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United States General Accounting Office
Washington, DC 20548

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Congressional Committees

Subject: *Medicare Home Health: Clarifying the Homebound Definition Is Likely to Have Little Effect on Costs and Access*

About 2.5 million Medicare beneficiaries used home health services in 2000 at a cost of \$8.7 billion—about 4 percent of Medicare expenditures that year. Medicare’s home health benefit provides skilled nursing and other services to beneficiaries who are “homebound,” that is, able to leave home only with great difficulty and for absences that are infrequent and of short duration.¹ Based on this statutory requirement, the Department of Health and Human Services (HHS) had a long-standing policy that beneficiaries who regularly attended adult day care were not considered homebound, particularly if the purpose of attending was to receive nonmedical or custodial care. Adult day care centers offer a range of social, medical, and other services to enrollees in a group setting.² This policy created uncertainty about Medicare home health eligibility for individuals receiving medical services at adult day care centers because of HHS’s premise that a homebound beneficiary was unlikely to be able to leave home on a regular basis to seek necessary medical treatment from a center.³

In December 2000, the Congress specified that attending adult day care would not disqualify Medicare beneficiaries from being considered homebound if they still met the other homebound requirements.⁴ Specifically, the change provided that a beneficiary’s eligibility for home health was not affected by absences from the home

¹Permitted absences include obtaining necessary medical care such as physician visits and treatment at a hospital, extended care facility, or rehabilitation center when the required medical equipment is too cumbersome to bring to the beneficiary’s home.

²Adult day care is not a Medicare-covered service and Medicare will not pay home health agencies for services delivered in an adult day care center. However, a small amount of Medicare funding supports adult day care through programs such as the Program for All-Inclusive Care for the Elderly, known as PACE. See U.S. General Accounting Office, *Medicare and Medicaid: Implementing State Demonstrations for Dual Eligibles Has Proven Challenging*, GAO/HEHS-00-94 (Washington, D.C.: Aug. 18, 2000).

³HHS, *Homebound: A Criterion for Eligibility for Medicare Home Health Care* (Washington, D.C.: Apr. 1999).

⁴Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act, P.L. 106-554, §507 114 STAT. 2763A-532, 2763A-533 (Dec. 21, 2000). The change became effective on December 21, 2000.

to attend adult day care, regardless of whether the beneficiary obtained medical treatment or therapeutic and psychosocial services at the center. With this change, however, there was some concern about a potential associated increase in Medicare expenditures resulting from additional numbers of individuals being able to access the home health benefit. Thus, at the same time, the Congress directed us to evaluate the effect of clarifying the homebound definition on the cost of and access to Medicare home health services.

To respond to this mandate, we attempted to identify national data on the numbers and costs of Medicare beneficiaries participating in adult day care and receiving home health care both before and after the effective date of the homebound definition clarification. Because such data were not available, we used the 1999 National Long Term Care Survey (NLTC) to estimate the number of elderly Medicare beneficiaries (65 years of age or older) who attended adult day care and had mobility or cognitive impairments that could potentially make them “homebound” and thus eligible for home health care. NLTC is the most current, nationally representative data available with information on the number of elderly Medicare beneficiaries who (1) “regularly” attend adult day care, (2) report mobility or cognitive impairments, and (3) live in the community. (See enclosure 1 for a more detailed discussion of the 1999 NLTC and the methodology for developing our estimates.) We also interviewed officials at (1) HHS, including the Centers for Medicare and Medicaid Services (CMS), the agency responsible for managing Medicare, and the Office of the Assistant Secretary for Planning and Evaluation; (2) groups that advocated the inclusion of language in the statute permitting Medicare beneficiaries to attend adult day care without losing eligibility for home health care, including the Alzheimer’s Association, the National Adult Day Services Association (NADSA), the National Association for Home Care and a state affiliate, and the National Council on the Aging; (3) the Center for Medicare Advocacy, which has represented beneficiaries who were deemed ineligible for home health because of their attendance at adult day care;⁵ and (4) Easter Seals, which operates the largest nonprofit adult day care chain. We did our work from December 2001 through April 2002 in accordance with generally accepted government auditing standards.

In summary, clarifying the Medicare definition of homebound to allow home health beneficiaries to participate in adult day care will likely have little effect on overall program costs or access to services because the number of affected individuals is probably small. On the basis of NLTC data, we estimate that, as of 1999, 0.2 percent of elderly Medicare beneficiaries (61,000 to 72,000 individuals) attended adult day care and had mobility or cognitive impairments that might have made some eligible for Medicare home health services. Our estimate does not include Medicare beneficiaries under age 65. In the view of officials at CMS, advocacy groups, and other cognizant associations we contacted, prior to the change, beneficiaries who

⁵The center is a nonprofit organization that represents individual Medicare beneficiaries in Connecticut and serves as an advocate for Medicare beneficiaries throughout the country.

were told that their participation in adult day care would render them ineligible for Medicare home health services were likely to have forgone adult day care in order to avoid jeopardizing their eligibility for home health services. Although some adult day care centers may offer both health and personal care services, such services are not covered by Medicare and are generally not a substitute for and do not include the individualized care available from a home health agency. Thus, officials from advocacy groups and associations suggested that the homebound clarification was more likely to increase the use of adult day care than the use of Medicare home health services. In reviewing a draft of this correspondence, CMS concurred with our findings.

