Advising the Congress on Medicare issues

Assessing payment adequacy: home health services

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Overview

- Review framework
  - Access to care
  - Quality of care
  - Access to capital
  - Payment and costs
- Improve payment accuracy
- Strengthen patient safeguards
- Establish beneficiary incentives
- Advance program integrity

Supply continues to grow and access to care is generally adequate

- 99 percent of beneficiaries live in an area served by home health
- Number of HHAs is over 11,300 in 2010
  - Number of agencies has increased almost 50 percent since 2002
  - Over a 1,000 new agencies in 2009
  - Growth concentrated in relatively few areas

Users and episodes continues to increase in 2009

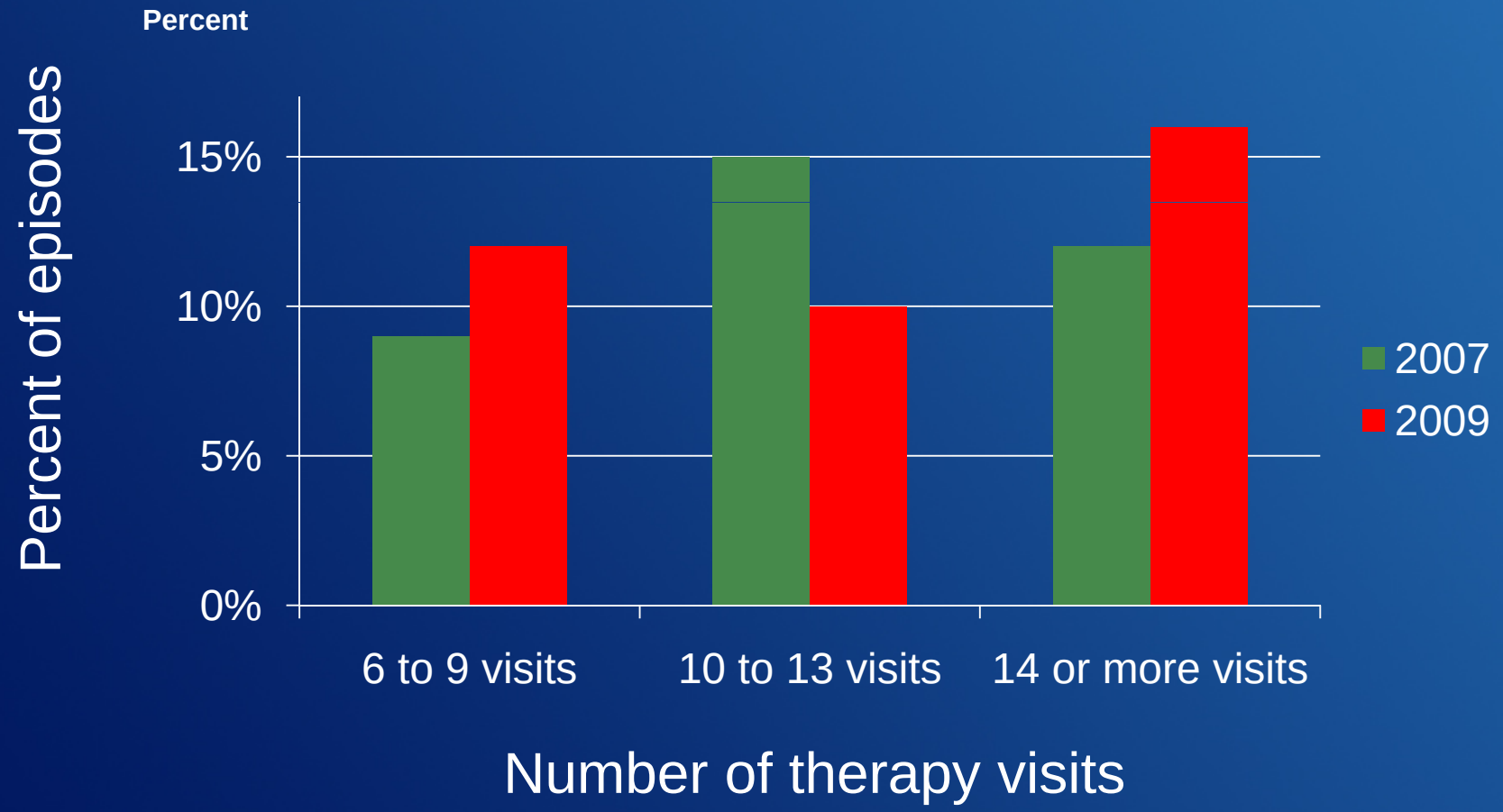
	2002	2008	2009	Annual Change 2002-2009	Annual Change 2008-2009
Users (millions)	2.5	3.2	3.3	3.9%	3.8%
Share of FFS beneficiaries (percent)	7.2	9.0	9.4	3.8%	4.3%
Episodes (millions)	4.1	6.1	6.5	6.9%	7.5%
Episodes per user	1.6	1.9	2.0	2.9%	4.5%

