SECTION 4B

Home health services

RECOMMENDATION

The Congress should eliminate the update to payment rates for home health care services for calendar year 2007.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

SECTION 4B

Home health services

Section summary

Access to home health services for most beneficiaries continues to be good, though some beneficiaries experience difficulties. Nearly 90 percent of all beneficiaries who sought home health services reported little or no problem with accessing care. The number of home health users grew again this year from 2.6 million in 2003 to 2.8 million in 2004. In 2004, 99 percent of all Medicare beneficiaries lived in an area served by at least one home health agency (HHA); most beneficiaries lived in areas served by two or more HHAs. The supply of HHAs has increased.

Quality has generally improved slightly. More patients improved their ability to accomplish activities of daily living such as bathing or walking. The rate of use of the hospital or the emergency room during a home health episode stayed the same.

The HHA margin for 2004 is 16.0. The Deficit Reduction Act of 2005 eliminates the update to the home health base rate for 2006.

In this section

Our projection of the 2006 margin is 14.7. Between 2001 and 2004, average costs per episode grew at an average annual rate of 0.6 percent.

Data regarding access, volume, and quality—along with more than adequate margins—suggest that agencies should be able to accommodate cost increases over the coming year without an increase in base payments.

Recommendation 4B

COMMISSIONER VOTES:
YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

The Congress should eliminate the update to payment rates for home health care services for calendar year 2007.

Evidence continues to grow that payments are not being distributed accurately within the system. The number of visits per episode and the mix of the type of visits (therapy, skilled nursing, and aide) have changed so substantially since the payment system was developed that it is unlikely that the relative costliness of episodes is still accurately predicted by the case-mix system. The variation in minutes per episode within payment groups suggests that the costs of episodes within the same payment group are not uniform. In another report we found that case mix had a small but statistically significant relationship with margins, although this result was within the context of a model that did not predict variation in margins well. Ideally, case mix should bring payments closer to costs and have no relationship to margin (MedPAC 2005b). ■

Are Medicare home health payments adequate in 2006?

Indicators suggest that current payments are adequate. Beneficiaries' access to home health care is unchanged from last year, and incremental improvements in quality have continued. The number of beneficiaries using home health, the amount of services they use, and the number of home health agencies (HHAs) have all increased over the past year. The aggregate average Medicare margin for freestanding HHAs was 16.0 in 2004.

Background: What is home health and the home health payment system?

Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech pathology, aide service, or 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 (temporary but not indefinite) skilled care to treat their illness or injury and must be unable to leave their homes without considerable effort. Beneficiaries have no copayments or deductibles for Medicare home health services.

Medicare pays for home health service in 60-day units called episodes. Episodes begin when patients are admitted to home health care. Most patients complete their course of care and are discharged before 60 days have passed. If they do not complete their care within 60 days, another episode will start—and hence Medicare makes another episode payment—without a break in care.

Agencies receive one payment per episode for home health services. Medicare adjusts this payment based on measures of patients' clinical and functional severity, the use of certain health services preceding the home health episode, and the use of therapy during the home health episode. Payment also is adjusted for differences in local wages using the pre-floor, pre-reclassification hospital wage index. Medicare makes additional adjustments to some episodes under special circumstances:

- An outlier payment can offset some of the excess cost of an episode if the imputed cost for the number of visits furnished exceeds the payment.
- A low utilization payment adjustment (LUPA) requires payment by the visit if a patient receives four or fewer visits during an episode.
- A significant change in condition adjustment can increase—or potentially decrease—the payment for days remaining in the episode following a major, unexpected change in the patient's health.
- A partial episode payment requires the initiating agency to split the payment for a patient who transfers from one agency to another during an episode.

More information on the home health prospective payment system (PPS) can be found at http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_HHA.pdf.

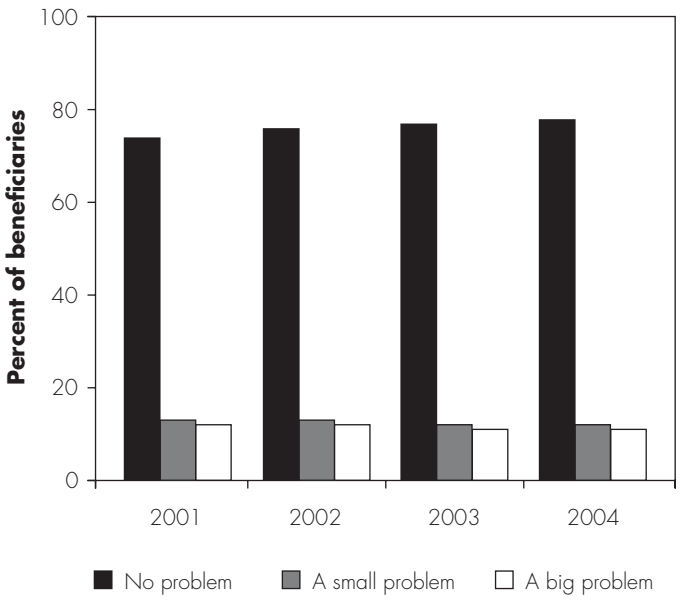
In the early 1990s, both the number of users and the amount of service they used grew rapidly. At the same time, the home health benefit increasingly began to resemble long-term care and look less like the medical services of Medicare's other post-acute care benefits (MedPAC 2005b).