BACKGROUND

Medicare's home health benefit enables certain beneficiaries with post-acute-care needs (such as recovery from joint replacement) and chronic conditions (such as congestive heart failure) to receive care in their homes rather than in other settings. To qualify for home health care, a beneficiary must be homebound and require intermittent skilled nursing care, physical therapy, or speech therapy. In addition, the beneficiary must be under the care of a physician, and the home health services must be furnished under a plan of care ordered and periodically reviewed by a physician. If these conditions are met, Medicare will pay for part-time or intermittent skilled nursing; physical, occupational, and speech therapy; medical social services; and home health aide visits.⁶ A beneficiary who does not need skilled care and requires only custodial or personal care does not qualify for the benefit. There are no annual or lifetime limits on home health care coverage as long as the beneficiary continues to meet the eligibility criteria. According to the most recent data available, about 6 percent of Medicare's nearly 40 million beneficiaries used home health services in 2000. Historically, most beneficiaries have received home health services for short periods of time, but according to 1999 data about 6 percent were long-term users.⁷ Over 80 percent of home health users have one or more mobility limitations, such as difficulty transferring from bed to chair or walking more than two or three blocks.

Adult day care provides community-based social and health services to adults of all ages who have physical or cognitive impairments. It can also provide respite support for caregivers, allowing them to work or pursue other activities. Services provided at adult day care centers may include social services, counseling, personal care, meals, transportation, nursing care, therapeutic activities, and rehabilitation therapies—including speech, occupational, and physical therapy. Even though some centers

⁶Skilled nursing and home health aide services may only be provided on a part-time or intermittent basis, that is, the services must be furnished fewer than 8 hours each day and for 28 or fewer hours each week. However, subject to review on a case-by-case basis, a beneficiary may receive up to 35 hours of care per week, or up to and including 8 hours per day, 7 days per week, for temporary periods up to 21 days or longer in exceptional circumstances.

⁷U.S. General Accounting Office, *Medicare Home Health Care: Prospective Payment System Could Reverse Recent Declines in Spending*, GAO/HEHS-00-176 (Washington, D.C.: Sept. 8, 2000).

have nursing staff, they generally do not provide the level of skilled care available through a home health agency. Services may be provided during any part of the day for fewer than 24 hours, but most centers operate during normal business hours 5 days a week. According to preliminary findings from ongoing research, approximately 3,500 centers exist nationwide.⁸ The most current information on adult day care participants, a 1997 survey conducted by NADSA, found that their average age was 76, two-thirds were women, and one-quarter lived alone.⁹ One-half of the participants surveyed were cognitively impaired, one-third required nursing services at least weekly, and over half required assistance with two or more activities of daily living (ADL).¹⁰ Funding for adult day care services comes from a variety of sources. While Medicare does not pay for adult day care, federal support is available through Medicaid and other sources, such as programs funded by HHS or the Department of Veterans Affairs.¹¹ Additional funding sources include state and local governments, philanthropic organizations, participant contributions, and private long-term care insurance. Adult day care centers are not required to meet any federal standards but many states either license or certify centers.

NUMBER OF MEDICARE BENEFICIARIES WHO REGULARLY ATTEND ADULT DAY CARE AND MAY MEET THE HOMEBOUND DEFINITION IS PROBABLY VERY SMALL

Based on our analysis of NLTC data, the impact of the homebound definition clarification on Medicare home health costs and access is likely to be very small. We estimate that, as of 1999, 0.2 percent (between 61,000 and 72,000) of the 34 million elderly Medicare beneficiaries regularly attended adult day care and were potentially “homebound” because of mobility or cognitive impairments. (See table 1; enclosure 1 describes the mobility and cognitive impairments we analyzed.) These potentially homebound individuals were about one-third of the estimated 208,000 elderly Medicare beneficiaries who regularly attended adult day care and about 2 to 3 percent of all beneficiaries who received Medicare home health care in 2000.

⁸Under contract with the Robert Wood Johnson Foundation, Wake Forest University is collecting comprehensive data on the characteristics of adult day care centers and the individuals they serve. The final census of adult day care centers, including characteristics of participants and financing sources, will be available later in 2002.