Source: Home health SAF 2002-2009
Note: Data are preliminary and subject to revision.

Home health volume has shifted to beneficiaries admitted from the community

- In 2001, episode volume split about equally between community admitted patients and post-hospital/PAC patients
- Since 2001 community admitted patients have increased by more than 10 percent annually
- In 2008, 64 percent of episodes are community admitted patients and 36 percent are post-hospital/PAC patients

Provision of therapy services reflects payment incentives



Source: Home health SAF 2009

Note: Data are preliminary and subject to revision.

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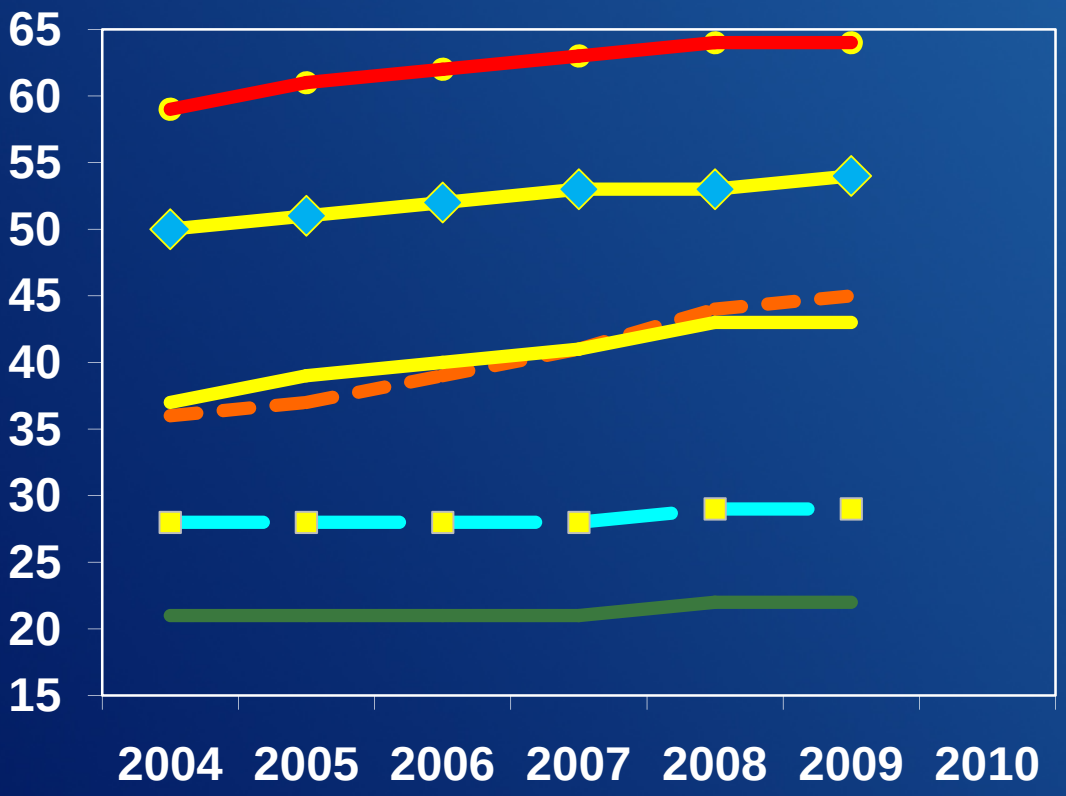
Quality of care continues to improve on most indicators

(percent of patients)



Improvements in:

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

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. Data are preliminary and subject to revision.

