



*Advising the Congress on Medicare issues*

# Assessing payment adequacy: home health services

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# Payment adequacy framework

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- Access
  - Supply
  - Volume
- Quality
- Access to capital
- Payments and costs<sup>1</sup>

# Home health overview

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- Must be homebound and have skilled need.
- Services provided in 2008:
  - 3.1 million beneficiaries served.
  - 6.1 million episodes.
  - \$16 billion in expenditures.
  - 10,026 providers.

# Supply continues to grow and access to care is widespread

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- 99 percent of beneficiaries live in an area served by home health.
- Number of HHAs is over 10,400 in 2009.
  - Number of agencies has increased almost 50 percent since 2002.
  - Average annual gain of 480 agencies a year since 2002.
- Supply growth has been concentrated in areas that have high supply growth.

# Volume of services and rate of use have increased

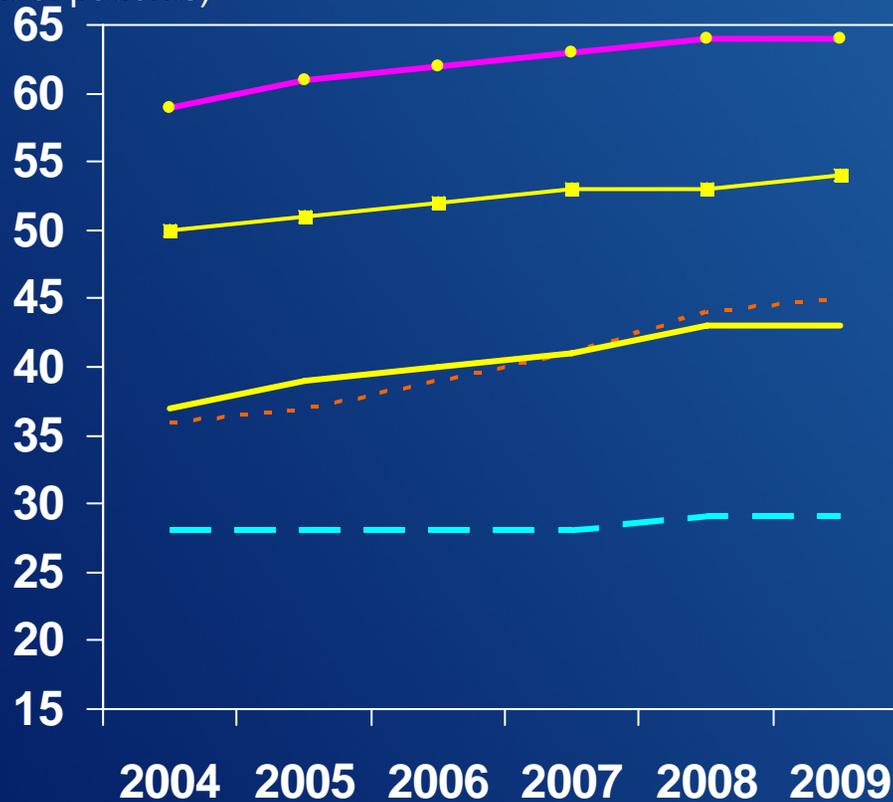
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	Annual Change				
	2002	2007	2008	2002-2007	2007-2008
Users (millions)	2.5	3.1	3.2	4%	2%
Share of FFS beneficiaries (percent)	7.2	8.7	9.1	3%	4%
Episodes (millions)	4.1	5.8	6.1	7%	4%
Episodes per user	1.6	1.9	1.9	3%	2%
Payment per episode	\$2,329	\$2,705	\$2,786	3%	3%

Source: Home health SAF 2002-2008

# Quality indicators need further analysis

(percent of patients)



Improvements in:

- - - Walking
- Getting out of bed
- Bathing
- Managing oral medications
- Patients have less pain
- - Any hospital admission

Source: Home health compare

Note: Improvements in bathing and pain management measures have identical values; the trend lines for these measures overlap on the table above.

# Access to capital is adequate

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- Less capital intensive than other sectors.
- Wall Street analysts conclude that large publicly-traded for-profit HHAs have access to capital markets.
- Entry of new providers suggests adequate access to capital for expansion.
  - Average annual gain of 480 providers.

## Agencies that serve very rural areas have margins equal to national average

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Percent of episodes in very rural counties\*:

Medicare Margin

All agencies which served rural remote areas	17.4%
1 to 24 percent	12.7%
25 to 49 percent	16.3%
50 to 74 percent	22.7%
75 to 100 percent	14.5%

\*Counties with urban populations of less than 2,500  
Source: 2008 Medicare cost reports

# Comparing the attributes of agencies with negative margins to those with positive margins

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Negative and non-Negative providers  
by characteristic:

	Negative	Non-Negative
N	1,093	3,976
Non-profit	23%	77%
For-profit	20%	80
Urban	20%	80%
Rural	26%	74%

Source: 2008 Medicare cost reports

# Variation in financial performance

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- Variation in home health margins similar to other systems
- Examined several potential differences between high and low margin agencies in November:

No significant difference	Some difference	Significant difference
Urban/rural	Case-mix	Cost per episode/cost per visit
Quality	Visits per episode	
Chronic conditions	MA risk score	
Functional limitations		

## Adequacy indicators for home health are positive

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- Almost all beneficiaries live in an area served by home health.
- Number of HHAs continues to grow.
- Share of users and volume of episodes continues to increase.
- Most quality measurements indicate small improvement, but more analysis needed.
- Access to capital is adequate.
- Margin for 2010: 13.7 percent.

# Addressing fraud and abuse

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- Medicare lacks the authority to stop enrolling providers when fraud accelerates in areas with known risks.
- Several patterns in the home health benefit suggest that increased scrutiny is necessary.
  - Geographic variation in home health use.
- Expanded authority and additional action would be prudent.

# Improving physician accountability

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- CMS and MedPAC have both expressed concerns about physician supervision of home health patients.
- Physician certifies need and eligibility for home health care every 60 days.
  - Homebound
  - Skilled need
- No requirement for the physician to examine patient prior to certification.

# Improving physician accountability

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- Prior to 2002 Medicare had a standardized form that physicians had to complete.
- Current policy sets broad guidelines for certification information, but no specific form or language.
- Reinstatement would ensure that program requirements are communicated to doctors when they certify care in a uniform and complete format.