Advising the Congress on Medicare issues

Mandated report: Impact of home health payment rebasing on beneficiary access to and quality of care

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September 12, 2014

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Mandated report on effects of home health rebasing

- Patient Protection and Affordable Care Act (PPACA) requires Commission to assess impact of home health payment rebasing:
  - Access, supply of agencies, and quality
  - For-profit, nonprofit, urban, and rural agencies
  - Report due January 2015
- Presented preliminary results at April 2014 meeting
- Met with representatives from home health industry
- Intend to transmit report fall 2014

Overview

- Review rebasing policy for home health payments
- Estimated impact of PPACA rebasing
- Analysis of impact of past payment changes on access and quality

Issues for Medicare home health care

- Effective service when appropriately targeted
- Broadly defined benefit coverage
- History of program integrity issues
- Provider behavior sensitive to Medicare financial incentives
- Payments too high; do not reflect cost of typical episode

Home health summary 2012

- Patient must be:
  - Homebound
  - Have a need for nursing or therapy
- $18 billion total expenditures
- Over 12,300 agencies
- 6.7 million episodes for 3.4 million beneficiaries

Rebasing is necessary to ensure efficient home health payments

- Commission recommended rebasing in 2010
- Medicare margins have averaged 17 percent (all providers) from 2001 through 2012
  - Average margins for urban, rural, for-profit and nonprofit agencies have always exceeded 12 percent
  - Recent audit found that costs were overstated by 8 percent and Medicare margin could be higher
- Rapid growth in volume and number of agencies
- Past payment adjustments have not significantly affected margins, or entry of new providers

Past reductions to the base rate have been offset by increases in reported case-mix

- Medicare has held payment updates below the rate of the market basket in 11 out of the 12 last years
- Increases in reported case-mix have offset these reductions
- CMS analysis concluded that higher reported case-mix was due to changes in agency diagnostic coding practices

Overview of PPACA rebasing provision

- PPACA rebasing will be phased in over 4-year period
- Reduction limited to $81 per episode per year
- Payment update to offset reduction (+$66 per year)
- Base rate in 2017 will be 2 percent lower than 2013 due to rebasing (-$58 cumulative)
- Sequester would increase cumulative reduction to 4 percent in 2017 (if still in effect)

Review historical trends to assess the impact of rebasing

- Report is due before data from first year of rebasing is available
- Examine past changes in episode payment, agency supply, utilization, and quality
- How sensitive have supply, access, and quality been to prior changes in average annual payment per episode?