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Access to capital is adequate

- Less capital intensive than other sectors
- Wall Street analysts conclude that large publicly-traded for-profit HHAs have access to capital markets, though on less favorable terms than prior years
- Continuing entry of new providers suggests adequate access to capital for expansion

Financial performance of freestanding HHAs in 2009

	Percent of HHAs	Margin
All	100%	17.7%
25th		2.2%
75th		26.2%
Majority Urban	83%	17.9%
Majority Rural	17%	16.6%
For-Profit	84%	18.7%
Non-Profit	11%	14.4%

Source: Home health cost reports
Data are preliminary and subject to revision.

HHAs have lower costs and lower rates of cost growth than Medicare assumes

- Number of visits in an average episode under PPS has been lower than what Medicare's rates assume
- Agency cost growth has been lower than the inflation assumed in the home health market basket
- Medicare margins have averaged 17.5 percent since 2001

PPACA implements a phased re-basing beginning in 2014

- Re-bases to estimated costs over 4 years
- Annual reductions limited to no more than 3.5 percent annually
- Reduction offset by the payment update in each year
- Delay will reduce impact of re-basing, allow for margins well in excess of cost before and after 2014

Analysis indicates need for revised payment system

- Providers may base therapy delivery on incentives of payment system
- Case-mix system overpays for higher weighted services (including therapy)
- Dependent on the use of therapy services provided as a predictor
- Very low accuracy for non-therapy services

Revised system better predicts therapy and non-therapy services

	Therapy	Non-therapy	Total
Current case-mix system (without therapy thresholds)	11.6%	8.2%	7.6%
Revised case-mix system	27.8%	14.6%	15.3%

Source: Urban Institute analysis of Datalink file.
Estimates are preliminary and subject to revision.

- Eliminates financial incentives to provide more therapy
- Prediction of all costs more accurate
- Improved prediction of high-cost non-therapy cases

Ensuring appropriate use of the home health benefit

- Physicians and HHAs principally responsible for following Medicare's policies
- Home health is an exception, most FFS services have some cost-sharing
- Design needs to set appropriate incentives
  - Should not drive beneficiaries to other high-cost settings
  - Minimize negative impact for high-need and low-income patients

Setting appropriate incentives

- Possible design
  - Fixed per-episode amount
  - For episodes provided to patients admitted from the community
  - Exempt Medicare/Medicaid dual eligibles
- Amount could take several forms (example: 10% of average episode payment = $300)
- No first dollar coverage

Counties with high shares of beneficiaries using home health also have high episodes per user

ST.	County	Share of FFS beneficiaries using HH	Episodes per user
TX	STARR	35%	4.2
TX	HIDALGO	33%	3.9
TX	DUVAL	33%	4.1
TX	BROOKS	32%	3.9
TX	JIM HOGG	30%	4.5
FL	MIAMI-DADE	26%	3.1
TX	ZAPATA	26%	4.1
TX	CAMERON	25%	3.2
OK	CHOCTAW	25%	4.1
TX	JIM WELLS	25%	4.0
MS	CLAIBORNE	25%	2.9
TX	RED RIVER	24%	4.2
TX	WILLACY	24%	3.1
LA	MADISON	24%	4.4
OK	MCCURTAIN	23%	4.3
MS	SHARKEY	23%	4.2
LA	EAST CARROLL	22%	4.3
TX	WEBB	22%	3.8
MS	JEFFERSON	22%	4.2
LA	AVOYELLES	22%	4.0
OK	PUSHMATAHA	22%	3.8
OK	LATIMER	22%	4.2
TN	HANCOCK	21%	3.8
LA	CALDWELL	20%	4.1
LA	WASHINGTON	20%	3.6
National average		**9.0%**	**1.9**

Source: 2008 HH SAF. Data are preliminary and subject to revision.

More efforts needed to address fraud and abuse

- Several areas have high rates of use that suggest the need for further investigation
- Many new agencies in high risk areas
- CMS has new authorities under the PPACA to address fraud in high-risk areas
  - Moratorium on new providers
  - Payment suspension