

CHAPTER

8

Home health care services

R E C O M M E N D A T I O N

- 8** The Congress should direct the Secretary to eliminate the payment update for 2017 and implement a two-year rebasing of the payment system beginning in 2018. The Congress should direct the Secretary to revise the prospective payment system to eliminate the use of therapy visits as a factor in payment determinations, concurrent with rebasing.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

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(Additionally, the Commission reiterates its March 2011 recommendations on improving the home health care benefit. See text box, pp. 218–219.)

Home health care services

Chapter summary

Home health agencies provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2014, about 3.4 million Medicare beneficiaries received care, and the program spent about \$17.7 billion on home health care services. Over 12,400 agencies participated in Medicare in 2014.

Assessment of payment adequacy

The indicators of payment adequacy for home health care are generally positive.

Beneficiaries' access to care—Access to home health care is generally adequate: Over 99 percent of beneficiaries live in a ZIP code where a Medicare home health agency operates, and 82 percent live in a ZIP code with five or more agencies.

- **Capacity and supply of providers**—In 2014, the number of agencies decreased by 1.2 percent after over a decade of continuous growth. From 2004 to 2014, the number of agencies increased by 65 percent. The decline in 2014 was concentrated in areas that experienced sharp increases in supply in prior years.
- **Volume of services**—In 2014, the volume of services declined slightly. The total number of users decreased slightly (–1.3 percent), while the

In this chapter

- Are Medicare payments adequate in 2016?
- How should Medicare payments change in 2017?

average number of episodes per home health user declined by 0.8 percent. This trend is not surprising because spending growth for all health care (including both public and private payers) has slowed in recent years, and Medicare inpatient admissions, an important source of referrals, have declined. These decreases for home health care follow several years of rapid increases; between 2002 and 2014, the total number of episodes increased by 60 percent, and the episodes per home health user increased from 1.6 to 1.9. Episodes not preceded by a prior hospitalization account for most of the growth in this period, and between 2001 and 2013, these episodes increased from 53 percent to 66 percent of total episodes.

Quality of care—In 2014, performance on quality measures did not change significantly. The share of beneficiaries reporting improvement in walking and transferring increased slightly; the share of beneficiaries hospitalized during their home health spell was 27.8 percent, similar to the rate in prior years.

Providers' access to capital—Access to capital is a less important indicator of Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. The major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs. The acquisition of two large home health companies by other health care companies indicates this sector is an attractive market to investors.

Medicare payments and providers' costs—From 2013 to 2014, Medicare spending declined by 1.6 percent to \$17.7 billion but increased by 84 percent since 2002. For more than a decade, payments have consistently and substantially exceeded costs in the home health prospective payment system. In 2014, Medicare margins for freestanding agencies averaged 10.8 percent and averaged 16.5 percent between 2001 and 2014. The marginal profit, excluding certain fixed costs, for home health agencies equaled 13.3 percent, indicating that agencies have an incentive to serve additional patients. The Commission projects a margin of 8.8 percent for 2016. Two factors have contributed to payments exceeding costs: Fewer visits are delivered in an episode than what is assumed in Medicare's rates, and cost growth has been lower than the annual payment updates for home health care.

The high margins of home health agencies have led the Commission to recommend eliminating the payment update for 2017 and implementing a two-year rebasing beginning in 2018. These two actions should help to better align payments with actual costs, ensuring better value for beneficiaries and the taxpayer.

We are also recommending that, beginning in 2018, Medicare eliminate the use of therapy as a payment factor in the home health prospective payment system (PPS). A review of utilization trends and other materials by the Commission and others suggests that this feature of the PPS may create financial incentives that distract agencies from focusing on patient characteristics when setting plans of care. Eliminating therapy as a factor would base home health payment solely on patient characteristics, a more patient-focused approach to payment. ■

Background

Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to beneficiaries in their homes. To be eligible for Medicare's home health benefit, beneficiaries must need part-time (fewer than eight hours per day) or intermittent skilled care to treat their illnesses or injuries and must be unable to leave their homes without considerable effort. Medicare requires that a physician certify a patient's eligibility for home health care and that a patient receiving service be under the care of a physician. In contrast to coverage for skilled nursing facility services, Medicare does not require a preceding hospital stay to qualify for home health care. Unlike for most services, Medicare does not require copayments or a deductible for home health services. In 2014, about 3.4 million Medicare beneficiaries received home care, and the program spent \$17.7 billion on home health services. Medicare spending for home health care has doubled between 2001 and 2014, and in 2014 accounts for about 4 percent of fee-for-service (FFS) spending.

Medicare pays for home health care in 60-day episodes. Payments for an episode are adjusted for patient severity based on patients' clinical and functional characteristics and some of the services they use. If beneficiaries need additional covered home health services at the end of the initial 60-day episode, another episode commences and Medicare pays for an additional episode. Episodes delivered to beneficiaries in rural areas receive a 3 percent payment increase through 2017. (An overview of the home health prospective payment system (PPS) is available at <http://www.medpac.gov/documents/payment-basics/home-health-care-services-payment-system-15.pdf?sfvrsn=0>.) Coverage for additional episodes generally has the same requirements (e.g., the beneficiary must be homebound and need skilled care) as the initial episode.

In 2011, Medicare implemented a requirement that a beneficiary have a face-to-face encounter with the physician ordering home health care. The encounter must take place in the 90 days preceding or 30 days following the initiation of home health care. Contacts through nonphysician practitioners or authorized telehealth services may be used to satisfy the requirement.

Use and growth of home health benefit has varied substantially due to changes in coverage and payment policy

The home health benefit has changed substantially since the 1980s. Implementation of the inpatient PPS in 1983 led to increased use of home health services as hospital lengths of stay decreased. Medicare tightened coverage of some services, but the courts overturned these curbs in 1988. After this change, the number of agencies, users, and services expanded rapidly in the early 1990s. Between 1990 and 1995, the number of annual users increased by 75 percent and the number of visits more than tripled to about 250 million a year. Spending increased more than fourfold in the five years between 1990 and 1995, from \$3.7 billion to \$15.4 billion. As the rates of use and lengths of stay increased, there was concern that the benefit was serving more as a long-term care benefit (Government Accountability Office 1996). Further, many of the services provided were believed to be improper. For example, in one analysis of data from 1995 to 1996, the Office of Inspector General found that about 40 percent of the services in a sample of Medicare claims did not meet Medicare requirements for reimbursement, mostly because services did not meet Medicare's standards for a reasonable and necessary service, patients did not meet the homebound coverage requirement, or the medical record did not document that a billed service was provided (Office of Inspector General 1997).

The trends of the early 1990s prompted increased program integrity actions, refinements to coverage standards, temporary spending caps through an interim payment system (IPS), and replacement of the cost-based payment system with a PPS in 2000.¹ Between 1997 and 2000, the number of beneficiaries using home health services fell by about 1 million, and the number of visits fell by 65 percent (Table 8-1, p. 214). The mix of services changed from predominantly aide services in 1997 to predominantly nursing visits in 2000, and therapy visits increased between 1997 and 2014 from 10 percent of visits to 36 percent. Between 1997 and 2000, total spending for home health services declined by 52 percent. The reduction in payments had a swift effect on the supply of agencies, and by 2000, the number of agencies had fallen by 31 percent. However, after this period, the PPS was implemented, and service use and agency supply rebounded at a rapid pace. Between 2001 and 2014, the number of home health episodes rose from 3.9 million to 6.7 million (data not shown). The number of agencies in 2014 was 12,461.

**TABLE
8-1**

Changes in supply and utilization of home health care, 1997-2014

	1997	2000	2013	2014	Percent change		
					1997-2000	2000-2013	2013-2014
Agencies	10,917	7,528	12,613	12,461	-31%	64%	-1%
Total spending (in billions)	\$17.7	\$8.5	\$17.9	\$17.7	-52	111	-2
Users (in millions)	3.6	2.5	3.5	3.4	-31	39	-1
Number of visits (in millions)	258.2	90.6	114.1	115.1	-65	26	1
Visit type (percent of total)							
Skilled nursing	41%	49%	53%	52%	20	8	-3
Home health aide	48	31	13	12	-37	-57	-13
Therapy	10	19	35	36	101	85	2
Medical social services	1	1	1	1	1	-22	-13
Number of visits per user	73	37	33	34	-49	-11	2
Percent of FFS beneficiaries who used home health services	11%	7%	9%	9%	-30	26	-3

Note: FFS (fee-for-service). Medicare did not pay on a per episode basis before October 2000. Yearly figures presented in the table are rounded, but percent change columns were calculated using unrounded data.