The trends of the early 1990s prompted stricter enforcement of integrity standards, refinements to eligibility standards, and the replacement of the cost-based payment system in the mid-1990s. Following these changes, beneficiaries received fewer visits, and skilled nursing and therapy became a greater share of services. The number of beneficiaries using home health fell by about one million, and one-third of agencies providing services left the program. Spending decreased by about half. In this decade, these trends have changed direction. The total number of beneficiaries using the benefit grew for the first time in several years between 2001 and 2002, and has continued to grow. Spending is also projected to grow at an average annual rate of 5.2 percent from 2005 to 2015 (Office of the Actuary 2005).

Assessing these historical trends is difficult because this service lacks clear, practical guidelines to identify beneficiaries whose characteristics suggest they would benefit from receiving the service and what services they ought to receive. Suggesting that more home health is better and less home health is worse oversimplifies the case (see "Is more home health service better?" (MedPAC 2005a)). The Commission expects to pursue a research agenda to help develop clinical guidelines. Such guidelines for home health services would be consistent with our stated goal across post-acute care: to base decisions about where beneficiaries receive post-acute care services on patient characteristics and resource needs. In other words, post-acute care will have its greatest impact when appropriate patients receive appropriate care.

FIGURE 4B–1

Most beneficiaries had little or no problem accessing home health care



Note: Percentages are proportions of those who answered the question. Missing responses were not included.

Source: Consumer Assessment of Health Plans Survey for Medicare fee-for-service 2001–2004.

Beneficiaries' access to care

In the home health setting we ask two questions: Do communities have providers? Do beneficiaries obtain care?

Most communities have more than one home health agency. In the 12 months preceeding September 2005, 99 percent of all Medicare beneficiaries lived in an area that was served by at least one HHA; 97 percent of beneficiaries lived in areas served by two or more HHAs. These numbers suggest that no substantially populated areas of the country lack HHAs. These percentages vary little from state to state, though rural states tend to have more areas served by only one HHA or areas not served by an HHA in the past 12 months.

Our geographic measure of access is based on data collected and maintained as part of CMS's "Home Health Compare" database as of September 2005. The service areas listed in the database are postal ZIP codes where an agency provided service in the past 12 months. This definition may overestimate access because agencies need not serve the entire ZIP code to be counted as serving it. On the other hand, this definition may underestimate access if HHAs are willing to serve certain ZIPs but did not receive any requests from those areas in the preceding 12 months.

An annual survey of fee-for-service beneficiaries gives us some information about whether beneficiaries can obtain home health care. Nearly 90 percent of the beneficiaries who responded to the Consumer Assessment of Health Plans Survey for Medicare fee-for-service (CAHPS–FFS) about their home health experiences in 2004 reported that they had little or no difficulty accessing home health services when they sought them (Figure 4B-1).[1] The 2004 results do not differ significantly from those in 2003.

The CAHPS–FFS measures include all beneficiaries who sought care, whether they received home health or not. Also, the CAHPS–FFS question is not restricted to beneficiaries who sought care following a hospitalization, as some prior surveys' questions were. However, unlike similar surveys of hospital discharge planners or home health agencies, CAHPS–FFS cannot differentiate beneficiaries who are eligible for the home health benefit from those who are not. Thus CAHPS–FFS may overestimate the difficulties of eligible beneficiaries by including some beneficiaries who were ineligible and had a big problem getting home health because they were not qualified for the Medicare home health benefit.

CAHPS–FFS gives us some additional information about those 11 percent of beneficiaries who had big problems accessing home health care. Between a quarter and a third of these beneficiaries also had problems accessing prescription drugs, doctors, or specialists. We also find that beneficiaries who had home health access problems were more than proportionally represented among the beneficiaries who had access difficulties in other areas of health care. They constitute about one-third of all of the beneficiaries who had big problems accessing prescription drugs, doctors, or specialists. This pattern might indicate that the big problems faced by some beneficiaries accessing home health care are not unique to home health; rather, their home health access difficulties are symptomatic of more general access difficulties. To the extent that home health access problems are symptoms of wider issues, the issues cannot be addressed by changing the level of the home health PPS base payment rate.