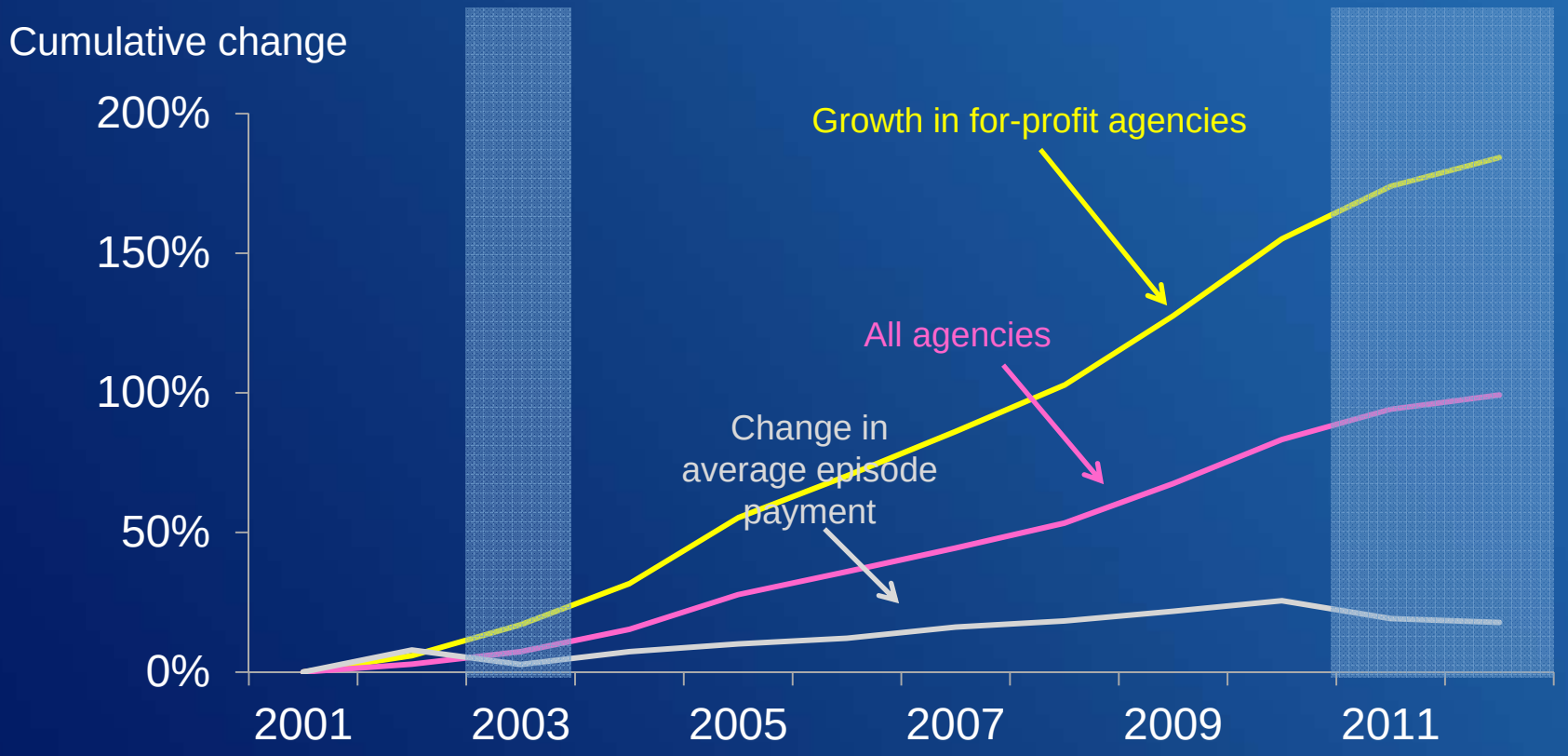
Medicare payments have increased in most years

	Annual change in average episode payment	Medicare margins for free-standing agencies
2001	NA	23.1%
2002	7.9%	17.4
2003	-4.8	15.0
2004	4.5	17.1
2005	2.6	17.8
2006	1.8	16.1
2007	3.6	16.7
2008	1.9	17.2
2009	3.0	17.7
2010	3.1	19.2
2011	-5.1	14.9
2012	-1.2	14.4

Source: Medicare Home Health Standard Analytic File; home health cost reports