Source: Home health standard analytical file 2014; *Health Care Financing Review*, Medicare and Medicaid Statistical Supplement 2002.

Almost all the new agencies since implementation of the PPS have been for-profit providers.

The steep declines in services under the IPS did not appear to have adversely affected the quality of care beneficiaries received; one analysis found that patient satisfaction with home health services was mostly unchanged in this period (McCall et al. 2004, McCall et al. 2003). A study by the Commission also concluded that the quality of care did not decline between the IPS and the implementation of the PPS (Medicare Payment Advisory Commission 2004). The similarity in quality of care under the IPS and the PPS suggests that the payment reductions in the Balanced Budget Act of 1997 led agencies to reduce costs and utilization without a measurable difference in the quality of patient care.

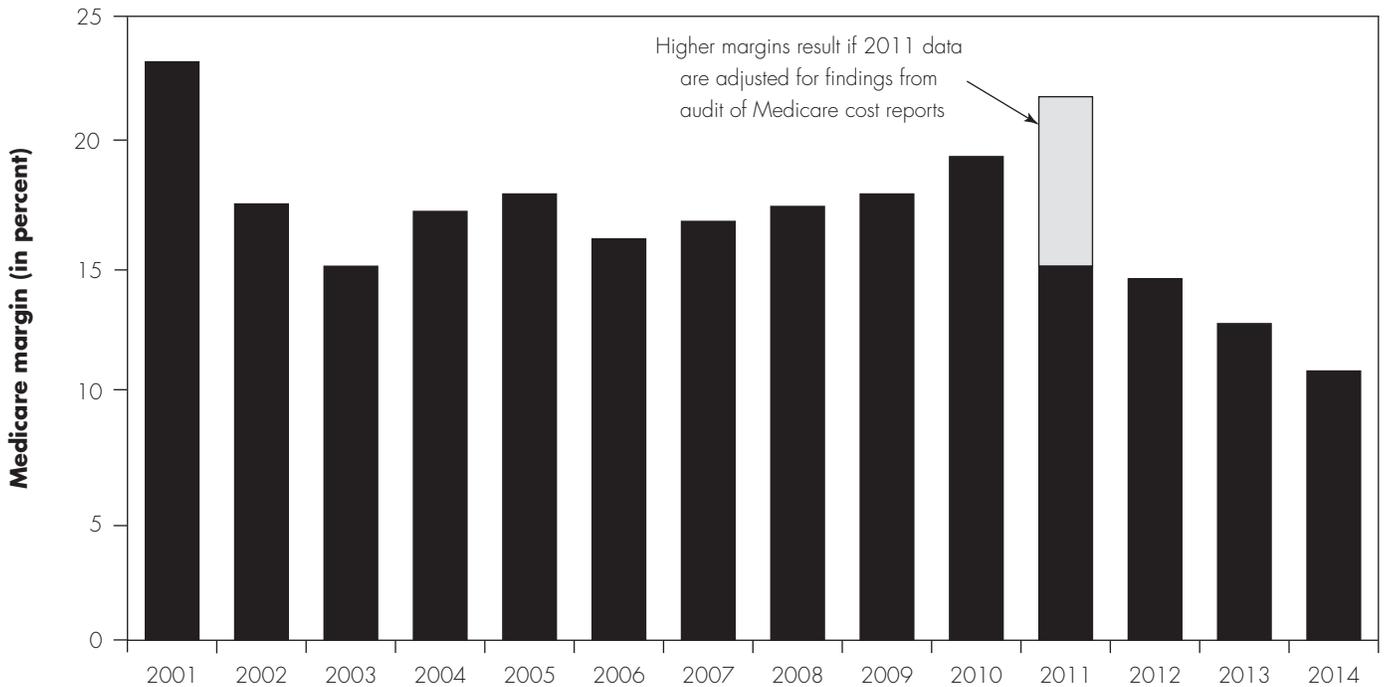
Medicare has paid more than costs for home health services under PPS

Payments for home health care have substantially exceeded operating costs since Medicare established the

PPS. In 2001, the first year of the PPS, average Medicare margins equaled 23 percent (Figure 8-1). The high margins in the first year suggest that the PPS established a base rate well in excess of costs. The base rate assumed that the average number of visits per episode would decline about 15 percent between 1998 and 2001, but the actual decline was about 32 percent (Table 8-2). In addition, agencies have been able to hold the rate of episode cost growth below 1 percent in many years, lower than the rate of inflation assumed in the home health payment update. Consequently, home health agencies (HHAs) were able to garner extremely high average payments relative to the services provided. Since 2001, agencies have been able to reduce visits further, and margins have averaged 16.5 percent between 2001 and 2014. In addition, there is the possibility that these reported margins may be low. An audit of 100 sample cost reports from 2011 by CMS found that agencies overstated their costs by about 8 percent; with this adjustment, their margins would have been in excess of 20 percent in that year (Figure 8-1).

FIGURE 8-1

Medicare margins of freestanding home health agencies since 2001



Source: Medicare cost reports, 2001–2014.

Patient Protection and Affordable Care Act of 2010 changes to payment for home health services

In 2010, the Commission recommended that Medicare lower home health payments to make them more consistent with costs, a process referred to as payment

rebased. The Patient Protection and Affordable Care Act of 2010 (PPACA) included several reductions intended to address home health care’s high Medicare payments, including rebasing the payment system. However, these policies may not achieve the Commission’s goal of making payments more consistent with actual costs.

TABLE 8-2

Medicare visits per episode before and after implementation of PPS

Type of visit	Visits per episode				Percent change in:		
	1998	2001	2013	2014	1998–2001	2001–2013	2013–2014
Skilled nursing	14.1	10.5	9.4	9.8	–25%	–10%	4.3%
Therapy (physical, occupational, and speech–language pathology)	3.8	5.2	6.4	6.7	39	23	4.7
Home health aide	13.4	5.5	2.4	2.2	–59	–57	–8.3
Medical social services	0.3	0.2	0.1	0.1	–36	–32	–26.0
Total	31.6	21.4	18.3	18.8	–32	–15	2.7

Note: PPS (prospective payment system). The PPS was implemented in October 2000. Data exclude low-utilization episodes. Yearly figures presented in the table are rounded, but percent change columns were calculated using unrounded data.

Source: Home health standard analytic file.

**TABLE
8-3****Impact of PPACA rebasing on payments for 60-day episodes**

	Annual percent change				Cumulative change, 2014-2017
	2014	2015	2016	2017	
Rebasing adjustment	-2.8%	-2.7%	-2.7%	-2.8%	-11.4%
Legislated payment update	2.3	2.1	1.9	1.9	8.5
Net annual payment reduction	-0.6	-0.7	-0.8	-0.9	-3.0

Note: PPACA (Patient Protection and Affordable Care Act of 2010). Payment update estimates are based on the second-quarter 2015 forecast of the home health market basket. Effects of payment changes are multiplicative.

Source: MedPAC analysis based on data from CMS.

PPACA calls for the annual rebasing adjustment to be offset by the payment update for each year in 2014 through 2017. CMS set the rebasing reduction to the maximum amount permitted under the PPACA formula, which was equal to 3.5 percent of the 2010 base rate, or an annual reduction of \$81 per 60-day episode. However, the size of the base rate has increased since 2010, so this payment reduction will actually be less than 3.5 percent, and in fact will average about 2.8 percent in each year from 2014 through 2017. In addition, over this period, the payment update will offset these reductions, resulting in a cumulative net payment reduction of 3 percent (Table 8-3). This modest reduction will likely leave substantial margins for HHAs, which have exceeded 10 percent since the implementation of the PPS.