CAHPS–FFS also allows us to compare rural and urban beneficiaries' experiences. As was the case in 2003, rural beneficiaries in 2004 report better access to care than their

urban counterparts: 82 percent of rural beneficiaries had no problem with access, compared to 77 percent of urban beneficiaries.

Changes in the volume of services

We considered three measures of volume: the number of beneficiaries using home health, the number of episodes provided, and the number of visits within an episode. The numbers of users and episodes continued to rise in 2004. The amount of service within an episode remained the same between 2003 and 2004.

- Nearly 2.8 million beneficiaries used home health in 2004—a 6 percent increase since 2003. This growth rate is higher than the growth in the number of beneficiaries.
- Over the same period, the number of episodes rose from 4.3 million to 4.6 million (about 7 percent).
- The average number of visits per episode was 18.4 in 2003 and in 2004.

The length of stay—the number of days between admission and discharge from home health services—also increased from 62 days to 65 days between 2003 and 2004. The average number of episodes per beneficiary in 2004 was 1.7. The average length of stay was longer than a single payment episode because many beneficiaries used two or more episodes of care during their home health care stay. More beneficiaries are using multiple episodes than they were at the inception of the PPS; in 2001, there were 1.5 episodes per beneficiary. We will investigate the second and subsequent episodes to determine whether they are systematically different from initial episodes and, if so, why.

Changes in quality

The maintenance or gradual improvement of indicators of patients' ability to function, frequency of pain, and use of hospital or emergency care suggest that the quality of home health care has not diminished over the previous year.

The first five rows in Table 4B-1 represent the percentage of patients who improved out of the total number who were admitted with some level of limitation. The final two rows represent the percentage of patients who used the hospital or the emergency room while under the care of a home health agency; the lower the percentage, the better. The increases among the percentages in the first five rows are indicative of improving or stable quality. The final two rows show no change. These quality indicators are risk adjusted to account for patients' diagnoses, comorbidities, and functional limitations. Thus, to the extent possible, the improvements over time measure small increases in the quality of care from home health agencies rather than changes in patient characteristics. However, improvements in coding could also influence the results.

TABLE 4B–1 **Share of patients achieving positive outcomes continues to increase**

Measure	June 2002–May 2003	June 2003–May 2004	June 2004–May 2005
Improvement in:			
Walking around	34%	36%	38%
Getting out of bed	49	51	52
Bathing	57	60	61
Managing oral medications	35	38	39
Patients have less pain	57	59	61
Any hospital admission	28	28	28
Any unplanned ER use	21	21	21

Note: ER (emergency room).

Source: MedPAC analysis of CMS Home Health Compare data.

Changes in the supply of agencies

Over the past 10 years the number of home health agencies in the program has risen, fallen, and risen again. Under the earlier cost-based payment system, hundreds of agencies entered the Medicare program. At the peak in 1997, more than 10,000 agencies had Medicare certification. The trend switched under the interim payment system of cost limits, which began in 1997. Between 1997 and 2000, about 3,000 agencies left the program. For a couple of years after the PPS was implemented, the number of agencies remained at about 7,000.

The number of agencies began growing again in 2003. By October 2004, there were 7,530 agencies; 8,082 agencies were in the program as of October 2005. This growth represents a 7 percent increase in the most recent year (compared to only about a 1.5 percent increase in the size of the beneficiary population) and a 14 percent increase in the total number of agencies since 2000.

TABLE 4B–2 **Freestanding home health Medicare margin, by agency group, 2004**

Agency group	Number of agencies	2004 margin
All agencies	3,979	16.0%
Caseload		
Urban	2,546	15.9
Mixed	985	17.0
Rural	448	11.8
Type of control		
Voluntary	686	12.4
Private	3,047	18.1
Government	246	8.1
Volume group, lowest to highest		
First quintile	843	13.1
Second quintile	781	10.5
Third quintile	794	12.9
Fourth quintile	792	15.9
Fifth quintile	769	17.5

Note: Some freestanding agencies were omitted because of data integrity concerns.

Source: MedPAC analysis of Medicare Cost Report data from CMS.

The growth in HHAs is not uniform across the country. For example, 379 new agencies—about one-third of the new HHAs—are located in Texas. Florida also had many new entrants. In contrast, some states had no new entrants over the same period.

Substantial growth in the number of agencies in the program is consistent with the positive margins we have noted over the past several years. However, the number of HHAs is not an indicator of system capacity. Agencies range in size from very small HHAs serving fewer than 100 beneficiaries annually to much larger ones serving more than 5,000 beneficiaries in a year. Also, the flexible structure of a home health agency does not fit the typical concept of capacity: HHAs are not restricted by bed size or other physical plant considerations (e.g., number of exam rooms or operating rooms). Even the number of employees is not a capacity measure because many HHAs use contracted therapists, aides, or nurses to meet their patients' additional needs.

