinical respiratory services (e.g., utilization of respiratory therapists) have declined.
- The annual increase in hospice payments was rolled back by 1 percent. Hospice did gain several provisions it was seeking, however. One such provision allows hospice to contract for physician services rather than require that hospice employees provide those services. It also eliminates the requirement that a doctor certify a patient as hospice eligible within two days after the start of care. Hospice eligibility certification now must be completed before a bill is submitted to Medicare.

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The Balanced Budget Act gradually transfers from Medicare Part A to Part B home health visits that are not part of the first 100 visits following a beneficiary's three-day stay in a hospital or skilled nursing facility. Forty billion dollars in home care costs will be paid out of Part B over five years as a result of the A to B shift. The real impact results from the increasing number of patients referred to home care by physician offices and outpatient clinics in an effort to prevent hospitalization. The original proposal included a $5 co-payment for every Part B home care visit a patient received up to a maximum equal to the amount of the hospital deductible each year. A major victory for patients came with the defeat of the co-pay measure.

Although the Medicare scope of benefits for home health services was relatively unchanged by the Balanced Budget Act, limiting payment to 1993 levels of care in a manner that ignores changes in patient mix for home care agencies and other factors that raise the total costs ultimately affects patient care and access. As we continue to move care away from the acute setting, it is imperative that all health care providers understand the direction Medicare is taking with home care benefits and the resulting implications for patients.

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