PPACA required the Commission to assess the impact of these payment changes on quality of care and beneficiary access (Medicare Payment Advisory Commission 2014). To meet this mandate, the Commission examined the historical relationship between changes in payment and changes in quality and access between 2001 and 2012. The volume of episodes grew substantially in this period, even in years that Medicare reduced home health payments. From 2001 through 2010, episode volume for urban, rural, for-profit, and nonprofit providers grew on a per beneficiary basis. These increases in utilization occurred not only in years in which the average episode payment decreased but also in years in which the average payment increased, suggesting that changes in access are not directly correlated with changes in payment. Utilization decreased slightly in 2011 and 2012, but these declines coincided with policies intended to address potential overuse such as the face-to-face visit requirement and

anti-fraud efforts in several high-use areas. The slowdown also coincided with an economy-wide slowdown in health spending and utilization.

The Commission examined three quality measures to assess the relationship between past payment reductions and quality, and the results suggest that payment changes during this period did not have a significant effect. During this period, HHAs' overall rate of unexpected hospitalization during the home health episode—an indicator of poor quality—remained steady at about 28 percent, while average payment per episode increased in most years.² This finding suggests that hospitalization was not sensitive to changes in payments; that is, higher payments to HHAs did not lead to fewer hospitalizations. Also during this period, performance on two functional measures of quality—the share of patients demonstrating improvement in walking and the share of patients demonstrating improvement in transferring—generally increased. These increases in quality occurred not only in years in which the average payment per episode decreased but also in years in which the average payment per episode increased, suggesting that changes in payment have little direct relationship to rates of functional improvement.

The Commission will continue to review access to care and quality as data for additional years become available. However, experience suggests that the small PPACA rebasing reductions will not change average episode payments significantly. HHA margins are likely to remain high under the current rebasing policy, and quality of care and beneficiary access to care are unlikely to be negatively affected.

Ensuring appropriate use of home health care is challenging

Policymakers have long struggled to define the role of the home health benefit in Medicare (Benjamin 1993). From the outset, there was a concern that setting a narrow policy could result in beneficiaries using other, more expensive services, while a policy that was too broad could lead to wasteful or ineffective use of home health care (Feder and Lambrew 1996). Medicare relies on the skilled care and homebound requirements as primary determinants of home health eligibility, but these broad coverage criteria permit beneficiaries to receive services in the home even when they are capable of leaving home for medical care, which most home health beneficiaries do (Wolff et al. 2008). Medicare does not provide any incentives for beneficiaries or providers to consider alternatives to home health care such as outpatient services. Beneficiaries who meet program coverage requirements can receive an unlimited number of home health episodes and face no cost sharing. In addition, the program relies on agencies and physicians to follow program requirements for determining beneficiary needs, but there is some evidence that they do not consistently follow Medicare's standards (Cheh et al. 2007, Office of Inspector General 2001). Concerns about ensuring the appropriate use of home health episodes not preceded by a hospitalization led the Commission to recommend a copay for these episodes (see text box on reiterated recommendations, pp. 218–219).

Even when enforced, the standards permit a broad range of services. For example, the skilled care requirement mandates that a beneficiary need therapy or nursing care to be eligible for the home health benefit. The intent of the skilled services requirement is that the home health benefit serves a clear medical purpose and is not an unskilled personal care benefit. However, Medicare's coverage standards do not require that skilled visits compose the majority of the home health services a patient receives. For example, in about 6 percent of episodes in 2014, most services provided were visits from an unskilled home health aide. These episodes raise questions about whether Medicare's broad standards for coverage are adequate to ensure that skilled care remains the focus of the home health benefit.

Fraud and abuse are continuing challenges in home health care

In 2010, the Commission made a recommendation to curb wasteful and fraudulent home health services

(Medicare Payment Advisory Commission 2010).

This recommendation calls on the Secretary to use her authorities under current law to examine providers with aberrant patterns of utilization for possible fraud and abuse. PPACA permits Medicare to implement temporary moratoriums on the enrollment of new agencies in areas believed to have a high incidence of fraud. In July 2013, Medicare implemented this moratorium authority for HHAs in the Chicago, Dallas, Detroit, Houston, and Miami-Dade areas (Fort Lauderdale was later included in the moratorium). There have also been numerous criminal prosecutions for home health fraud, most notably in Detroit and Miami. However, the Commission still observes many areas with aberrant patterns of utilization. For example, even though Miami has been an area of concentrated effort by CMS and law enforcement agencies, this area still has a utilization rate well in excess of other areas. The persistence of aberrant patterns of utilization suggests that continued, or perhaps even expanded, efforts by all enforcement agencies are needed to address the scope of fraud in many areas. In addition, Medicare has the authority to require HHAs to hold surety bonds, but has not exercised this authority.³ Another approach, so far unexplored by Medicare, would be to set performance thresholds on quality measures for HHAs as part of the conditions of participation. Agencies that could not meet these thresholds could be removed from the program or placed on a probationary review that scrutinizes their operations.

Are Medicare payments adequate in 2016?

The Commission reviews several indicators to determine the level at which payments will be adequate to cover the costs of an efficient provider in 2016. We assess beneficiary access to care by examining the supply of home health providers and annual changes in the volume of services. The review also examines quality of care, access to capital, and the relationship between Medicare's payments and providers' costs. Overall, the Medicare payment adequacy indicators for HHAs are positive.

Beneficiaries' access to care: Almost all beneficiaries live in an area served by home health care

Supply and volume indicators show that almost all beneficiaries have access to home health services. In 2014, over 99 percent of beneficiaries lived in a ZIP code served

The Commission reiterates its March 2011 recommendations on the home health care benefit

In 2011, the Commission noted several problems with the home health care benefit and made several recommendations to reduce fraud and address beneficiary incentives. Two of those recommendations are included here with updated commentary and rationales.

Recommendation 8-1, March 2011 report

The Secretary, with the Office of Inspector General, should conduct medical review activities in counties that have aberrant home health utilization. The Secretary should implement the new authorities to suspend payment and the enrollment of new providers if they indicate significant fraud.

For many years, the Commission has published a list of counties with questionable utilization patterns (see Table 8-7, p. 223). As the Commission recommended in its March 2011 report, these counties would be appropriate areas for the Secretary to exercise new Patient Protection and Affordable Care Act of 2010 (PPACA) authorities for investigating and interdicting home health fraud. The Department of Health and Human Services began exercising some of these authorities in 2013 when it announced a moratorium on the enrollment of new agencies in several areas of the country, and some of the decline in agencies observed in 2014 is likely attributable to these efforts.

Medicare and the law enforcement community have made some progress in closing questionable agencies. However, the continued high utilization in many areas, including areas that have experienced significant law enforcement activity, suggests that expanded efforts are warranted. These efforts could include expanded enforcement activity or use of the program's administrative authority. For example, PPACA permits Medicare to suspend payments if CMS, in consultation with the Office of Inspector General (OIG), finds credible evidence of fraud at a provider, though CMS has yet to use the authority. Medicare and the other enforcement entities should continue to review home health care spending and pursue providers that appear to engage in behavior that is potentially fraudulent or wasteful.

Implications 8-1

Spending

- The Congressional Budget Office has scored savings from the PPACA provision, so its baseline assumes savings based on the new authority. Implementing this authority would lower home health spending if fraud were discovered. CMS and OIG would incur some administrative expenses.

Beneficiary and provider

- Appropriately targeted reviews would not affect beneficiary access to care or provider willingness to serve beneficiaries. Any reduction in provider supply is likely to occur in areas that have experienced rapid growth in the number of providers.

Recommendation 8-4, March 2011 report

The Congress should direct the Secretary to establish a per episode copay for home health episodes that are not preceded by hospitalization or post-acute care use.

Health services literature has generally found that beneficiaries consume more services when cost sharing is limited or nonexistent, and some evidence suggests that the additional services do not always contribute to better health. The lack of cost sharing is a particular concern for home health care because the prospective payment system pays for care on a per episode basis that rewards additional volume. The lack of a cost-sharing requirement stands in contrast to most other Medicare services, which generally require the beneficiary to bear some of the costs of Medicare services.

