

CHAPTER

8

Home health care services

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

- 8** For calendar year 2022, the Congress should reduce the 2021 Medicare base payment rate for home health agencies by 5 percent.

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

Home health care services

Chapter summary

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2019, about 3.3 million Medicare fee-for-service beneficiaries received care, and the program spent \$17.8 billion on home health care services. In that year, over 11,300 HHAs participated in Medicare.

In this chapter, we recommend a payment rate update for 2022. Because of standard data lags, the most recent complete data we have for most payment update indicators is 2019. When relevant, we have also considered the effects of the 2020 coronavirus public health emergency (PHE) on our indicators and whether these effects are likely to be temporary or permanent. Though the PHE was a disruption for HHAs, the emergency has not significantly changed the financial outlook or service delivery practices of the industry. To the extent the effects of the PHE are temporary or vary significantly across HHAs, they are best addressed through targeted temporary funding policies rather than a permanent change to all HHA payment rates in 2022 and future years.

Assessment of payment adequacy

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

In this chapter

- Are Medicare payments adequate in 2021?
- How should Medicare payments change in 2022?

Beneficiaries' access to care—Access to home health care is adequate: Over 99 percent of beneficiaries lived in a ZIP code where at least one Medicare HHA operated in 2019, and 86 percent lived in a ZIP code with five or more HHAs.

- ***Capacity and supply of providers***—Between 2018 and 2019, the number of HHAs declined by 1.7 percent, continuing a slow decline since 2013. However, the decline follows a long period of growth in supply. From 2002 to 2013, the number of HHAs increased by over 80 percent. The decline since 2013 was concentrated in areas that experienced sharp increases in supply in prior years.
- ***Volume of services***—Between 2018 and 2019, the number of 60-day episodes declined by 3.0 percent, continuing a slight decline that began in 2011. In 2019, episodes not preceded by a hospitalization accounted for 66 percent of episodes, similar to prior years.
- ***Marginal profit***—In 2019, freestanding HHAs' marginal profit—that is, the rate at which Medicare payments exceed providers' marginal costs—was 18 percent, suggesting a significant financial incentive for HHAs to increase their volume of Medicare patients.

Quality of care—In 2019, our outcome measures were mixed. The rate of home health patients who were hospitalized during their spell of home health services increased slightly, but the share that was successfully discharged to the community (did not experience an unplanned hospitalization within 30 days of the end of their spell of home health care) increased slightly.

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.

Medicare payments and providers' costs—In 2019, Medicare spending for home health care declined by 0.5 percent to \$17.8 billion. For more than a decade, payments under the home health prospective payment system have consistently and substantially exceeded costs. In 2019, Medicare margins for freestanding agencies averaged 15.8 percent. Two factors have contributed to payments exceeding costs: Agencies have reduced episode costs by decreasing the number of visits provided, and cost growth in recent years has been lower than the annual payment updates for home health care. Though we expect higher per episode cost growth in 2020 due to the PHE, we project that Medicare margins for freestanding HHAs in 2021 will be 14 percent.

How should payments change in 2022?

Our review of payment adequacy for Medicare home health services indicates that access is more than adequate in most areas and that Medicare payments are substantially in excess of costs. Home health care can be a high-value benefit when it is appropriately and efficiently delivered. Medicare beneficiaries often prefer to receive care at home instead of in institutional settings, and home health care can be provided at lower costs than institutional care. However, Medicare's payments for home health services are too high, and these overpayments diminish the service's value as a substitute for more costly services. On the basis of these findings, the Commission recommends that for calendar year 2022, the Congress reduce the 2021 Medicare base payment rate for home health agencies by 5 percent. ■

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. In contrast to coverage for skilled nursing facility services, Medicare does not require a preceding hospital stay to qualify for home health care. Also, unlike for most services, Medicare does not require copayments or a deductible for home health services. In 2019, about 3.3 million Medicare beneficiaries received home care, and the program spent \$17.8 billion on home health services.

Medicare requires that a physician, nurse practitioner, clinical nurse specialist, or physician assistant certify a patient's eligibility for home health care.¹ 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. An encounter with a nonphysician practitioner or through telehealth services may be used to satisfy the requirement.²

Major changes to the home health prospective payment system in 2020

CMS implemented major changes required by the Bipartisan Budget Act of 2018 in 2020: a new 30-day unit of payment (replacing the 60-day unit of payment) and elimination of the number of therapy visits as a factor in the payment system. These changes follow several years of analysis by the Commission and CMS to identify possible reforms to the home health prospective payment system (PPS). The elimination of the therapy thresholds is consistent with a recommendation we first made in 2011 and reiterated in subsequent reports (Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2016, Medicare Payment Advisory Commission 2011a). CMS also implemented a new case-mix system in 2020, the Patient-Driven Groupings Model.³

Payments for a 30-day period are adjusted by the case-mix system to account for differences in patient severity. If beneficiaries need additional home health services at the end of the initial 30-day period, another period

commences and Medicare makes an additional payment. Coverage for additional periods generally has the same requirements as the initial period (i.e., the beneficiary must be homebound and need skilled care). The analysis in this chapter uses claims data from 2019 and prior years, when the 60-day episode was the unit of payment.

