SECTION 2E

Home health services

RECOMMENDATIONS

2E-1 The Congress should extend for two years the 10 percent add-on payments for home health services provided in rural areas.

***YES: 14 • NO: 0 • NOT VOTING: 0 • ABSENT: 3**

2E-2 The Congress should update home health payments by market basket for fiscal year 2003.

YES: 14 • NO: 0 • NOT VOTING: 0 • ABSENT: 3

2E-3 The Congress should eliminate the payment cut for home health services scheduled for October 2002 in current law.

YES: 14 • NO: 0 • NOT VOTING: 0 • ABSENT: 3

***COMMISSIONERS' VOTING RESULTS**

SECTION 2E

In this section

- Assessing payment adequacy
- Accounting for cost changes in the coming year
- Update recommendation

Section 2E: Home health services

The home health sector has experienced many changes in the past decade. Rapid growth in spending and use of services in the early 1990s was followed by changes in the basic structure of the payment system, eligibility for the benefit, and efforts to reduce fraud and abuse. Spending and use of services fell dramatically. Nonetheless, over the past two years more stable market conditions and evidence that beneficiaries do not face difficulties in accessing home health services suggest that current payments are neither too high nor too low. In the absence of evidence of problems with current payments, the Commission supports stabilizing payment policy. To maintain the current relationship of payments and costs, Medicare's payments should increase by market basket—the rate at which we expect costs to grow. In addition, the Congress should eliminate the substantial reduction in the base rate currently scheduled for October 2002 and retain the rural add-on payment for two additional years.

Under the prospective payment system (PPS), home health agencies receive payment for 60-day episodes of care. The payment is intended to cover the costs an efficient provider would incur in furnishing skilled nursing, aide service, medical social work, or therapy to homebound beneficiaries in their places of residence. Payments totaled $9.4 billion in 2000. Neither copayments nor deductibles apply to home health.

The base payment amount for a 60-day episode of care is $2,274.17 in fiscal year 2002. This amount is adjusted to account for differences in patients' expected resource needs, as reflected by their clinical and functional severity, recent use of other health services, and therapy use. Payment also is adjusted for differences in local market conditions by a version of the hospital wage index. Adjustments for several other special circumstances, such as outliers or episodes with four or fewer visits, can also modify the payment (see Chapter 1, p. 23, for more information).

The current structure of home health payment follows several years of near-constant change. During the late 1980s and early 1990s, both the proportion of beneficiaries using home health and average number of visits per user increased dramatically (MedPAC 1998). In 1987, the average number of visits per user was 23; by 1997 it had risen to 78. Over the same period, Medicare spending for home health services grew from $2 billion to $17 billion. The escalation reflected two factors: a cost-based payment system that provided weak incentives for agencies to limit the volume of services, and a program that was increasingly providing essentially long-term care under what was intended to be a post-acute care benefit.

Escalating costs and growing use of home health services provided a catalyst for policy action. The payment system was changed from a cost-based system to an interim system with stricter payment limits in 1997, then changed again to the prospective payment system in October 2000. Eligibility for the benefit was also modified; some low-intensity, long-term beneficiaries no longer qualify for a full range of home health services if their only skilled need is the drawing of blood. Finally, Operation Restore Trust and other anti-fraud and abuse initiatives reduced unnecessary care and decreased use by beneficiaries who probably were not eligible for the benefit.

The new payment systems, adjustments to eligibility, and fraud and abuse reduction efforts were intended to reduce spending and redirect the benefit toward briefer, more intense care. Changes in spending and use between 1997 and 1999 demonstrate that these changes had some dramatic effects (McCall et al. 2001):

- Total Medicare spending on home health fell 52 percent;
- The proportion of beneficiaries who used home health fell 20 percent;
- Average visits per user fell 40 percent;
- Average home health length of stay declined; and
- The proportion of therapy visits, a relatively intense service, increased from 10 percent of all visits in the first quarter of 1997 to 18 percent by the last quarter of 1999; and visits by home health aides, a low-intensity service, decreased from 49 percent to 34 percent over the same interval.