One concern with cost sharing is that it can lead beneficiaries to reduce their use of effective as well as ineffective care. Although some studies have found evidence of adverse effects of reduced care due to cost sharing (Chandra et al. 2010, Rice and Matsuoka 2004), the RAND health insurance experiment concluded that, on average, non-elderly patients who consumed less health care because of cost sharing suffered no net adverse effects (Newhouse 1993). The Commission's

(continued next page)

The Commission reiterates its March 2011 recommendations on the home health care benefit (cont.)

review of the impact of medigap insurance generally found that beneficiaries with this insurance had higher total Medicare spending (Medicare Payment Advisory Commission 2009). The results of the RAND health insurance experiment and the Commission’s study suggest that a home health care copayment would decrease use of home health care and result in lower overall Medicare spending.

To encourage appropriate use, the Commission recommended that Medicare add an episode copayment for services not preceded by a hospitalization or other post-acute use.⁴ The high growth rates for these types of episodes, which have more than doubled since 2001, suggest there is significant potential for overuse. The addition of a copayment would allow beneficiary cost consciousness to counterbalance the broad nature of the

benefit’s use criteria and the volume-rewarding aspects of Medicare’s per episode payment policies.

Implications 8-4

Spending

- A copay of \$150 per episode (excluding low-use and posthospital episodes) would reduce Medicare spending.

Beneficiary and provider

- Some beneficiaries might seek services through outpatient or ambulatory care for which Medicare already has cost-sharing requirements. Some beneficiaries who need relatively few services would have lower cost sharing if they substituted ambulatory care for home health care. ■

by at least one HHA, 95 percent lived in a ZIP code served by two or more HHAs, and 82 percent lived in a ZIP code served by five or more agencies. These findings are consistent with our review of access from prior years.⁵

Supply of providers: Agency supply surpasses previous peak

In 2014, the number of HHAs in Medicare had increased 65 percent since 2002, reaching 12,461 agencies (Table 8-4). The number of agencies declined slightly in 2014 relative to the prior year, but even with this decline, nationwide the number of agencies is now higher than the previous peak in the 1990s when supply exceeded 10,900 agencies.

The decline was concentrated in areas that experience higher than average increases in supply: Florida, Michigan, and Texas. These states have been targeted by a myriad of antifraud measures, including criminal investigations and moratoriums on the entry of new agencies in some parts of the three states. The number of agencies exiting the program has increased in recent years in these states, and the moratoriums have likely slowed the entry of new agencies. Even with the declines in these states, however, the supply of agencies in the three states is more than three times the supply of agencies that were available in 2002—over 4,500 agencies in 2014.

TABLE 8-4

Number of participating home health agencies has increased significantly since 2004

	2004	2008	2012	2013	2014	Percent change	
						2004–2012	2013–2014
Active agencies	7,651	9,787	12,311	12,613	12,461	65%	-1.2%
Number of agencies per 10,000 FFS beneficiaries	2.1	2.8	3.3	3.4	3.3	61	-2.1

Note: FFS (fee-for-service). “Active agencies” includes all agencies operating during a year, including agencies that closed or opened.

Source: CMS’s Provider of Services file and 2015 annual report of the Boards of Trustees of the Medicare trust funds.

**TABLE
8-5**

Spending and utilization changes in home health care, 2002-2014

	2002	2010	2011	2012	2013	2014	Percent change		Cumulative change, 2002-2014
							2002-2013	2013-2014	
Home health users (in millions)	2.5	3.4	3.4	3.4	3.5	3.4	37.8%	-1.3%	36.0%
Share of beneficiaries using home health care	7.2%	9.4%	9.4%	9.2%	9.3%	9.1%	28.9	-2.2	26.0
Episodes (in millions):	4.1	6.8	6.8	6.7	6.7	6.6	63.6	-2.1	60.1
Per home health user	1.6	2.0	2.0	2.0	1.9	1.9	18.7	-0.8	17.7
Per FFS beneficiary	0.12	0.19	0.19	0.18	0.18	0.17	53.0	-3.0	48.4
Payments (in billions)	\$9.6	\$18.4	\$18.4	\$18.0	\$17.9	\$17.7	87.3	-1.6	84.4
Per home health user	\$3,803	\$5,679	\$5,347	\$5,247	\$5,169	\$5,156	35.9	-0.3	35.6
Per FFS beneficiary	\$274	\$540	\$504	\$484	\$479	\$468	75.2	-2.5	70.8

Note: FFS (fee-for-service). Percent change is calculated on numbers that have not been rounded.

Source: MedPAC analysis of home health standard analytical file.

From 2004—when 99 percent of beneficiaries lived in a ZIP code served by an HHA—to 2014, the number of agencies per 10,000 FFS beneficiaries rose 61 percent, from 2.1 to 3.3 (Table 8-4, p. 219). Most of the new agencies were for profit. However, supply varies significantly among states. In 2013, Texas averaged 10.5 agencies per 10,000 beneficiaries, while New Jersey averaged less than 1 agency per 10,000 beneficiaries. Some of this variation was likely due to differences in agency size; for example, in New Jersey, the average agency provided 2,909 episodes compared with 354 episodes per agency for Texas. The extreme variation demonstrates that the number of providers is a limited measure of capacity because agencies can vary in size. Also, because home health care is not provided in a medical facility, agencies can adjust their service areas as local conditions change. Even the number of employees may not be an effective metric because agencies can use contract staff people to meet their patients’ needs.

Growth in episode volume slows after many years of rapid growth

Episode volume has declined since 2011, but this decline was preceded by a period of rapid growth (Table 8-5 and Figure 8-2). Between 2002 and 2011, total episodes increased by 67 percent from 4.1 million episodes to 6.8 million episodes. The decline since 2011 has been concentrated in a few states, with five states (Florida, Illinois, Louisiana, Tennessee, and Texas) accounting for

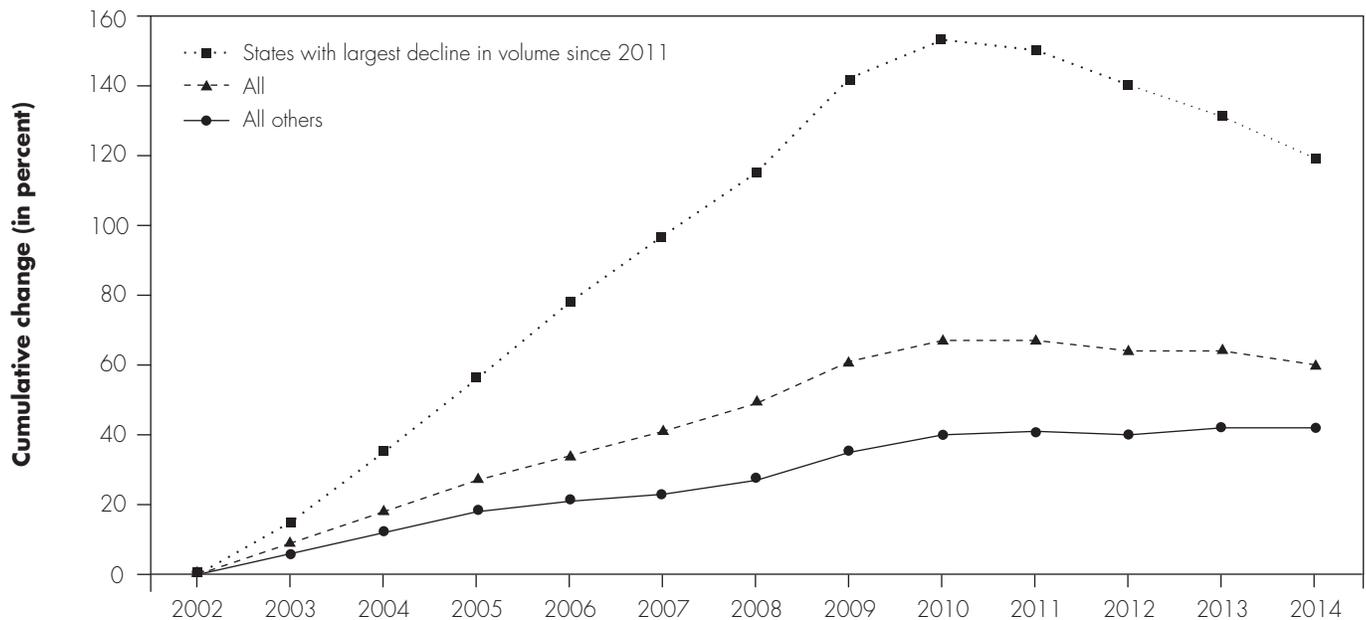
about 70 percent of the decline in episodes. However, volume in these five states grew by more than double in the 2002 to 2011 period, higher than most other areas (Figure 8-2).