The coronavirus public health emergency (PHE) has affected beneficiaries and home health agencies (HHAs) in 2020 (see text box on the PHE and the Commission's analysis of payment adequacy, p. 237). In response, CMS made several changes to the home health benefit (Centers for Medicare & Medicaid Services 2020). These changes were intended to maintain access to care during the emergency. Key changes included:

- Broadening the telehealth services permissible under the home health benefit to include additional services, such as two-way video and audio-only encounters.⁴ The services must be identified in a patient's plan of care and not replace in-person services. CMS subsequently made these additional telehealth services a permanent element of the benefit.
- Permitting the face-to-face encounter required for certification of home health care to be provided by means of telehealth.
- Extending the homebound requirement for home health care to beneficiaries who have been advised by a physician not to leave the home due to a confirmed or presumptive COVID-19 diagnosis, and considering beneficiaries homebound if they have a condition that makes them more susceptible to contracting COVID-19.

Medicare has always overpaid for home health services under the PPS

Payments for home health care have substantially exceeded costs since Medicare established the PPS. In 2001, the first full year of the PPS, average Medicare margins for freestanding HHAs equaled 23 percent.⁵ The high margins in the first year suggested that the PPS established a base rate well in excess of costs. Indeed, the base rate assumed that the average number of visits per episode between 1998 and 2001 would decline about 15 percent (with a corresponding reduction in costs); instead, the actual decline was 32.3 percent (Table 8-1, p. 236). Between 2001 and 2018, the number of visits per episode continued to decline, falling an additional 17.3 percent. The average number of therapy services per episode

**TABLE
8-1**

Medicare visits per episode before and after the implementation of the PPS

	Visits per episode				Percent change in visits per episode		
	1998	2001	2018	2019	1998-2001	2001-2018	2018-2019
Skilled nursing	14.1	10.5	8.2	8.1	-25.5%	-21.9%	-1.2%
Therapy (physical, occupational, and speech-language pathology)	3.8	5.2	8.0	8.1	38.6	53.8	1.3
Home health aide	13.4	5.5	1.4	1.3	-59.0	-74.5	-7.1
Medical social services	0.3	0.2	0.1	0.1	-35.8	-50.0	>0.01
Total	31.6	21.4	17.8	17.7	-32.3	-17.3	>-0.01

Note: PPS (prospective payment system). The PPS was implemented in October 2000. Data exclude low-utilization episodes. Components may not sum to totals due to rounding.

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

increased, but this increase was more than offset by the decline in visits per episode for all other service types (nursing, home health aide, and medical social services). Consequently, HHAs were able to hold the rate of episode cost growth below 1 percent in many years, lower than the rate of inflation assumed in the annual home health payment update. Thus, HHAs were able to garner extremely high average payments relative to the cost of services provided. Between 2001 and 2018, freestanding HHA margins averaged 16.2 percent (Figure 8-1, p. 238).

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 the home health benefit. 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 though they are capable of leaving home for medical care, which most home health users 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 they face no cost sharing. In

addition, the program relies on HHAs and physicians to follow program requirements for determining beneficiary needs, but evidence from prior years suggests that they do not consistently follow Medicare’s standards (Cheh et al. 2007, Department of Health and Human Services 2018, 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 copayment for these episodes (Medicare Payment Advisory Commission 2011b). In 2020, Medicare estimated that 9.3 percent of home health payments were improper; that is, for these claims, the supporting documentation for the claim did not support the amount Medicare paid (Department of Health and Human Services 2020). Though this is a decline from the peak of 59 percent in 2015, the rate in 2020 is still higher than the improper payment rate for the entire Medicare program of 6.3 percent.

Are Medicare payments adequate in 2021?

The Commission reviews several indicators to determine whether payments are adequate to cover the costs of an efficient provider in 2021. We assess beneficiary access to care by examining the supply of home health providers, annual changes in the volume of services, and marginal profit. The review also examines quality of care, access to capital, and the relationship between Medicare’s payments

The coronavirus public health emergency and the Commission's payment adequacy framework

The coronavirus pandemic and associated public health emergency (PHE) has had tragic effects on beneficiaries' health in 2020. It also had material effects on providers' patient volume, revenues, and costs. The effects of COVID-19 have varied considerably both geographically and over time, and it is not clear when or whether the pandemic's full effects will end. For home health agencies (HHAs), reports indicate that volume dropped in March and April of 2020 (Amedisys 2020a, Encompass Health 2020a, LHC Group 2020). In some parts of the country, HHAs reported an increase in admissions because of COVID-19 infections, offsetting some of the decline. COVID-19 has required HHAs to use more personal protective equipment, and there have been reports that this equipment has increased in price and sometimes has been hard to procure. HHAs have also reported lower payments because beneficiaries were initially declining home health visits. While home health care volume returned to normal levels later in 2020, there remains uncertainty regarding the future effects of the pandemic on volume and provider

financial performance in 2021 and 2022 (Amedisys 2020b, Encompass Health 2020b).

In this chapter, we recommend payment rate updates for 2022. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators are from 2019. We use available data as well as changes in payment policy to project margins for 2021 and make payment recommendations for 2022. To the extent the effects of the coronavirus PHE are temporary changes or vary significantly across individual HHAs, they are best addressed through targeted temporary funding policies rather than a permanent change to all home health prospective payment system rates in 2022 and future years. For each payment adequacy indicator, we discuss whether the effects of the coronavirus PHE on those indicators will most likely be temporary or permanent. Only permanent effects of the pandemic will be factored into recommended permanent changes in Medicare base payment rates. (For an overview of how our payment adequacy framework has been affected by the PHE, see Chapter 2.) ■

and providers' costs. The indicators of payment adequacy for home health care are generally positive.