- Data are preliminary and subject to change -

Overall agency supply has increased regardless of changes in average episode payment



Source: Medicare Home Health Standard Analytic File; provider of service file

- Data are preliminary and subject to change -

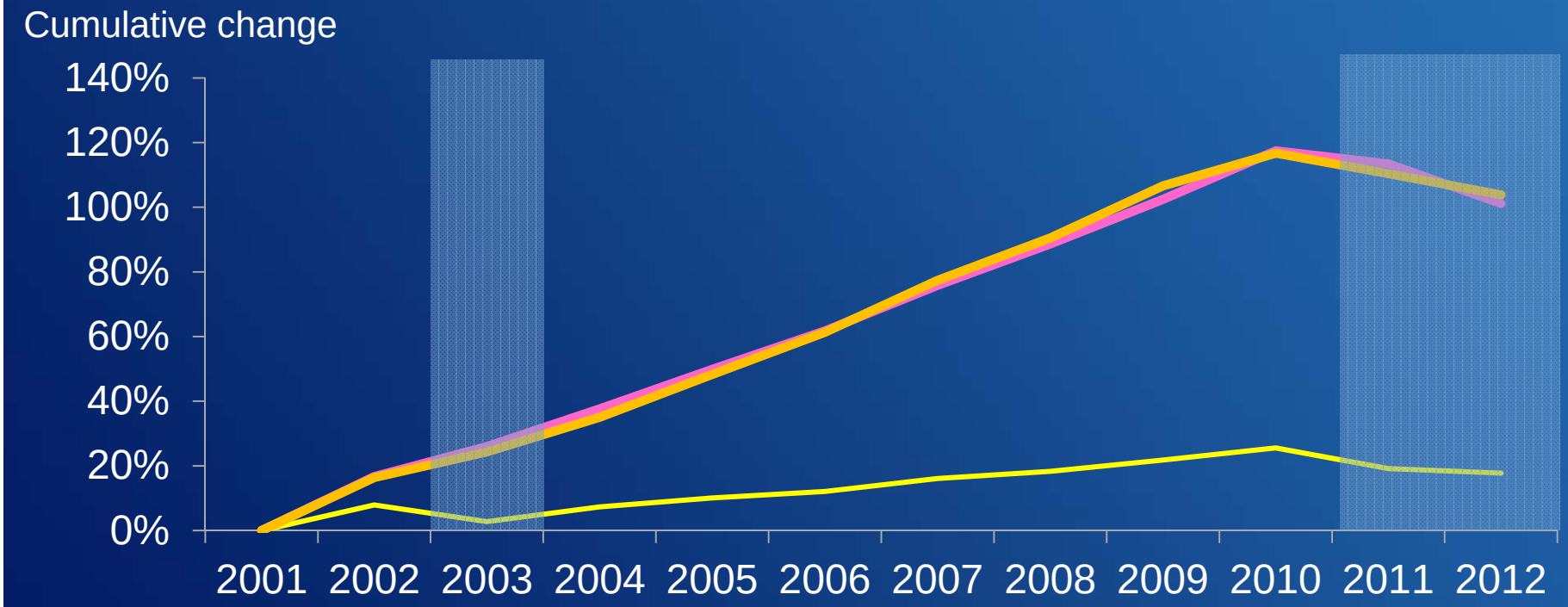
Trends in agency supply were consistent from 2001 to 2012