Although average payment per episode has declined since 2011, the declines in home health utilization likely reflect changes in both the demand for home health services, and, most recently, the decline in the supply of agencies in 2014. The number of hospital discharges, a common source of referrals, has declined since 2009, mitigating the demand for post-acute services. The period has also seen relatively low growth in economy-wide health care spending. In addition, several actions have been taken to curb fraud, waste, and abuse in Medicare home health care. The Department of Justice and other enforcement agencies have launched a number of investigative efforts that scrutinize Medicare HHAs. CMS has implemented moratoriums on new agencies in several areas that have seen rapid growth in supply and utilization. In 2011, Medicare implemented a PPACA requirement that a physician have a face-to-face encounter with the beneficiary. These factors likely affected spending and utilization in recent years.

The Commission has long been concerned about the incentives in the home health PPS. Throughout the history of the payment system, Medicare has used the number of therapy visits as a factor in payment, and

**FIGURE
8-2**

Cumulative change in home health episode volume since 2002 for different groups of states



Note: States with largest decline since 2011 include Florida, Illinois, Louisiana, Tennessee, and Texas.

Source: MedPAC analysis of home health standard analytic file from CMS.

the number of episodes that qualify for these payments has increased faster than other types of episodes. In the current PPS, episodes with six or more therapy visits qualify for additional payments, with the exact amount determined by the number of therapy visits provided beyond this threshold. In past work, the Commission has found that agencies that provide more therapy episodes tend to be more profitable. The higher profitability and rapid growth in the number of therapy episodes suggest that financial incentives may be causing agencies to favor therapy services when possible. In 2011, the Commission recommended that Medicare eliminate the use of the number of therapy visits provided in an episode as a payment factor, a recommendation that has yet to be implemented (Medicare Payment Advisory Commission 2011a). CMS has made several efforts to tighten therapy utilization, such as requiring periodic reassessments and lowering payments for therapy episodes. However, even with these changes the incentive remains, with additional therapy visits yielding higher per episode payments.

Utilization trends since 2011 indicate that the number of therapy episodes has declined by 2 percent in the five states mentioned earlier, most of which have been

the focus of numerous anti-fraud initiatives.⁶ However, therapy episodes have increased by 11 percent in the other states that were not the primary focus of many of the anti-fraud activities. Without the growth of therapy episodes in the 45 other states in this period, home health utilization would have been 200,000 episodes lower in 2014.

Since 2002, home health care stays have grown longer and less focused on post-acute care

Between 2002 and 2014, the average number of episodes per user increased by 18 percent, rising from 1.6 to 1.9 episodes per user. The increase indicates that beneficiaries are receiving home health care for longer periods and suggests that home health care is serving more as a long-term care benefit for some beneficiaries. This concern is similar to those in the mid-1990s that led to major program integrity activities and payment reductions. The increase in episodes coincides with Medicare's PPS incentives that encourage additional volume: the unit of payment per episode encourages more service (more episodes per beneficiary), and the PPS makes higher payments for the third and later episodes in a consecutive spell of home health episodes.

**TABLE
8-6**

Home health episodes not preceded by hospitalization or PAC stay increased at a higher rate than other episodes

	Number of episodes (in millions)		Cumulative growth	Share of episodes	
	2001	2013		2001	2013
Episodes not preceded by a hospitalization or PAC stay:					
First	0.8	1.4	80%	20%	21%
Subsequent	<u>1.3</u>	<u>3.0</u>	137	<u>32</u>	<u>45</u>
Subtotal	2.1	4.5	115	53	66
Episodes preceded by a hospitalization or PAC stay:					
First	1.6	1.9	18%	40	27
Subsequent	<u>0.3</u>	<u>0.5</u>	60	<u>8</u>	<u>7</u>
Subtotal	1.9	2.4	25	47	34
Total	3.9	6.9	72	100	100

Note: PAC (post-acute care). "First" and "subsequent" refer to the timing of an episode relative to other home health episodes. "First" indicates no home health episode in the 60 days preceding the episode. "Subsequent" indicates the episode started within 60 days of the end of a preceding episode. "Episodes preceded by a hospitalization or PAC stay" indicates the episode occurred fewer than 15 days after a stay in a hospital (including long-term care hospitals), skilled nursing facility, or inpatient rehabilitation facility. "Episodes not preceded by a hospitalization or PAC stay" indicates that there was no hospitalization or PAC stay in the 15 days before the episode began. Some data have been rounded, which may affect subtotals and totals.

Source: CMS Datalink file, 2013.

The rise in the average number of episodes per beneficiary also coincides with a relative shift away from using home health care as a post-acute care (PAC) service. Over the 2001–2013 period, the number of episodes not preceded by a hospitalization or PAC stay (in an inpatient rehabilitation facility, skilled nursing facility, or long-term care hospital) increased by 115 percent compared with a 25 percent increase in episodes that were preceded by a hospitalization or PAC stay (Table 8-6). During that period, the share of all episodes not preceded by a hospitalization or PAC stay rose from about 53 percent to 66 percent.

The Commission examined the characteristics of beneficiaries based on how they most frequently used home health care. Beneficiaries were classified into two categories based on their home health utilization: beneficiaries for whom the majority of home health episodes in 2013 were preceded by a hospitalization or other post-acute stay were classified as PAC users of home health, while beneficiaries for whom the majority of episodes for 2013 were not preceded by a hospital or PAC stay were classified as community-admitted users.

This cross-sectional analysis suggests that Medicare is serving distinct populations within the home health benefit. In 2013, PAC users averaged 1.4 episodes, while community-admitted users averaged 2.5 episodes. About 40 percent of the episodes provided to community-admitted users were for dual-eligible Medicare and Medicaid beneficiaries; in contrast, the comparable share for PAC users was 24 percent. Community-admitted users also had a larger share of episodes with high numbers of visits from home health aides; for example, aide services were the majority of services provided in 14 percent of the episodes for community-admitted users compared with 5 percent for PAC users. Community-admitted users generally had fewer chronic conditions, but had higher rates of dementia and Alzheimer’s disease.

Rural add-on payments are poorly targeted and most payments benefit areas that do not have low utilization

An add-on payment of 3 percent for each home health care episode provided to beneficiaries in rural areas expires in 2017. The intent of the add-on is presumably to bolster access, but the high level of utilization in many

**TABLE
8-7****Most counties with the highest rates of beneficiaries using home health in 2014 were rural**

State	County	Share of FFS beneficiaries using home health services	Episodes per user	Episodes per 100 FFS beneficiaries
TX	Duval	35%	4.5	157
TX	Brooks	33	4.1	136
TX	Willacy	28	3.7	103
TX	Jim Hogg	28	4.4	122
TX	Zapata	27	4.0	109
TX	Jim Wells	26	3.9	103
FL	Miami-Dade*	26	2.3	60
TX	Starr	25	3.7	95
LA	East Carroll	25	3.9	100
OK	Choctaw	24	4.2	101
MS	Claiborne	23	2.6	61
TX	Foard	22	3.6	77
LA	Madison	22	4.1	89
TX	Webb*	21	3.8	83
TX	Throckmorton	21	3.9	82
TX	Baylor	21	3.2	65
OK	Coal	20	3.4	69
MS	Yazoo*	20	3.1	62
TX	Falls*	20	3.5	70
TX	Culberson	20	3.5	69
MS	Holmes	20	3.1	61
OK	McCurtain	19	4.2	82
OK	Atoka	19	3.6	70
KY	Cumberland	19	3.6	69
TX	Hidalgo*	19	3.4	66

Note: FFS (fee-for-service). Counties with fewer than 100 home health users have been excluded.
*Urban county; all others rural.