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

Supply and volume indicators show that almost all beneficiaries have access to home health services. In 2019, over 99 percent of beneficiaries lived in a ZIP code served by at least one HHA, 97 percent lived in a ZIP code served by two or more HHAs, and 86 percent lived in a ZIP code served by five or more agencies. These findings are consistent with our prior reviews of access.⁶

Supply of providers: Agency supply remains high despite recent decline

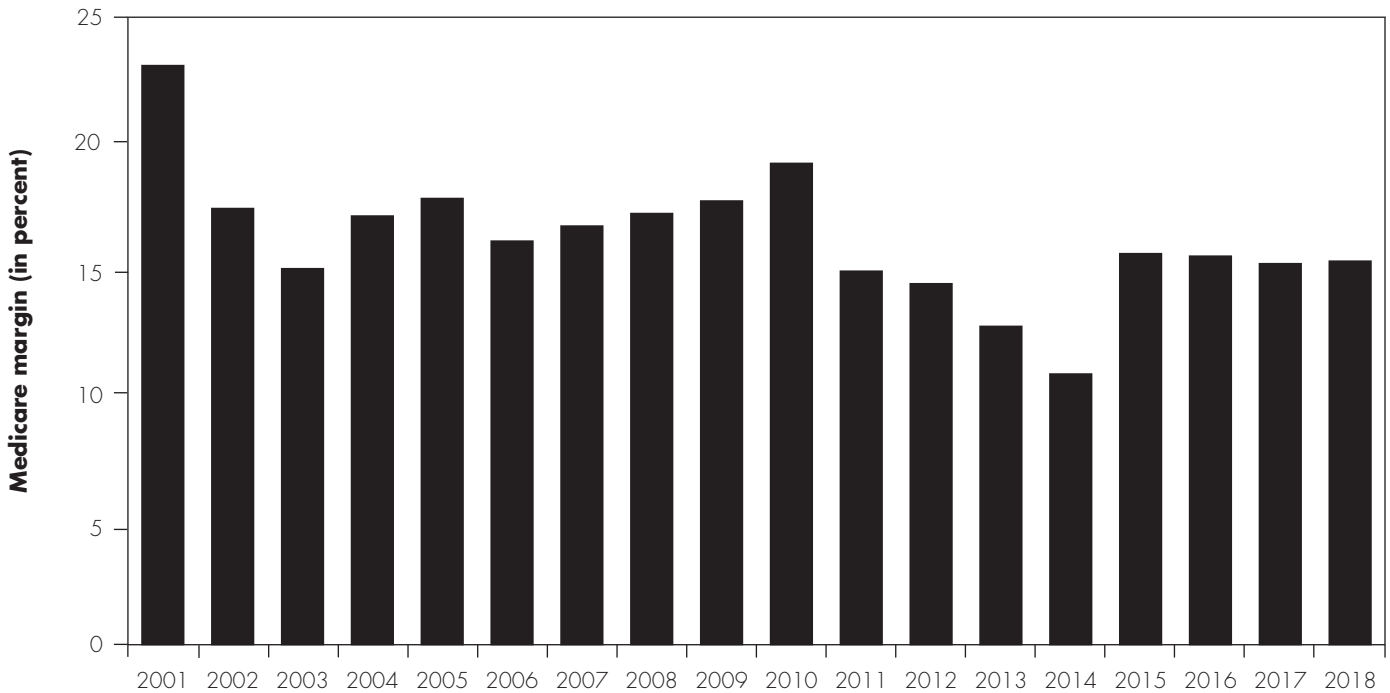
In 2019, the number of HHAs declined by 1.7 percent compared with 2018, and between 2013 and 2018, the supply of HHAs declined by 8.3 percent (Table 8-2, p.

239). However, the decline was preceded by a long period of growth in supply. From 2002 to 2013, the number of HHAs increased by 80 percent (data not shown). The decline since 2013 was concentrated in areas that experienced sharp increases in supply in prior years.

The decline in 2019 was concentrated in Florida and Texas, states with a history of program integrity concerns that experienced higher than average increases in supply in prior years. These states have been targeted by a myriad of antifraud measures, including criminal investigations and moratoriums on the entry of new HHAs. In recent years, the number of HHAs exiting the program has picked up in these states, and moratoriums have likely stopped the entry of new HHAs. Nevertheless, in 2019, the supply of agencies in Florida and Texas was well above the national average of 3 agencies per 10,000 FFS beneficiaries.

**FIGURE
8-1**

Medicare margins of freestanding home health agencies remained high between 2001 and 2018



Source: MedPAC analysis of Medicare cost report data from CMS.

The supply of HHAs varies significantly among states. In 2019, Texas averaged 7.9 HHAs per 10,000 FFS beneficiaries, while New Jersey averaged less than 1 HHA per 10,000 FFS beneficiaries. The extreme variation demonstrates that the number of providers is a limited measure of capacity because HHAs can vary in size. Also, because home health care is not provided in a medical facility, HHAs can adjust their service areas as local conditions change. Even the number of employees may not be an effective metric because HHAs can use contract staff to meet their patients' needs.

Episode volume declined slightly in 2019

The number of episodes per FFS beneficiary declined by 1.7 percent in 2019 relative to the prior year (Table 8-3). This decline is part of a trend that began after 2011, but this period of decline was preceded by a period of rapid growth. Between 2002 and 2011, total episodes increased by 67 percent, from 4.1 million episodes to 6.8 million episodes.

The decline in home health utilization since 2011 reflects changes in both the demand for home health services and the supply of HHAs. From 2011 to 2019, the number of hospital discharges, a common source of referrals, declined by 19 percent on a per capita basis, suggesting that demand for posthospital care using home health services has not increased in Medicare FFS since 2011. In addition, several actions have been taken to curb fraud, waste, and abuse in Medicare home health care.