The magnitude of the changes since 1997 suggests that the policies implemented thus far have substantially met their goal of reducing home health spending and use. However, frequent changes impair providers' abilities to foresee their own costs and payments and to make decisions about participating in the program. Frequent changes also impair our ability to evaluate the adequacy of current payments by limiting both the data available and our ability to identify and interpret trends.

Given the recent disruptions, the Commission supports stabilizing payment policy. In evaluating the need for a payment update, we assessed the adequacy of current payments and accounted for cost changes next year.

Assessing payment adequacy

We evaluated payment adequacy by considering beneficiaries' access to care and the entry or exit of providers. Recent changes in the payment system and the lack of a clear definition of the benefit limit our ability to use current payments and costs to determine whether payments are too high or too low.

Current payments and costs

Typically, one factor that the Commission uses to evaluate the adequacy of current payments is the ratio of payments to estimated current costs. Current costs are estimated by updating the most recent available data. However, for the home health sector, the most recent available cost reports cover 1999. Those costs were generated before the payment system changed to its current structure. The interim payment system in place in 1999 was very different from the current one. Home health care is likely very different under the current payment system because of incentives for efficiency under the PPS; therefore, the 1999 costs would tell us very little about expenses in 2002 under the PPS. Cost reports from the current payment system are not yet available because programming difficulties at the Centers for Medicare & Medicaid Services (CMS) have delayed the statistical reports upon which providers rely to produce the cost reports.

Product changes

The PPS replaced the visit as the unit of payment with a new unit, the episode. This change has fundamentally altered the incentives of the payment system and may affect the product that home health agencies provide.

Prior to the PPS, home health agencies were paid per visit according to visit type, such as therapy, nursing, or home health aide. Paying per visit encouraged agencies to provide as many visits as possible as long as their costs were less than the per-visit payment limits for that type of visit.

This incentive was a catalyst for the rapid growth in the number of visits delivered, and hence in spending, until 1997.

In contrast, because the unit of payment is an episode under the PPS, agencies have the incentive to make at least five visits to qualify for an episode payment[1] but not more, because additional visits will not increase the episode payment. Under the episode payment of the PPS, agencies maximize profit by limiting costs per episode. To the extent that agencies respond to the financial incentives of the new unit of payment, we would expect the home health product to change from short, frequent visits to fewer (perhaps somewhat longer) visits and to include more non-visit services such as telemonitoring. Decreases in the number of visits per beneficiary provide some evidence that this change may be occurring.

Appropriateness of current costs

Judgment about whether Medicare home health costs are appropriate is limited by lack of a clear definition of the benefit. The absence of clinical practice standards also limits our ability to interpret costs and service use. At present, home health use varies considerably over time and by geographic location, but we do not know whether this variation reflects differences in access, in beneficiaries' health, in the supply of alternatives (such as nursing homes), excessive use or stinting on care, or some other factor.

CMS is pursuing several research projects to develop standards for home health services, including a contract to test whether the volume of home health services is related to outcomes (HCFA 2001). Thus far, the research has not found strong volume-outcome relationships after controlling for patient condition. Another study is developing ways to identify instances when stinting on services has affected the quality of care. Both studies could lead to standards for the appropriate amount of service.

Relationship of payments to costs

Although we lack a direct measure of costs, we would expect large discrepancies between payments and costs to be evident in the exit and entry of providers or beneficiaries' access to care. Our analysis of these market indicators provides no compelling evidence that payments are not appropriate.

Entry and exit of providers

The absence of substantial entry or exit of home health agencies in 2000 or 2001 may suggest that costs and payments are roughly in line with each other. In the past two years, the number of participating agencies has remained stable around 7,000. In 1996, under the cost-based payment system, about three new agencies entered for each exiting agency. During 1999 under the interim payment system, exiting agencies outnumbered entering ones 8 to 1.