Source: MedPAC analysis of the 2014 home health standard analytical file and the 2014 Medicare denominator file.

rural areas results in Medicare's per episode add-on being poorly targeted, with most payments made to areas with higher than average utilization. The use of such a broadly applied add-on, providing the same payment for all rural areas regardless of access, results in rural areas with the highest utilization drawing a disproportionate share of the add-on payments. For example, 76 percent of the episodes that received the add-on payments in 2014 were in rural counties with higher utilization than the median utilization for all counties. Rural counties in the lowest fifth of utilization accounted for less than 5 percent of the episodes eligible for the rural add-on payment. Relatively few of the add-on payments were made to areas with low utilization.

In its June 2012 report to the Congress, the Commission noted that Medicare should target rural payment adjustments to those areas that have access challenges (Medicare Payment Advisory Commission 2012). The large share of payments made to rural areas with above-average utilization does nothing to improve access to care in those areas and raises payments in markets that appear to be more than adequately served by HHAs. Some of the counties with aberrant patterns of utilization suggestive of fraud and abuse are rural; for example, 20 of the 25 top-use counties in 2014 were rural areas (Table 8-7). Higher payments in areas without access problems can encourage the entry or expanded operations of agencies that seek

**TABLE
8-8**

Average home health agency performance on select quality measures

	2004	2008	2012	2013	2014
Hospitalization rate	27.7%	28.8%	27.5%	26.5%	27.8%
Share of an agency's beneficiaries with improvement in:					
Walking	37.2%	45.0%	59.0%	61.2%	63.6%
Transferring	51.0	53.1	55.2	57.1	58.9

Note: All data are for fee-for-service beneficiaries only and are risk adjusted for differences in patient condition among home health patients. The measures for walking and transferring changed in 2011 and are not comparable with data from prior years.

Source: MedPAC analysis of data provided by the University of Colorado.

to exploit Medicare's financial incentives. More targeted approaches that limit rural add-on payments to areas with access problems should be pursued.

The counties listed in Table 8-7 (p. 223) all have the highest utilization rates, but high utilization is not confined solely to these areas. Counties in the top quintile have an average utilization of 31 episodes per 100 beneficiaries, 78 percent higher than the national average. These counties include 211 urban counties and 428 rural counties, indicating that high utilization is prevalent in both geographic categories (81 percent of the Medicare beneficiaries residing in the top quintile counties reside in urban counties). In 2014, the county at the 75th percentile used 17.3 episodes per 100 beneficiaries, while the county at the 25th percentile used 7.6 episodes per 100 beneficiaries. In the Commission's review of geographic variation in Medicare spending, post-acute care services had the greatest variation in spending among areas, and variation in home health services contributed to the wide spread of spending (Medicare Payment Advisory Commission 2011b). This wide distribution suggests that reducing use and spending in many high-spending areas, beyond those listed in Table 8-7 (p. 223), could lower program costs.

Quality of care: Quality measures generally held steady or improved

Medicare reports several quality measures on its Home Health Compare website, from which we identified recent trends for measures associated with function and hospitalization (Table 8-8). In general, the share of beneficiaries showing improvement on the functional

measures has increased since 2004. The rate of hospitalization has not changed significantly. In 2014, the share of patients improving in walking and transferring increased slightly relative to the prior year. Functional improvement data are collected only for beneficiaries who do not have their home health care stays terminated by a hospitalization, which means that the beneficiaries included in the measure are probably healthier and more likely to have positive outcomes. In 2016, Medicare will begin to phase in a value-based purchasing model for home health care (see text box, pp. 226–227).

The trends in functional improvement reported above raise concerns about the nature of these measures. For practical and economic reasons, these data are collected by agencies at the start and end of care. It is difficult to independently confirm these data, unlike hospitalizations or emergency department use. Although functional outcomes are important for a significant share of home health care patients, the rates should be interpreted carefully. It may be appropriate to place less emphasis on these measures compared with measures that can be correlated with other sources of data such as Medicare claims.

A limitation of the measures reported in this section is that they are silo-specific to home health care and are not designed to compare quality across post-acute settings. Legislation passed in 2014, the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT), required CMS to develop cross-sector quality measures for post-acute care, and CMS has begun action to develop these measures. The Commission is also developing cross-sector measures of rehospitalization and plans to report them in 2016.

**TABLE
8-9**

Common reasons for hospitalization reported at end of home health care, 2010

Reason for hospitalization	Share of all reported hospitalizations in 2010
Urinary tract infection	4.5%
Respiratory infection	4.4
Heart failure	3.6
Uncontrolled pain	3.4
Injury caused by fall	2.3
Dehydration/malnutrition	2.0
Hypo/hyperglycemia	2.0
Wound infection/deterioration	1.9
Myocardial infarction	1.9

Source: MedPAC analysis of data provided by the University of Colorado.

Focusing on hospitalization may be particularly important for home health care because avoiding hospitalization is a primary goal of the service. Despite this focus, and as the data in Table 8-8 indicate, hospitalization is a common outcome for many patients, and the rate has not changed significantly since Medicare initiated a measure for it. The common clinical reasons reported for hospitalization would be those expected of the frail, community-dwelling elderly population (Table 8-9). Additional studies have identified factors associated with hospitalization risk such as polypharmacy, wound deterioration, falling in home, functional limitations, and others that should be manageable through quality home health care (Flaherty et al. 2000, Fortinsky et al. 2006, Rosati et al. 2003, Taft et al. 2005).

The care practices of HHAs, in addition to the clinical conditions of HHAs, are also a factor in the hospitalization of home health patients. Studies of adverse events in home health and related settings have found a range of care practices that contribute to poor outcomes, including poor assessment of beneficiary care needs, inadequate plans of care for identified needs, poor communication among providers, and ineffective patient education activities (Coleman et al. 2006, Masotti et al. 2010, Silver et al. 2010). Agencies that can improve their performance in these areas could be able to prevent or reduce hospitalizations for their patient populations. In general, larger agencies, which may have greater resources, have better outcomes than smaller agencies (Table 8-10).

Providers’ access to capital: Access to capital for expansion is adequate

Few HHAs access capital through publicly traded shares or through public debt (actions such as issuing bonds). HHAs are not as capital intensive as other providers because they do not require extensive physical infrastructure, and most are too small to attract interest from capital markets. Information on publicly traded home health care companies provides some insight into access to capital but has limitations. Publicly traded companies may have other lines of business in addition to Medicare home health care, such as hospice, Medicaid, and private-duty nursing. Also, publicly traded companies are a small portion of the total number of agencies in the industry. For these reasons, access to capital is a smaller consideration for home health than for other health care sectors receiving Medicare payment.

Analysis of for-profit companies indicates that they had adequate access to capital in 2015. While the large publicly traded home health firms divested or closed

**TABLE
8-10**

Larger home health agencies have lower rates of hospitalization, 2010

Quintile, by size	Mean hospitalization rate for agencies in quintile	Share of home health cases
First (smallest agencies)	35%	1%
Second	34	3
Third	31	7
Fourth	29	17
Fifth (largest agencies)	27	72

Source: MedPAC analysis of data provided by the University of Colorado.

Medicare initiated a value-based purchasing program for HHAs in 2016

In 2016, Medicare initiated a value-based purchasing (VBP) model for home health care. The model will test whether home health agencies (HHAs) in nine states (Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington) improve or maintain high quality when they are subject to a VBP incentive. Under the demonstration, agencies with higher performance will receive bonuses while those with lower scores will receive lower payments relative to current levels. Agency performance will be evaluated against separate improvement and attainment scores, with payment tied to the higher of these two scores. The demonstration commenced in 2016 by providing HHAs quarterly reporting of their performance on the measures in the demonstration.

CMS will use calendar year 2015 as the baseline year for performance, with calendar year 2016 as the first year for performance measurement. The first payment adjustment would begin January 1, 2018, applied to that calendar year based on 2016 performance data. The payment withhold would increase from 3 percent in 2018 to 8 percent in 2022. Agencies that do not have the number of episodes (20) required to produce

data for at least 5 measures will not be subject to the payment adjustment.