The decline in episode volume since 2011 has been concentrated in five states. Since 2011, Florida, Illinois, Louisiana, Tennessee, and Texas have seen a decline of about 32 percent in episode volume. However, utilization in these five states had more than doubled between 2002 and 2011, an increase higher than in most other areas. The remaining 45 states experienced aggregate growth of 2.4 percent for the 2011 to 2019 period, though there was a range of increases and declines across these states. This geographic variation underscores the fact that many

**TABLE
8-2****Number of participating home health agencies has declined since 2013**

	2013	2017	2018	2019	Cumulative percent change	
					2013-2018	2018-2019
Active home health agencies	12,613	11,844	11,556	11,356	-8.3%	-1.7%
Number of home health agencies per 10,000 FFS beneficiaries	3.3	3.0	3.0	3.0	-11.1	-0.3

Note: FFS (fee-for-service). "Active home health agencies" includes all agencies operating during a year, including agencies that closed or opened at some point during the year.

Source: MedPAC analysis of CMS's Provider of Services file and 2020 annual report of the Boards of Trustees of the Medicare trust funds.

areas continued to see growth despite the overall drop in episode volume since 2011. Among the 45 states, growth in California between 2011 and 2019 accounted for a significant share of the increase, with episode volume rising by 46 percent.

In March and April 2020, HHAs reportedly experienced substantial reductions in the demand for home health care services due to the coronavirus PHE (Amedisys 2020a,

Encompass Health 2020a, LHC Group 2020, The Motley Fool 2020). HHAs attributed the decline to several factors, including the decline in inpatient hospital discharges during the PHE, assisted living facilities limiting HHA staff access to residents, and beneficiaries declining home health care services. However, some reports indicate that, in aggregate, the demand for home health care services recovered in the remainder of 2020 (Amedisys 2020a, Amedisys 2020b, Encompass Health 2020b). In addition,

**TABLE
8-3****Number of home health episodes, beneficiaries using services, and total payments have declined since 2011, after a period of rapid growth**

	2002	2011	2017	2018	2019	Annual percent change		
						2002-2011	2011-2018	2018-2019
Home health users (in millions)	2.5	3.4	3.4	3.4	3.3	3.6%	-0.3%	-2.4%
Share of beneficiaries using home health care	7.2%	9.4%	8.8%	8.7%	8.6%	3.1	-1.1	-1.1
Episodes (in millions):	4.1	6.8	6.4	6.3	6.1	5.9	-1.2	-3.0
Per home health user	1.6	2.0	1.9	1.9	1.9	2.2	-0.9	-0.6
Per FFS beneficiary	0.12	0.19	0.16	0.16	0.16	5.4	-2.1	-1.7
Payments (in billions)	\$9.5	\$18.3	\$17.8	\$17.9	\$17.8	7.5	-0.3	-0.5
Per home health user	3,783	5,312	5,242	5,303	5,406	3.9	<-0.1	1.9
Per home health episode	2,645	2,916	3,039	3,089	3,167	1.1	0.8	2.5

Note: FFS (fee-for-service). Percent change is calculated on numbers that have not been rounded; payment per episode excludes low-utilization payment adjustment cases.

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

**TABLE
8-4****Home health episodes not preceded by hospitalization or PAC stay account for two-thirds of home health episodes in 2019**

	Episodes			Cumulative percent change	
	2001	2011	2019	2001-2011	2011-2019
Number of episodes preceded by a hospitalization or PAC stay (in millions)	1.9	2.2	2.1	14.8%	-0.5%
Number of episodes not preceded by a hospitalization or PAC stay (in millions)	2.1	4.6	4.0	127.4	-10.3
Share of episodes not preceded by a hospitalization or PAC stay	53%	67%	66%	N/A	N/A
Total (in millions)	3.9	6.8	6.1	74.0	-7.8

Note: PAC (post-acute care), N/A (not applicable). "Episodes preceded by a hospitalization or PAC stay" indicates the episode occurred fewer than 15 days after a stay in a hospital (including a long-term care hospital), 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. Numbers may not sum to totals due to rounding. Percent change columns were calculated on unrounded data.

Source: MedPAC analysis of home health standard analytical file and Medicare Provider Analysis and Review file for 2001, 2011, and 2019, from CMS.

some HHAs have reported that the PHE has increased demand as beneficiaries seek to substitute home health care for a stay at a skilled nursing facility. While there is uncertainty about the impact of the PHE on home health care services in the future, the disruption caused by the emergency may have increased beneficiary preference for home health care services when they can substitute for institutional settings.

Length of home health service has increased and shifted to episodes not preceded by a hospitalization

Between 2002 and 2011, the average number of episodes per user increased from 1.6 to 2.0 (Table 8-3, p. 239), though the average number of episodes declined slightly from 2011 to 2019. The increase in episodes per user in the 2002 to 2011 period coincides with Medicare's PPS incentives that encourage additional volume: The per episode unit of payment in the PPS encourages more services (more episodes per beneficiary). The use of home health care for longer periods raises concerns that home health care, in some instances, serves more as a long-term care benefit. These concerns are similar to those in the

mid-1990s that led to major program integrity activities and payment reductions.

The rise in the average number of episodes per home health user coincided with a sharp increase in the number of episodes not preceded by a hospitalization or institutional post-acute care (PAC) service. Between 2001 and 2011, episodes not preceded by a hospitalization or institutional PAC stay increased by about 127 percent, compared with an almost 15 percent increase in episodes preceded by a prior PAC stay or hospitalization (Table 8-4). Between 2011 and 2019, the volume of episodes not preceded by a hospital or institutional PAC stay dropped by 10.3 percent, while the volume of episodes preceded by a hospitalization or PAC stay remained fairly steady. However, the 10.3 percent decrease did not significantly change the share of episodes not preceded by an inpatient or institutional PAC stay, which in 2019 accounted for 66 percent of episodes.