⁹Because the survey had a response rate of about 45 percent, these figures may not reflect the characteristics of all adult day care participants.

¹⁰ADLs are self-care activities, including bathing, dressing, eating, getting around inside, getting in and out of bed, and toileting.

¹¹Medicaid, jointly funded by states and the federal government, provides health care for certain low-income individuals. With approval from CMS, states can provide a variety of social services and supports to elderly and disabled individuals under Medicaid waivers. See U.S. General Accounting Office, *Adults With Severe Disabilities: Federal and State Approaches for Personal Care and Other Services*, GAO/HEHS-99-101 (Washington, D.C.: May 14, 1999).

Table 1: Estimate of Elderly Medicare Beneficiaries Who Regularly Attended Adult Day Care and Who Were Potentially Homebound, 1999

Category	Estimate of elderly Medicare beneficiaries	
	Number	Percentage (of 34 million)
Regularly attended adult day care	208,000 ^a	0.6
Potentially homebound: regularly attended adult day care and had at least one mobility or cognitive impairment	61,000 ^b to 72,000 ^c	0.2

^aThe 95 percent confidence interval ranges from 108,000 (0.3 percent) to 307,000 (0.9 percent).

^bThe 95 percent confidence interval ranges from 39,000 (0.1 percent) to 83,000 (0.2 percent).

^cThe 95 percent confidence interval ranges from 48,000 (0.1 percent) to 97,000 (0.3 percent).

Source: GAO analysis of 1999 NLTCS.

The proportion of elderly Medicare beneficiaries with mobility or cognitive impairments who attended adult day care and who actually qualified for home health might be lower than 0.2 percent. Adult day care attendance might indicate that their impairments were not severe enough at the time to confine such beneficiaries to their homes. In fact, officials from advocacy groups and associations told us that the homebound clarification is more likely to increase the use of adult day care than the use of Medicare home health services. When faced with the choice between adult day care or home health services before the homebound definition clarification, we were told consistently that beneficiaries were likely to have forgone adult day care in order to qualify for Medicare-covered home health services. In addition, adult day care often does not provide the individualized skilled care typically available through home health, and beneficiaries may have to pay for adult day care, which is not covered by Medicare. Medicare home health services, on the other hand, have no associated out-of-pocket costs. However, there might have been a small group of beneficiaries that chose adult day care over home health services. An official with a state home health association suggested that some of the potential new home health users might be beneficiaries with limited skilled-care needs who had been unwilling to give up adult day care because of the perceived value to themselves or their caregivers and because it was available for the entire day. Now such beneficiaries may receive home health services in addition to attending adult day care.

Our estimate does not include nonelderly disabled Medicare beneficiaries who might qualify for home health care. Nonelderly Medicare beneficiaries number about 5 million or 13 percent of the total Medicare population. No data source on adult day care participation by this group of Medicare beneficiaries could be identified.

AGENCY COMMENTS

CMS reviewed a draft of this correspondence and concurred with our approach to identifying the beneficiaries affected by the homebound definition clarification and with our finding that the impact on Medicare costs and access is likely limited because this group of beneficiaries is probably very small. CMS's comments are included in enclosure 2.

We are sending copies of this letter to the Administrator of CMS and interested congressional committees. This letter is also available on GAO's home page at <http://www.gao.gov>.

If you or your staffs have any questions, please call me at (202) 512-7118 or Walter Ochinko at (202) 512-7157. Other major contributors to this correspondence include Connie Peebles Barrow, Beth Cameron Feldpush, Dean Mohs, and Jeffrey Schmerling.



Kathryn G. Allen
Director, Health Care—Medicaid and
Private Health Insurance Issues

Enclosures

List of Committees

The Honorable Max Baucus

Chairman

The Honorable Charles E. Grassley

Ranking Minority Member

Committee on Finance

United States Senate

The Honorable W.J. "Billy" Tauzin

Chairman

The Honorable John D. Dingell

Ranking Minority Member

Committee on Energy and Commerce

House of Representatives

The Honorable William M. Thomas

Chairman

The Honorable Charles B. Rangel

Ranking Minority Member

Committee on Ways and Means

House of Representatives

METHODOLOGY FOR ESTIMATING IMPACT OF HOMEBOUND
DEFINITION CLARIFICATION USING THE 1999 NLTC

NLTCS, a nationally representative survey of elderly Medicare beneficiaries, is conducted every 5 years by Duke University's Center for Demographic Studies under sponsorship by HHS's Office of the Assistant Secretary for Planning and Evaluation and the National Institute on Aging of the National Institutes of Health. The 1999 survey included 19,907 Medicare beneficiaries aged 65 or older.¹² All beneficiaries were screened to identify those who were functionally impaired. Beneficiaries were considered impaired if they had difficulty with at least one ADL or instrumental activity of daily living (IADL).¹³ The 6,183 beneficiaries identified as functionally impaired were asked to complete a detailed survey that included questions on topics such as their health, functional status, social activities, nutrition, health insurance, housing characteristics, and demographic characteristics. Among those identified as impaired, 1,036 resided in nursing homes and the remaining 5,147 lived in the community. Beneficiaries in this last group were asked if they regularly attended adult day care. Of the 5,147 beneficiaries who lived in the community, 52 indicated that they regularly attended adult day care.