CMS's home health VBP (HHVBP) model has adopted a scoring approach similar to that used in the hospital VBP program, including allocating points based on achievement or improvement and calculating those points based on industry benchmarks and thresholds. For each measure, agencies will receive points along an achievement range, a scale between the achievement threshold and a benchmark.

CMS proposes to calculate the achievement threshold as the median of all agencies' performance on the specified quality measure during the baseline period and to calculate the benchmark as the mean of the top decile of all agencies' performance on the specified quality measure during the baseline period. In a departure from the hospital VBP program approach, in which CMS uses a national sample to calculate the achievement thresholds and benchmarks, CMS proposes for the HHVBP model to calculate the achievement thresholds and benchmarks separately for each selected state and for cohorts of similarly sized agencies.

(continued next page)

some agencies in 2015, there was also major investment to expand operations. For example, in 2015, Kindred Healthcare Incorporated purchased Gentiva, the second largest publicly traded home health care company. Amedisys and Almost Family made several acquisitions to expand their operations. The HealthSouth Corporation, which operates inpatient rehabilitation facilities, purchased a regional home health care company for \$750 million. Interest by investors suggests that access to capital remains adequate.

Medicare payments and providers' costs: Payments decreased in 2014 while cost growth has been low historically

In 2014, average Medicare payments per episode increased by about 0.5 percent for freestanding agencies. Total spending declined by 1.6 percent to \$17.7 billion.

However, this decline is modest compared with the growth the home health benefit has experienced in prior years; since 2002, Medicare spending has increased by over 80 percent.

The average cost per episode increased 2.7 percent in 2014, higher relative to the average of about 0.5 percent annual increase for the last five years. Low or no cost growth has been typical for home health care, and in some years, cost per episode declined (in 2012, by 1.3 percent). The ability of HHAs to keep costs low in most years has contributed to their high margins under the Medicare PPS.

Medicare margins in 2014 declined slightly

In 2014, HHA margins in aggregate were 10.8 percent for freestanding agencies (Table 8-11, p. 228). Financial performance varied from -3.8 percent for an agency at the

Medicare initiated a value-based purchasing program for HHAs in 2016 (cont.)

Likewise, under the HHVBP model, CMS will calculate improvement points for each measure by assigning points along an improvement range, a scale indicating change between an agency's performance during the performance period and the baseline period. As in the HHVBP achievement calculation, the improvement benchmark and threshold will be calculated separately for each state and for cohorts of similarly sized agencies. CMS proposed this approach to ensure that agencies would be competing only with similarly sized agencies in their state.

An agency will be rated on a scale of 1–10 both in improvement and achievement for the 25 measures in the starter set that are already in use. The improvement or achievement result for each of the 25 measures—whichever is highest—will be summed; that sum will constitute 90 percent of the agency's Total Performance Score (TPS) under the HHVBP program. The remaining 10 percent of the TPS will be based on whether the agency reports some or all of the four new measures proposed for the starter set.

The VBP program is an important step forward for moving Medicare away from volume-rewarding fee-for-service incentives, and the Commission has recommended a rehospitalization penalty for HHAs. Compared with its predecessor demonstration, the HHVBP design has been strengthened, in that participation is compulsory for the agencies active in the nine states selected. The prior VBP demonstration was voluntary, and agencies with low quality could

avoid penalties by not participating. In addition, the demonstration places a significant portion of payments at risk, 8 percent by 2022. This risk factor should ensure that even agencies with relatively high margins have an incentive to maintain or improve quality.

However, there are some improvements that could be made that would strengthen Medicare's ability to assess the quality of home health care. The program uses 26 quality measures: 13 outcome measures, 8 process measures, and 5 patient experience measures. The plethora of measures complicates administration of the program and makes it difficult for agencies to focus quality improvement efforts.

In comments on CMS's HHVBP proposed rule, the Commission suggested that CMS trim the measures involved to focus more on outcomes. The Commission also recommended that the program focus on rewarding attainment (or the absolute level of performance) and not improvement. An agency's absolute level of performance matters most to a beneficiary, and rewarding attainment is the best way to recognize this achievement. In addition, rewarding improvement creates potential inequities in that agencies with equal or better achievement scores receive smaller incentive payments than agencies with lower attainment scores but higher improvement scores. The greatest rewards in a VBP program should flow to the agencies with the best quality, and attainment-based scoring better achieves this goal. ■

25th percentile of the margin distribution to 20.1 percent for an agency at the 75th percentile (not shown in table). For-profit agencies had higher margins than nonprofit agencies, and urban agencies had slightly higher margins than rural agencies. (These margins include the effects of the budget sequester in effect since 2013.)

The Commission includes hospital-based HHAs in the analysis of inpatient hospital margins because these agencies operate in the financial context of hospital operations. Margins for hospital-based agencies in 2014 were –22.4 percent. The lower margins of hospital-based

agencies are chiefly because of their higher costs, some of which may be due to overhead costs allocated to the HHA from their parent hospitals. Despite these low margins, hospital-based HHAs may help their parent institutions if they help shorten inpatient stays, lowering expenses in the most costly setting.

Another consideration in evaluating the adequacy of payments is to assess whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, the provider compares the marginal revenue it will receive

**TABLE
8-11**

Medicare margins for freestanding home health agencies, 2013 and 2014

	Medicare margin		Percent of agencies, 2014	Percent of episodes, 2014
	2013	2014		
All	12.7%	10.8%	100%	100%
Geography				
Majority urban	13.1	11.2	85	84
Majority rural	11.0	8.5	15	16
Type of ownership				
For profit	13.7	12.2	89	79
Nonprofit	10.0	6.4	11	21
Government*	N/A	N/A	N/A	N/A
Volume quintile				
First (smallest)	6.1	4.0	20	3
Second	7.8	5.4	20	6
Third	8.9	7.6	20	11
Fourth	11.2	10.0	20	19
Fifth (largest)	14.8	12.5	20	61

Note: N/A (not available). Agencies were classified as majority urban if they provided more than 50 percent of episodes to beneficiaries in urban counties and were classified as majority rural if they provided more than 50 percent of episodes to beneficiaries in rural counties.

*Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of Home Health Cost Report files from CMS.

(i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. However, if marginal payments do not cover the marginal costs, the provider may have a disincentive to serve Medicare beneficiaries. To operationalize this concept, we compare payments for Medicare services with marginal costs, which is approximated as the following:

$$\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and equipment costs})) / \text{Medicare payments}$$

The Commission estimates the marginal profit of HHAs to be 13.3 percent in 2014, about 20 percent higher than the overall Medicare margin. This estimate is a lower bound on the marginal profit because we ignore any potential labor costs that are fixed. For providers with available

data, we find that Medicare payments exceed marginal costs, suggesting that HHAs have a significant incentive to service additional patients.

Relatively efficient HHAs serve patients similar to patients in all other HHAs

Across all sectors, the Commission follows two principles when selecting a set of efficient providers. First, the providers must do relatively well across cost and quality metrics. Second, the performance has to be consistent, meaning that the provider cannot have poor performance on any metric over the past three years. The Commission’s approach is to develop a set of criteria and then examine how many providers meet them. It does not establish a set share (for example, 10 percent) of providers to be considered efficient and then define criteria to meet that pool size.

Periodically, we review the set of criteria used to define efficient providers and evaluate the potential for improvements to our methodology. This year, we tested our methodology under selection criteria that had different thresholds of minimum acceptable quality or that relaxed

the consistency requirement. The Commission concluded that while the alternative methods could change the number of efficient providers by varying degrees, the alternative methods did not result in greater distinction between the efficient and average providers, and in some cases the differences were reduced. Most fundamentally, the clarity of the information provided for assessing payment adequacy would not improve significantly with any of the new methods tested. Therefore, the Commission will continue to use its previous definition of an efficient provider in this year's report. In the future, we will continue to look for improvements in our methods, including using new quality metrics as better indicators of patient outcomes are developed.