Marginal profits

Another factor we consider when evaluating access to care is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve.

**TABLE
8-5**

Since 2015, HHAs have reported a modest improvement in the rate of successful discharge from home health care to the community, but the rate of hospitalization during care has increased

	2015	2016	2017	2018	2019
Successful discharge to the community	68.3%	69.2%	69.6%	70.4%	72.2%
Hospitalization during home health care	20.6	20.8	21.4	21.5	21.4

Note: HHA (home health agency). “Successful discharge to the community” includes beneficiaries discharged to the community (including those discharged to the same nursing home) who did not have an unplanned hospitalization or die in the 30 days after discharge. The hospitalization measure captures all unplanned hospital admissions and readmissions and outpatient observation stays that occur during the stay. Both measures are uniformly defined and risk adjusted across the four post-acute care settings. Providers with at least 60 stays in the year (the minimum count to meet a reliability threshold of 0.7) were included in calculating the average facility rate.

Source: MedPAC analysis of Medicare Provider Analysis and Review and home health standard analytical files from CMS.

In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments exceed the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for Medicare beneficiaries.⁷ In 2019, the marginal profit, on average, for freestanding HHAs was 18 percent. This substantial marginal profit indicates that these HHAs have a strong incentive to serve Medicare beneficiaries.

Quality of care: Rate of successful discharge to the community after home health care improved slightly, but rate of all-condition hospitalization within a home health care spell increased

This year, the Commission evaluated quality with two measures that are common across the four PAC settings (skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, and home health care): average risk-adjusted rates of successful discharge to the community and all-condition hospitalizations within a set period (a spell of care in the case of home health care). Successful discharge to the community includes beneficiaries discharged to the community, including those discharged to the same nursing home, who did not have an unplanned hospitalization and did not die in the

next 30 days. The hospitalization measure captures all unplanned hospitalizations (admissions and readmissions) and outpatient observation stays that occur from the start of a home health care spell until the end of service. Both measures are uniformly defined and risk adjusted across the four PAC settings, thus representing another step toward evaluation of outcomes across PAC settings.⁸ Providers with at least 60 spells in the year (the minimum count to meet a reliability threshold of 0.7) were included in calculating the average facility rate.

Over the five years between 2015 and 2019, the share of patients successfully discharged from home health care to the community rose from 68.3 percent to 72.2 percent (higher rates indicate better performance) (Table 8-5). In this period, the share of patients hospitalized during their care increased slightly from 20.6 percent to 21.4 percent (lower rates indicate better performance). In general, hospital-based HHAs, HHAs located in urban areas, and nonprofit HHAs performed better than their counterparts on these measures (Table 8-6, p. 242). Performance varied across providers; for example, the HHA at the 25th percentile of the distribution for hospitalization had a rate of 17.3 percent, while the agency at the 75th had a rate of 25.4 percent. Overall, these measures suggest modest improvement in the rate of successful discharge to the community after home health care, but a slight worsening in the rate of beneficiaries hospitalized during home health care.

This year, we no longer consider measures of functional improvement in our assessment of quality.

**TABLE
8-6**

Performance on quality measures varies by provider characteristic

	Successful discharge to the community	Hospitalization during home health stay
All	72.2%	21.4%
Nonprofit	78.9	19.0
For profit	70.7	22.0
Freestanding	71.6	21.6
Hospital based	77.5	19.4
Rural	70.4	22.2
Urban	72.5	21.3

Note: "Successful discharge to the community" includes beneficiaries discharged to the community (including those discharged to the same nursing home) who did not have an unplanned hospitalization or die in the 30 days after discharge. The hospitalization measure captures all unplanned hospital admissions and readmissions and outpatient observation stays that occur during the stay. Both measures are uniformly defined and risk adjusted across the four post-acute care settings. Providers with at least 60 stays in the year (the minimum count to meet a reliability threshold of 0.7) were included in calculating the average facility rate.

Source: MedPAC analysis of Medicare Provider Analysis and Review and home health standard analytical files from CMS.

While the Commission believes that maintaining and improving functional status is a key outcome of PAC, the Commission has raised serious questions about the integrity of this information (Medicare Payment Advisory Commission 2019). Because functional assessments are used in the case-mix system to establish payments, it is unlikely that this information can be divorced from payment incentives. In our June 2019 report to the Congress, the Commission discussed possible strategies to improve the assessment data, the importance of monitoring the reporting of these data, and alternative measures of function (such as patient-reported surveys) that do not rely on provider-completed assessments (Medicare Payment Advisory Commission 2019).

Providers’ access to capital: Access to capital is adequate

In 2019, the overall (all-payer) margins for freestanding HHAs averaged 5.9 percent, indicating that many HHAs yield positive financial results that should appeal to capital markets. 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. Few HHAs access capital through

publicly traded shares or through public debt, such as issuance of bonds.

Information on publicly traded home health care companies provides some insight into access to capital, but it has limitations. Publicly traded companies may have other lines of business in addition to Medicare home health care, such as hospice, Medicaid-covered services, and private-duty nursing. Also, publicly traded companies are a small portion of the total number of HHAs in the industry. However, since they are the largest corporate entities in home health care, they can provide some insight about the industry’s financial status.