We used mobility and cognitive impairments to identify the potentially homebound subset of 52 beneficiaries who reported that they regularly attended adult day care. Many Medicare home health users have mobility impairments that may lead to an individual's becoming homebound. In addition, cognitive and mental conditions may confine beneficiaries to the home. First, we determined how many of the 52 beneficiaries had mobility impairments and then separately examined how many had either mobility or cognitive impairments. The mobility impairments we selected included three ADLs (getting in or out of bed, getting around inside, and getting to the bathroom and using the toilet) and one IADL (getting around outside) that also measures mobility.¹⁴ Inclusion of the IADL raised the threshold of impairment, as 37 (71.2 percent) of the 52 adult day care respondents had an impairment in at least one of the four mobility ADLs and the IADL, while only 28 (53.8 percent) had at least one impairment when the IADL was excluded (see table 2). We selected three IADLs that may indicate cognitive limitations—managing money, making telephone calls, and taking medication. As shown in table 2, including these three IADLs in our analysis increased to 43 (82.7 percent) the number of adult day care users who had at least one of seven mobility or cognitive impairments. We used the range of 37 to 43 beneficiaries as the upper threshold to estimate that about 61,000 to 72,000 elderly

¹²Younger beneficiaries who qualify for Medicare because of disabilities or because they have end-stage renal disease are not included in the survey.

¹³The ability to carry out more complex self-care tasks involving higher levels of physical and cognitive functioning are assessed by IADLs—getting around outside; going places outside of walking distance; doing housework or laundry; making phone calls; managing money; preparing meals; shopping for groceries; and taking medicine.

¹⁴Other ADLs, such as dressing, are much less likely to result in an individual's being homebound.

Medicare beneficiaries who regularly attended adult day care in 1999 were potentially “homebound” and thus might have been eligible for Medicare home health.

Table 2: Mobility and Cognitive Impairment of the 52 Adult Day Care Users from the 1999 NLTCS

Category	Number	Percentage (of 52)
At least one of three mobility impairments ^a	28	53.8
At least one of four mobility impairments ^b	37	71.2
At least one of seven mobility or cognitive impairments ^c	43	82.7

^aGetting in and out of bed, getting around inside, and getting to the bathroom and using the toilet.

^bGetting in and out of bed, getting around inside, getting to the bathroom and using the toilet, and getting around outside.

^cThe measures of cognitive impairment were managing money, making telephone calls, and taking medication. We used the same four mobility impairments described in the preceding text.

Source: GAO analysis of 1999 NLTCS.

COMMENTS FROM THE CENTERS FOR MEDICARE
AND MEDICAID SERVICES



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

APR 23 2002

Administrator
Washington, DC 20201

TO: Kathryn G. Allen
Director, Health Care—Medicaid
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General Accounting Office

FROM: Thomas A. Scully 
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: General Accounting Office (GAO) Draft Correspondence, *Medicare Home Health: Clarifying the Homebound Definition Is Likely to Have Little Effect on Costs and Access*, (GAO-02-555R)

Thank you for sending the above-referenced report to us for comments. We appreciate GAO's review of the effect of clarifying the homebound definition on the cost of, and access to, Medicare home health care.

We concur with the findings in the GAO report. We agree that clarifying the Medicare definition of homebound to allow home health beneficiaries to participate in adult day care will likely have little effect on overall program costs or access to services. As indicated in your report, this result is expected because the number of affected individuals is probably very small. However, as reported by the news media, CMS has directed Medicare contractors to remove any claims edits that would deny claims for covered services for individuals diagnosed with Alzheimer's Disease. This action reinforces Medicare's commitment to making sure that beneficiaries with Alzheimer's Disease receive the care to which they are entitled under Medicare.

According to current law, in order to be eligible for home health services, a beneficiary must: (1) need intermittent skilled nursing care, or physical therapy, speech therapy, or continue to need occupational therapy; (2) be "homebound" (e.g., normal inability to leave); (3) be under a plan of care established and periodically reviewed by a physician; and (4) receive the services from a Medicare participating home health agency.

The change in the statute recognizes that a beneficiary's eligibility for home health is not affected by absences from the home to attend adult day care.

We believe that GAO has taken appropriate steps to identify this population and has arrived at a reasonable assumption that this population is likely to be very small.

We look forward to working with GAO on this and other issues in the future.

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