Medicare's payments are a key factor influencing agencies' exit and entry, but two factors unrelated to costs and payments may also cause exit or prevent entry. First, agencies must meet Medicare's quality-of-care and financial standards or they can be involuntarily removed from the program. Involuntary exits may be unrelated to costs and payments. Second, some entries to the program may be prevented or delayed by state regulations that limit the number of participating agencies in that state. Finally, the structure of the PPS may favor larger agencies with the ability to average profit and loss over a large and varied patient population, thus creating a barrier to entry for small, start-up agencies in this new system.

A reduction in the number of Medicare-certified agencies does not necessarily indicate a reduction in home health care capacity. Some observers have suggested that having only a small number of agencies per Medicare beneficiary in an area may impair access, but no evidence exists to suggest that the number of agencies is a meaningful measure of access. Despite closures and changes in practice patterns, access generally had not been impaired (GAO 1999). Furthermore, because the home health industry has been experiencing consolidation, the agencies still participating in Medicare may be larger than their predecessors.

Beneficiaries' access to care

According to the Office of Inspector General (OIG), beneficiaries continue to maintain good access to care (OIG 2001a, OIG 2001b), suggesting that payments are at least adequate to induce agencies to serve Medicare beneficiaries. The OIG surveyed hospital and nursing home discharge planners in early 2001, after the PPS had been in place for about six months. Most discharge planners reported placing beneficiaries in home care without difficulty. Of the few planners who reported difficulties, most were unable to place only a small fraction of discharged beneficiaries.

Until recently, observations on access focused on beneficiaries discharged from a hospital or nursing home. However, this year the OIG also studied beneficiaries admitted to home health care directly from the community. The OIG surveyed physicians, representatives from community services for the elderly, home health agencies, and others about the experience of beneficiaries who did not use the resources of a facility-based discharge planner. Those surveyed reported little difficulty in placing beneficiaries from the community.

Home health in rural areas

Concerns about access to home health services in rural areas led the Congress to provide an additional 10 percent payment for home health services provided to

1 Providing four or fewer visits within a 60-day period results in per visit payment based on the visit type (the low utilization payment adjustment, LUPA) instead of the episode payment. Even the higher LUPA payments are much lower than the lowest episode payment.

beneficiaries living in rural areas.[2] This addition is scheduled to expire in April 2003.

In June 2001, the Commission concluded that the new PPS should work equally well in both urban and rural settings based upon our analysis of the design of the PPS. We found that the unit of payment, the base payment, and the case mix adjustment should work as well in rural as in urban areas. Although the Commission was concerned that costs per patient could be higher in rural areas than in urban because of the small scale of operations, the distances to travel among rural clients, and differences in the use of therapy, our inability to measure costs made it difficult to assess this issue.

As discussed earlier, we have no evidence to suggest that payments are not adequate for home health generally. Our information about rural home health specifically is mixed. On one hand, two market indicators (McCall et al. 2001) suggest that continuing the add-on may be appropriate. The proportion of beneficiaries using home health declined significantly more rapidly between 1997 and 1999 in rural areas (–26 percent) than it did in urban areas (–19 percent). Also, rural areas lost a larger proportion of their agencies than urban areas. On the other hand, OIG's finding that discharge planners at urban and rural hospitals were able to place Medicare beneficiaries in home health at similar rates does not support the argument that special treatment for rural areas is necessary (OIG 2001b).

Given the mixed evidence, it may be appropriate to continue the add-on payment until additional data become available to make a more accurate evaluation. In the interim, the Commission makes the following recommendation:

RECOMMENDATION 2E-1

The Congress should extend for two years the 10 percent add-on payments for home health services provided in rural areas.

Services for beneficiaries in rural areas were recently in sharp decline and a higher proportion of rural agencies than urban agencies closed. Although we have no evidence to suggest that access to care in rural areas is impaired with rural payments at their current level, we do not know if that would persist without the rural add-on.

Accounting for cost changes in the coming year

In addition to accounting for the adequacy of current payments, a payment update for home health services should account for changes in costs in the coming year. To account for changes in the cost of inputs, the Commission's update framework begins with the forecasted increase in the indicator for price change—in this case the home health market basket. Unless we believe some factor would cause costs to rise more or less quickly than input prices, we expect the market basket to capture the changes in costs for the coming year.