Analysis of the for-profit publicly traded companies indicates that they have access to capital. Though the coronavirus public health emergency reduced the demand for home health care for a period in the spring of 2020, firms reported implementing several efficiency measures to reduce the financial impact (Amedisys 2020a, Encompass Health 2020a, LHC Group 2020). For example, many companies pay staff on a per visit basis, so costs fall when fewer services are delivered. At the same time, firms also reported higher per episode costs for personal protective equipment. However, by the fall

**TABLE
8-7****Medicare margins for freestanding home health agencies, 2018 and 2019**

	Medicare margin		Share of home health agencies, 2019	Share of episodes, 2019
	2018	2019		
All	15.3%	15.8%	100%	100%
Geography				
Majority urban	15.7	16.1	82	84
Majority rural	12.6	13.9	18	16
Type of ownership				
For profit	16.8	17.2	87	79
Nonprofit	10.1	11.0	13	21
Volume quintile				
First (smallest)	10.4	9.8	20	3
Second	11.0	11.5	20	6
Third	13.8	13.3	20	11
Fourth	14.4	14.3	20	19
Fifth (largest)	16.7	17.4	20	61

Note: Home health 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.

Source: MedPAC analysis of Medicare home health cost report files from CMS.

of 2020, for-profit firms reported that demand for home health care services had returned to near pre-COVID levels (Amedisys 2020b, Encompass Health 2020b).

Medicare payments and providers' costs: Payments per episode increased while cost per episode remained low in 2019

In 2019, average Medicare payments per episode for freestanding HHAs increased by 2.5 percent. In 2019, the average cost per episode increased by 1.8 percent, greater than the average annual increase between 2016 and 2018 of about 0.9 percent. Despite the greater increase in 2019, it was significantly lower than the cost growth experienced by other Medicare health care sectors. In addition, the cost growth rate was substantially below the rate implied by the home health care market basket, which averaged 2.5 percent for the 2017 to 2019 period. Meanwhile, low or no cost growth has been typical for home health care, and in some years, cost per episode has declined. In 2019, Medicare accounted for about 55 percent of revenue for freestanding HHAs.

Medicare margins for freestanding HHAs remained high in 2019

In 2019, the aggregate Medicare margin for freestanding HHAs was 15.8 percent (Table 8-7).⁹ The margin ranged from 3.0 percent to 24.5 percent for those at the 25th percentile and 75th percentiles, respectively, of the margin distribution (not shown in Table 8-7). For-profit HHAs had higher margins than nonprofit HHAs, and urban HHAs had higher margins than rural HHAs. Agencies with higher volume had better financial results, likely reflecting the economies of scale possible for larger operations. For example, margins for HHAs in the bottom quintile of episode volume averaged 9.8 percent, compared with a 17.4 percent average margin for HHAs in the top quintile.

The Commission includes hospital-based HHAs in its calculation of acute care hospitals' Medicare margins because these agencies operate in the financial context of hospital operations (see Chapter 3). In 2019, margins for hospital-based HHAs were -19.8 percent (data not

shown). The lower margins of hospital-based HHAs are attributable chiefly to their higher costs, some of which are a result of overhead costs allocated to the HHA from its parent hospital. Hospital-based HHAs help their parent institutions financially if they can shorten inpatient stays, lowering expenses in the more costly inpatient hospital setting.

FFS payments are reportedly higher than rates paid by Medicare Advantage plans

Comparing FFS Medicare payments with those paid by Medicare Advantage (MA) plans is another way of assessing payment adequacy. MA plans are required to offer home health services that are comparable with what is available in FFS, though plans have the latitude to limit the HHAs in their network and may use utilization management tools like prior authorization. HHAs have reported that MA payment rates are lower than FFS, but that they accept the lower rates because they need managed care patients to remain competitive or economically viable (Pozniak et al. 2019). Some noted the need to accept managed care patients in markets where managed care beneficiaries are a significant share of the Medicare population. In addition, HHAs reported that they saw accepting these patients as a way of maintaining relations with referring physicians and institutions, and they were concerned that a referral source might be less likely to refer FFS patients if they did not also accept referrals for MA patients.

Relatively efficient HHAs serve patients similar to those served by other HHAs

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with efficient providers. The analysis informs the Commission's update discussion by examining the adequacy of payments for those providers that perform relatively well on cost and quality measures.

The Commission follows two principles when selecting a set of efficient providers. First, the providers must do relatively well on both cost and quality metrics. Second, performance has to be consistent, meaning that the provider cannot have poor performance on any metric in any of three consecutive years preceding the year under evaluation. The Commission's approach is to examine how many providers meet a preestablished set of criteria. 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.

To identify efficient HHAs, 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 8-8). The cost measure was on a per episode basis, adjusted for risk (patient's health status) and local wages; the quality measures were risk-adjusted rates of hospitalizations during the home health spell and rate of successful discharge to the community after the home health spell. Our approach categorized an HHA as relatively efficient if it was in the best performing third on at least one measure (low cost per episode, a low hospitalization rate, or a high rate of beneficiaries with a successful discharge to the community) and was not in the worst performing third of any of these measures for three consecutive years (2016 to 2018). About 14 percent of freestanding HHAs met these criteria in this period.

In 2019, relative to other HHAs, efficient HHAs served a similar mix of patients but had a median margin that was 7.7 percentage points higher, a median hospitalization rate that was 5.2 percentage points lower (lower is better performance), a better median risk-adjusted rate of discharge to community, and a median cost per episode that was 12.2 percent lower. Relatively efficient HHAs tended to be larger in median volume but provided 1.7 fewer visits per episode. The mix of nursing, therapy, aide, and medical social services visits did not differ significantly between relatively efficient and other HHAs. Efficient providers were less likely to be for profit and tended to provide fewer episodes in rural areas.