- Supply of non-profit agencies declined
- Urban agencies increased in all years; rural agencies declined (urban agencies serve some rural agencies)
- Access did not change significantly
  - 99 percent of beneficiaries have lived in a ZIP code served by home health since 2004 (84 percent live in a ZIP code served by 5 or more agencies in 2012)
- Urban and rural areas have experienced comparable levels of utilization and growth in utilization

Aggregate utilization of FFS home health care has risen rapidly

- Total episodes more than doubled overall
- Share of beneficiaries using home health increased from 6.2 percent of FFS beneficiaries to 9.6 percent (+54 percent)
- Episodes per home health user increased from 1.4 to 1.8 (+30 percent)
- Episodes per 100 beneficiaries have increased at comparable rates for urban and rural areas

Per-beneficiary utilization of home health care doubled 2001-2012



Source: Home Health Standard Analytic File; provider of service file

- Change in average payment per episode
- Change in episodes per 100 beneficiaries for urban areas
- Change in episodes per 100 beneficiaries for rural areas

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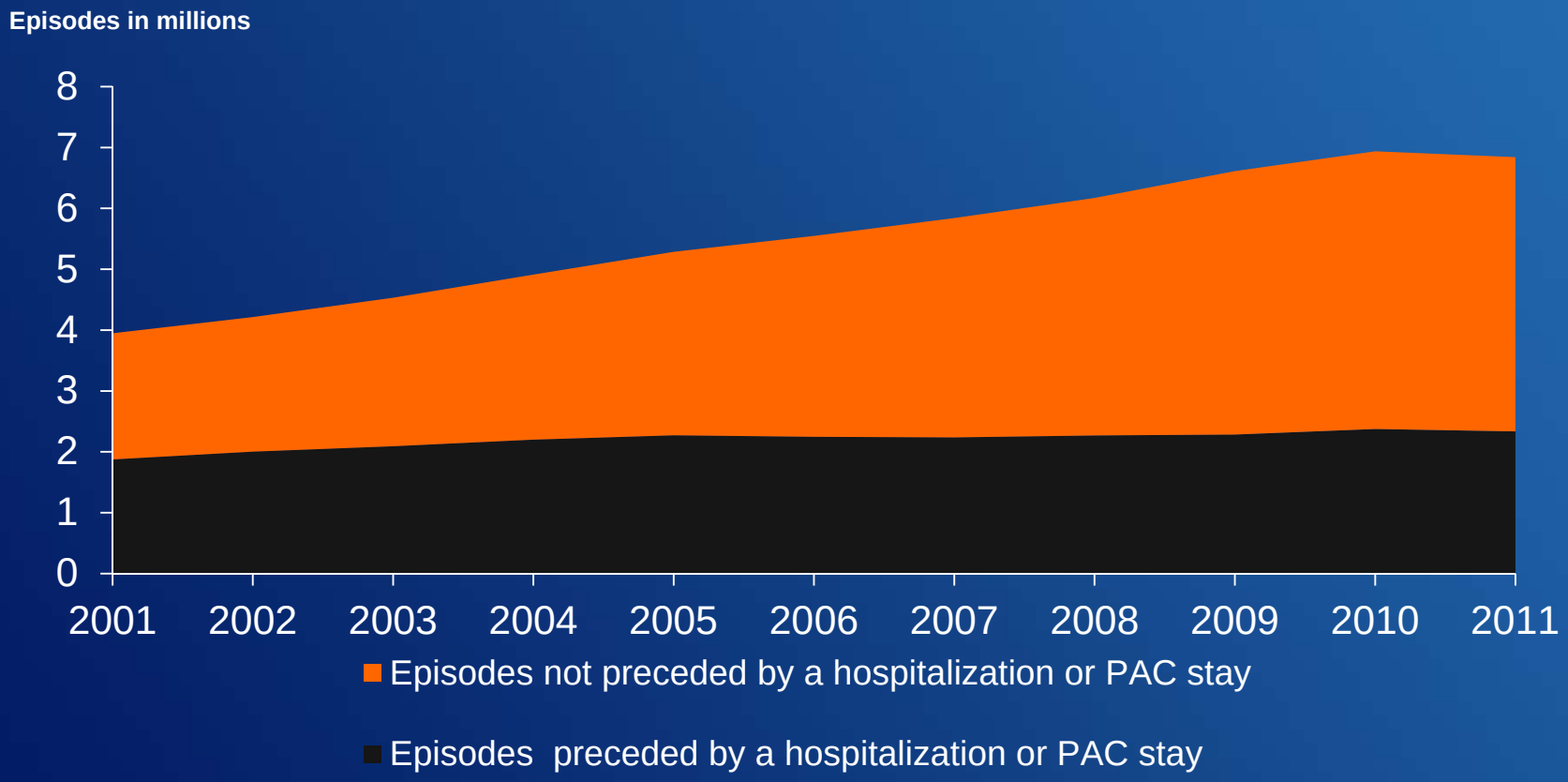
Small per-beneficiary utilization declines in 2011 and 2012 likely reflect factors other than payment policy

- Per-beneficiary utilization decline is concentrated in 5 states
- Economy-wide (public and private) slowdown in rate of health care spending growth in recent years
- In 2011 Medicare established a requirement for a physician to conduct a face-to-face examination of beneficiaries when ordering home health care
- Expanded efforts to combat fraud, waste and abuse

Non-post acute episodes account for the majority of episode growth



Source: Home health datalink file

- Data are preliminary and subject to change -

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Impact of rebasing reductions on access likely to be limited

- Small size of rebasing reductions (half-percent or less in each year)
- Rebasing reductions not likely to significantly reduce access
- Utilization near record peak
- Decline in recent years followed rapid growth and likely influenced by factors other than payment policy

Hospitalization rates have not changed significantly, 2003-2012

Type of agency	2003	2012
For-profit	28.7%	28.6%
Nonprofit	26.6	25.5
Urban	27.1	27.2
Rural	29.2	29.8
All	27.5	27.5

Source: Home health compare

- Average payment per episode increased 18 percent

Share of patients with improvement in function increased in most years

- Functional measures of quality have improved annually since measures were implemented in 2003
  - 58 percent of patients reported improvement in walking in 2012
  - 53 percent of patients reported improvement in transferring in 2012
- Functional measures increased every year, including years with payment decreases and years with payment increases

Small changes in payment under PPACA rebasing unlikely to significantly affect quality

- Rebasing cut is small, 2 percent over 4 years (4 percent with sequester)
  - Agencies still receive annual payment update
- Past payment reductions have not had a negative impact on access and quality
  - Utilization and agency supply has more then doubled in 2001 through 2012
  - Functional measures improved while hospitalization was unchanged

Small changes in payment under PPACA rebasing unlikely to significantly affect quality

- Margins have remained high despite past reductions to base payments
- Higher case-mix has offset past attempts to lower base rate
- Agencies have been successful in controlling costs
- PPACA reductions unlikely to significantly reduce access