We examined the quality and cost efficiency of freestanding HHAs to identify a cohort that demonstrated better performance on these metrics relative to its peers (Table 8-12, p. 230). The measure of cost was a risk-adjusted and wage-adjusted cost per episode, and the measure of quality was a risk-adjusted measure of hospitalization (the hospitalization measure included hospital stays that occurred during or up to 30 days after a home health episode of care). Our approach categorized an HHA as relatively efficient if the agency was in the lowest third on at least one measure (either low cost per episode or a low hospitalization rate) and was not in the highest (worst) third of any measure for three consecutive years (2011 to 2013). About 15 percent of agencies met these criteria in this period.

Relatively efficient agencies had median margins that were 11.8 percentage points higher in 2013, and a median hospitalization rate that was 7 percentage points lower compared with other HHAs in 2013, and the median cost per visit was 11 percent lower compared with other HHAs. Relatively efficient HHAs provided more episodes but about 1.6 fewer visits per episode. On most measures of patient attributes, there was generally no significant difference between the relatively efficient providers and other agencies, with the exception of the episodes provided to rural beneficiaries and the share of episodes admitted from the community. Efficient providers tended to provide fewer episodes in rural areas and had a lower share of episodes admitted from the community.

Medicare margins remain high in 2016

In modeling 2016 payments and costs, we incorporate policy changes that will go into effect between the year of

our most recent data, 2014, and the year for which we are making margin predictions, 2016. The major changes are:

- –0.5 percent base rate payment changes in 2015 and 2016, the net impact of the PPACA rebasing adjustments, partially offset by the payment updates for each year;
- coding adjustment of –0.97 percent in 2016 consistent with CMS's policy;
- assumed nominal case-mix growth of 0.5 percent in 2015 and 2016 to reflect recent trend;
- 3 percent add-on in effect for episodes provided in rural areas in 2015 and 2016; and
- assumed episode cost growth of 0.5 percent per year.

On the basis of these policies and assumptions, the Commission projects a margin of 8.8 percent in 2016. This projection assumes that the sequester reduction of 2 percent remains in effect through 2016.

How should Medicare payments change in 2017?

Our review of the Medicare home health benefit indicates that access is more than adequate in most areas and that Medicare payments are substantially in excess of costs. On the basis of these findings, the Commission has concluded that home health payments need to be significantly reduced. In addition to payment adequacy, the Commission is concerned that the current payment system provides a financial incentive for agencies to favor therapy services when delivering care. Although PPACA includes a provision intended to lower payments, the reductions under this provision are modest, and substantial margins for many agencies are likely to remain, particularly for those that are efficient or focus on higher paying services.

RECOMMENDATION 8

The Congress should direct the Secretary to eliminate the payment update for 2017 and implement a two-year rebasing of the payment system beginning in 2018. The Congress should direct the Secretary to revise the prospective payment system to eliminate the use of therapy visits as a factor in payment determinations, concurrent with rebasing.

**TABLE
8-12****Performance of relatively efficient home health agencies**

Provider characteristics	All	Relatively efficient providers	All other providers
Number of agencies	4,840	702	4,138
Share of for-profit agencies	85%	73%	86%
Medicare margin (median)			
2013	11.5%	21.8%	10.0%
2012	12.4%	20.5%	11.0%
Quality (median)			
Hospitalization rate (2013)	26%	20%	27%
Costs and payments (median)			
Cost per visit, standardized for wages (2013)	\$145	\$132	\$148
Patient severity case-mix index	1.00	1.03	1.00
Visits per episode			
Total visits per episode (2013)	16.8	15.5	17.1
Share of visits by type			
Skilled nursing visits	51%	54%	51%
Aide visits	12%	10%	12%
MSS visits	1%	1%	1%
Therapy visits	36%	35%	37%
Size, 2013 (number of 60-day payment episodes)			
Median	461.5	573	447
Mean	841	1,134	791
Share of episodes, 2013			
Low-use episode	9%	11%	8%
Outlier episode	2%	3%	2%
Community-admitted episodes	66%	55%	70%
Therapy episodes	42%	40%	42%
Beneficiary demographics, 2013			
Share of episodes provided to dual-eligible Medicare/Medicaid beneficiaries			
	36%	33%	37%
Average age			
	77	77	77
Share of episodes provided to rural beneficiaries			
	22%	8%	25%

Note: MSS (medical social services). Sample includes freestanding agencies with complete data for three consecutive years (2011–2013). A home health agency is classified as relatively efficient if it is in the best third of performance of quality or cost and is not in the bottom third of either measure for three consecutive years. Quality is measured using a risk-adjusted measure of hospitalization, and cost is measured using risk-adjusted cost per episode. Low-use episodes are those with 4 or fewer visits in a 60-day episode. Outlier episodes are those that received a very high number of visits and qualified for outlier payments. Community-admitted episodes are those episodes that were not preceded by a hospitalization or prior post-acute care stay. Therapy episodes are those with six or more therapy visits.

Source: Medicare cost reports and standard analytic file.

RATIONALE 8

This recommendation addresses two problems with the home health PPS: the high level of payments and the incentives created by the use of therapy thresholds in the PPS. The payment level recommendation begins with eliminating the market basket update for 2017 and then implements a two-year rebasing beginning in 2018.

Under the rebasing policy, CMS would assess the average margins of HHAs in the most recent year of data available (using audited cost reports to the extent feasible) and reduce payments accordingly in 2018 and 2019. In determining the amount by which payments would be reduced, CMS could also use information on the costs of efficient providers, not just the average provider, since data suggest that efficient providers can provide adequate service for lower costs. With these adjustments, payments should be better aligned with costs compared with current policy.

The recommendation also calls for an end to the use of the number of therapy visits as a payment factor in the PPS when rebasing begins in 2018. The current system relies on a series of visit-number thresholds that increase payments beginning with 6 or more therapy visits and topping out at 20 visits per episode. Increasing the number of therapy visits increases payments significantly,

sometimes increasing payment by hundreds of dollars for a single additional visit. A Senate Finance Committee investigation of the therapy management practices of publicly traded home health companies concluded that CMS needs to eliminate the therapy thresholds in the home health PPS (Committee on Finance 2011). The continued use of these thresholds distorts the incentives of the payment system and distracts HHAs from focusing on patient needs and characteristics when delivering services.

IMPLICATIONS 8

Spending

- The spending recommendations would lower payment relative to current law.

Beneficiary and provider

- Appropriately targeted reviews would not affect beneficiary access to care or provider willingness to serve beneficiaries. The elimination of therapy thresholds would redistribute payments among providers, generally raising payments for providers that provide therapy less frequently and lowering them for providers that deliver relatively more therapy. In practice, payments would increase for nonprofit and facility-based agencies and would decrease for for-profit and freestanding agencies. ■

Endnotes

- 1 The Balanced Budget Act of 1997 ended coverage of home health care solely for the purpose of venipuncture services.
- 2 The rate is risk adjusted and excludes hospitalizations that were not planned in advance or part of a normal course of treatment (for instance, organ transplant).
- 3 Surety bond firms review the organizational and financial integrity of an HHA and agree to cover the Medicare obligations, up to a set amount, for those agencies that the surety bond firm believes are low risk. A surety bond would cover liabilities that occur when an agency does not repay funds it owes Medicare (for example, when an agency is found to have improperly billed for services) (Government Accountability Office 1999). A requirement for a surety bond would prevent agencies judged to be high risk by a surety firm from participating in the Medicare program.
- 4 The recommendation would apply only to full episodes—those that included five or more visits.
- 5 As of November 2014, our measure of access is based on data collected and maintained as part of CMS’s Home Health Compare database. The service areas listed are postal ZIP codes where an agency has provided services in the past 12 months. This definition may overestimate access because agencies need not serve the entire ZIP code to be counted as serving it. At the same time, the definition may understate access if HHAs are willing to serve a ZIP code but did not receive a request in the previous 12 months. The analysis excludes beneficiaries with unknown ZIP codes.
- 6 Since 2008, the PPS has increased payments for episodes with more than five therapy visits in an episode, with payments increasing as the number of visits rises after this threshold.

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