The Commission projects that Medicare margins will remain high in 2021

In modeling 2021 payments and costs, we incorporate policy changes that will go into effect between the year of our most recent data, 2019, and the year for which we are making the margin projection, 2021. The major changes are:

- a 1.5 percent payment update for 2020;
- a 0.3 percent cumulative decrease in payments due to the phasing out of the rural add-on payments for home health in 2020 and 2021 required under the Bipartisan Budget Act of 2018;
- a 2.0 percent payment update for 2021;
- the suspension of the two percent sequester for Medicare payments from March 1, 2020, to March 31, 2021;

**TABLE
8-8**

Performance of relatively efficient home health agencies in 2019

Provider characteristics	All providers in analysis	Relatively efficient providers	All other providers
Number of home health agencies	3,561	532	3,029
Share that are for profit	88%	77%	90%
Median:			
Medicare margin	16.8%	23.4%	15.7%
Hospitalization during home health care	22.1%	17.8%	23.0%
Successful discharge to community relative to expected	0.95	1.07	0.97
Cost per episode	\$2,521	\$2,252	\$2,564
Patient severity case-mix index	1.00	1.00	0.99
Visits per episode			
Average visits per episode	16.3	15.0	16.7
Share of visits by type			
Skilled nursing visits	43%	42%	43%
Aide visits	6%	6%	6%
MSS visits	1%	1%	1%
Therapy visits	50%	51%	50%
Number of 60-day episodes			
Median	646	738	640
Mean	1,107	1,241	2,447
Share of episodes			
Low-use episode	8.5%	10.5%	8.0%
Outlier episode	3.5%	3.5%	3.8%
Provided to rural beneficiaries	23.0%	13.0%	25.5%

Note: MSS (medical social services). Sample includes freestanding agencies with complete data for three consecutive years (2016–2018). A home health agency is classified as relatively efficient if it is in the best third of performance for quality or cost and is not in the bottom third of either measure for three consecutive years. Low-use episodes are those with 4 or fewer visits in a 60-day episode. Outlier episodes are those that receive a very high number of visits and qualify for outlier payments.

Source: MedPAC analysis of Medicare cost reports and home health standard analytic file, from CMS.

- assumed case-mix growth of 2.18 percent for 2020 and 2021; and
- assumed cost growth of 3 percent in 2020. Two percentage points of the growth in 2020 reflect changes that will affect costs in future years, such as inflation, higher expenses for personal protective

equipment, and telehealth. We assume that 1 percentage point is temporary, reflecting surge pricing for personal protective equipment and other temporary costs associated with the PHE. The assumed cost growth for 2021 is 1.3 percent, the average annual cost increase in the 2017 to 2019 period.

On the basis of these policies and assumptions, the Commission projects a margin of 14 percent in 2021.

The margin projection for 2021 reflects the significant changes that occurred in home health in 2020, including the PHE and the planned changes to the home health PPS. Since complete cost and utilization data for 2020 are not yet available, our estimates of the impact of these events is an extrapolation based on prior experience and anecdotal industry reporting. We recognize that 2020 was a year of significant change for Medicare HHAs, and our projection assumes trends in cost and payments that depart significantly from prior projections. For example, the per episode cost growth of 3 percent we assumed in 2020 is more than twice the three-year average of 1.3 percent. In the past, home health agencies have been able to hold cost per episode growth below 1 percent a year, and if this trend returns in 2021, the aggregate margin for Medicare HHAs could be higher than our estimate.

Payment history under the home health PPS demonstrates that HHAs change coding, utilization, and the mix of services provided in reaction to new payment incentives. CMS has estimated that in 2020, a combination of coding and utilization changes by HHAs in response to the new Patient-Driven Groupings Model (PDGM) will increase payments by 4.36 percent. Statute requires that the PDGM be implemented in a budget-neutral manner, and CMS has accordingly included a 4.36 percent payment reduction in 2020. Because the PHE may have delayed the ability of providers to implement the anticipated behavioral changes, our projection includes a nominal payment increase of 2.18 percent, half the amount of the increase CMS expected.

How should Medicare payments change in 2022?

Our review of payment adequacy for Medicare home health services 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 should be significantly reduced. We anticipate that

payments in 2021 will be well in excess of cost, even after accounting for the addition of new telehealth services and any incremental costs resulting from the PHE. These overpayments do not accrue to the advantage of the beneficiary or the Medicare program and do not encourage the efficient use of the home health care benefit.

Home health care can be a high-value benefit when it is appropriately and efficiently delivered. Medicare beneficiaries often prefer to receive care at home instead of in institutional settings, and home health care can be provided at lower costs than institutional care. However, Medicare's payments for home health services are too high, and these overpayments diminish the service's value as a substitute for more costly services. There are also indications that utilization under FFS Medicare is not always efficient, as suggested by the broad geographic variation in the use of the benefit.

RECOMMENDATION 8

For calendar year 2022, the Congress should reduce the 2021 Medicare base payment rate for home health agencies by 5 percent.

RATIONALE 8

- An immediate reduction of 5 percent in 2022 would represent a significant action to address the magnitude of the overpayments embedded in Medicare's rates. However, this reduction would likely be inadequate to align Medicare payments with providers' actual costs. Though the public health emergency was a disruption for HHAs, the emergency has not significantly changed the financial outlook or service delivery practices of the industry.

IMPLICATIONS 8

Spending

- This recommendation would decrease federal program spending relative to the expected payment update by \$750 million to \$2 billion in 2022 and by more than \$10 billion over five years.