Home health agencies may have decreased their costs following the implementation of the PPS. However, the same data shortfall that limited our ability to estimate current costs also limits our ability to estimate changes in costs over the coming year.

Our analysis of the components of the PPS suggests that agencies that were paid a prospective amount per episode have an incentive to lower their costs per episode. In 1996, CMS conducted a demonstration to test the effects of the PPS's incentives on the cost of home health care services (Cheh and Trenholm 1999). Treatment-group agencies were paid a lump sum for 120-day episodes of care. Control groups enrolled in the demonstration for comparison were paid per visit. In this demonstration, prospectively paid agencies significantly decreased the number of visits per episode, compared with the control group. Though the prospectively paid agencies' costs per visit increased, the net effect was that costs per episode were lower for the treatment group than for the control group.

Though both our analysis of the components of the PPS and CMS's demonstration suggest that agencies will decrease their costs, we cannot conclude that costs will grow more slowly than input prices in the coming year for two reasons. First, we do not have evidence that cost decreases have definitely occurred. Though preliminary evidence suggests that the number of visits per episode has decreased[3] and decreasing visits per episode could lead to decreased costs per episode, the decrease could be offset by rising costs per visit. Without data on the costs per visit, we cannot conclude that declining visits per episode implies a proportionate decline in costs per episode. Second, we do not know when any cost decreases occurred or whether there are more to come. The PPS will have been in place for two years by the time the Commission's update recommendation is implemented. If the efficiencies have already been realized, then costs in fiscal year 2003 may indeed rise at the same rate as the price of inputs.

Update recommendation

The numerous recent changes, the immaturity of the current system, the lack of standards by which to judge the appropriateness of service use, and uncertainty regarding both appropriate costs and the likely changes in costs all

2 Under the legislation, rural beneficiaries are those who reside outside a metropolitan statistical area.

3 In an episode database developed by CMS when it created the PPS, CMS estimated that the average number of visits per episode was 31 in 1997 and 27 in 1998. Findings somewhat better than anecdote but less reliable than a scientifically drawn and analyzed sample of claims and agencies suggest that the average number of visits per episode was fewer than 20 during the first three quarters of the PPS (October 2000 through June 2001).

caution against substantial payment changes for this sector. Instead, the Commission supports a period of stability for payments for home health and makes the following two recommendations for minimizing disruptions to the system.

RECOMMENDATION 2E-2

The Congress should update home health payments by market basket for fiscal year 2003.

RECOMMENDATION 2E-3

The Congress should eliminate the payment cut for home heath services scheduled for October 2002 in current law.

Our recommendation for a full market basket update is based on two conclusions. First, we do not have evidence that payments for home health are inappropriate, whether too high or too low. Second, we have no evidence to suggest that costs will not grow at the same rate as input prices. In the absence of such evidence, we conclude that a full market basket update is appropriate.

Under current law, a substantial change to the system is imminent. The so-called 15 percent cut in home health payments, currently scheduled for October 2002, would be the last phase of the process begun in legislation in 1997 to reduce spending on home health services. Substantial reductions in spending and use have already occurred, however, and implementing the cut does not appear to be necessary to achieve the goals of the legislation.

Postponing the cut would prolong the uncertainty about payment rates. The uncertainty comes both because providers do not know when the cut will actually be implemented and because it is not clear how large the cut would actually be. The scheduled reduction would not necessarily cut the payment rate by 15 percent. Instead, the reduction would be computed in such a manner so that the total amounts payable in fiscal year 2003 would be equal to the amount that would have been paid had the interim payment system remained in effect with its limits 15 percent lower than they were in 2000. Thus, the size of the cut depends upon the difference between the projected spending under the interim payment system and the projected spending under the PPS.

In addition, future adjustments to the system can be achieved through annual evaluations of payment adequacy, although without clinical standards or a clear definition of the benefit it will be difficult to know whether we have achieved the long-term goal of buying the right services at the right price. ■

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