Beneficiary and provider

- Beneficiaries' access to care should not be affected. Lowering payments should not affect providers' willingness to deliver appropriate home health care. ■

Endnotes

- 1 The Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 (P.L. 226-136) permanently expanded ordering and supervision authority for home health care to include nurse practitioners, clinical nurse specialists, and physician assistants (before this statute, only physicians had this authority). State medical scope of practice laws also govern the services these practitioners are permitted to deliver and may limit the ability of some practitioners to order home health care.
- 2 The requirement may also be satisfied by an encounter with a nurse practitioner, certified nurse midwife, or physician assistant.
- 3 An overview of the home health PPS is available at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_hha_final_sec.pdf?sfvrsn=0.
- 4 In 2019, CMS added remote patient monitoring to the Medicare home health benefit. Remote patient monitoring was defined as “the collection of physiologic data . . . digitally stored and transmitted by the patient or caregiver or both to the home health agency” (Centers for Medicare & Medicaid Services 2018).
- 5 Freestanding providers accounted for about 90 percent of the episodes provided in 2019.
- 6 As of November 2019, 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 HHA has provided services in the past 12 months. This definition may overestimate access because HHAs 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.
- 7 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:

Marginal profit = (Medicare payments – (total Medicare costs – fixed costs)) / Medicare payment.

This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 8 The risk adjustment for the successful discharge to the community measure includes age and sex of the beneficiary, end-stage renal disease (ESRD) and disability status for Medicare entitlement, principal diagnosis, comorbidities, the length of stay of the preceding hospital stay (if there was one), and a count of the hospitalizations during the preceding year. Risk adjusters for the hospitalization measure include primary diagnosis, comorbidities and severity of illness, special conditions (severe wounds, difficulty swallowing, and bowel incontinence), age and sex, disability and ESRD status, hospitalization in the previous month, days in the intensive care unit during a preceding hospitalization (if there was one), a count of the hospitalizations during the preceding year, and the provision of ventilator care during the PAC stay.
- 9 Freestanding agencies accounted for about 90 percent of home health episodes in 2019.

References

- Amedisys. 2020a. Amedisys Corporation (AMED) CEO, Paul Kusserow on Q2 2020 results—Earnings call transcript. <https://seekingalpha.com/article/4362058-amedisys-inc-amed-ceo-paul-kusserow-on-q2-2020-results-earnings-call-transcript>.
- Amedisys. 2020b. Amedisys Corporation (AMED) CEO, Paul Kusserow on Q3 2020 results—Earnings call transcript. <https://seekingalpha.com/article/4383625-amedisys-inc-amed-ceo-paul-kusserow-on-q3-2020-results-earnings-call-transcript>.
- Benjamin, A. E. 1993. An historical perspective on home care policy. *Milbank Quarterly* 71, no. 1: 129–166.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2020. Home health agencies: CMS flexibilities to fight COVID-19. <https://www.cms.gov/files/document/covid-home-health-agencies.pdf>.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2018. Medicare and Medicaid programs; CY 2019 home health prospective payment system rate update and CY 2020 case-mix adjustment methodology refinements; home health value-based purchasing model; home health quality reporting requirements; home infusion therapy requirements; and training requirements for surveyors of national accrediting organizations. Final rule. *Federal Register* 83, no. 151 (July 12): 32340–32522.
- Cheh, V., N. Duda, B. L. Carlson, et al. 2007. *Evaluation of the Home Health Independence Demonstration: Barriers to a successful experiment were multifaceted and difficult policy issues remain*. Prepared for the Centers for Medicare & Medicaid Services. Princeton, NJ: Mathematica Policy Research, Inc. October.
- Department of Health and Human Services. 2020. *2020 Medicare fee-for-service supplemental improper payment data*. Washington, DC: HHS.
- Department of Health and Human Services. 2018. *2017 Medicare fee-for-service supplemental improper payment data*. Washington, DC: HHS.
- Encompass Health. 2020a. Encompass Health Corporation (EHC) Q2 2020 earnings call transcript. <https://s22.q4cdn.com/748396774/files/Events/2020/Q2-2020-Transcript.pdf>.
- Encompass Health. 2020b. Q3 2020 earnings call. October 29. <https://s22.q4cdn.com/748396774/files/Events/2020/Transcript-Q3-2020-EHC-US-20201029-2429767-C.pdf>.
- LHC Group. 2020. LHC Group (LHCG) CEO, Keith Myers on Q2 2020 results—Earnings call transcript. <https://seekingalpha.com/article/4366295-lhc-group-inc-lhcg-ceo-keith-myers-on-q2-2020-results-earnings-call-transcript>.
- Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2011a. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2011b. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Motley Fool. 2020. Encompass Health Corporation (EHC) Q2 2020 earnings call transcript. <https://www.fool.com/earnings/call-transcripts/2020/07/28/encompass-health-corporation-ehc-q2-2020-earnings.aspx>.
- Office of Inspector General, Department of Health and Human Services. 2001. *The physician's role in Medicare's home health services*. OEI-02-00-00620. Washington, DC: OIG.
- Pozniak, A., M. Turenne, P. Mukhopadhyay, et al. 2019. *Evaluation of the home health value based purchasing model: Second annual report*. Report prepared for the Centers for Medicare & Medicaid Services (CMS) Center for Medicare & Medicaid Innovation (CMMI) by the Arbor Research Collaborative for Health. Washington, DC: CMMI. <https://innovation.cms.gov/Files/reports/hhvbpc-secann-rpt.pdf>.
- Wolff, J., A. Meadow, C. Weiss, et al. 2008. Medicare home health and the role of physicians. Presentation at Academy Health, Medicare and Post-Acute Care. June 8.