Home health agencies' access to capital

Few home health agencies access capital through publicly traded shares or public debt. Access to capital for the overwhelming majority of HHAs appears to be largely determined by size: Most agencies are too small for commercial capital markets. Investor analyses of the leading publicly traded companies are confounded for two reasons. First, Medicare home health care has a small share of the entire "home care" market that they analyze, which includes nonskilled Medicaid and private duty nursing, nurse staffing services, home infusion, and home oxygen services. Second, publicly traded companies are a small portion of the total number of agencies in the industry.

Payments and costs for 2006

The Commission considers the relationship between Medicare payments and costs in the current year, fiscal year 2006. We assess the adequacy of Medicare's payments to cover the costs of caring for Medicare beneficiaries. Our model of home health agencies' margins is based on data from freestanding home health agencies. We exclude provider-based HHAs from the margin analysis because the wide divergence of margins between provider-based and freestanding HHAs cannot be accounted for by factors that could cause efficient providers' margins to differ (MedPAC 2004).

In modeling 2006 payments and costs, we incorporate policy changes that went into effect between the year of our most recent data, 2004, and the year of margin projection in 2006, as well as those changes scheduled to be in effect in 2007. These include:

- *The expiration of the 5 percent rural add-on for services provided to beneficiaries living outside metropolitan areas on April 1, 2005.* The expiration of the rural add-on removed some payments from the system for rural providers and for those providers who served both urban and rural beneficiaries. The Deficit Reduction Act of 2005 restarts the 5 percent add-on for one year in 2006. This will increase payments to HHAs that serve rural beneficiaries.

- *An update of 2.3 percent in 2005.* The regular update increased payments to reflect increases in the prices for a "basket" of inputs to home health, including nurses' wages and transportation. The Deficit Reduction Act will freeze the 2006 base payment at the 2005 level.

- *The decrease in the fixed dollar loss (FDL) amount for outlier episodes that is projected to increase outlier payments.* In an analysis of claims from 2002 and 2003, CMS found that about 3 percent of episodes qualified for additional outlier payments under the higher FDL; under the new, lower FDL implemented in 2005, 5.9 percent of episodes will qualify for the higher payments.
- *The transition to a new definition of metropolitan areas in 2006.* This change raises payments to rural providers somewhat more than urban providers and changes the distribution of payments; it is budget neutral once it is applied to all HHAs.

The aggregate margin in 2004 for freestanding home health agencies was 16.0 percent (Table 4B-2). This margin indicates that payments more than cover the costs of caring for Medicare beneficiaries. The distribution of margins in 2004 was similar to previous years; about 20 percent of HHAs reported negative margins. At the 25th percentile, the margin was 4.2 percent. The median agency margin was 15.9 percent, and at the 75th percentile, the margin was 27.4 percent.

Agencies vary by the location of beneficiaries they serve (rural, urban, or mixed), their type of control (voluntary, private, or government), and size as measured by the annual number of episodes provided. In this analysis, more than a quarter of HHAs provided fewer than 150 episodes. Another quarter of agencies provided more than 1,000 episodes; some of the largest agencies provide 5,000 episodes in a year. Margins among the smallest agencies were 13.1 percent compared with 17.5 percent among the larger agencies. The aggregate cost of providing an episode of home health care has increased very little over the past several years. Between 2001 and 2004, the reported average cost per episode had an average annual growth of 0.6 percent. Because the average cost per episode is rising more slowly than the price of inputs—the market basket grew about 3 percent per year from 2001 to 2004—and the average number of visits has remained about the same, it would appear that the cost per visit has decreased. Agencies might be reducing the length of visits, reducing overhead costs, or making other changes that reduce the cost of visits.

As the average visits per episode have remained about the same, the outcomes of care have stayed the same or improved slightly. Agencies appear to vary in terms of their ability to increase productivity. One-quarter of the agencies experienced high cost growth, with an average annual rate of 3.4 percent. Over the same period, a quarter of agencies had costs decline at an average annual rate of 0.7 percent. Generally, government agencies have had the greatest rate of cost growth, voluntary agencies somewhat slower cost growth, and private agencies have had cost declines. Cost growth does not appear to be related to size. In each case, there is more variation within each of these categories (type of control or size) than among the categories.

How should Medicare payments change in 2007?

We consider the current market basket as well as recent trends in costs per episode and technology to determine how costs may change.

The most recent estimate of the projected increase in the market basket for home health for 2007 is 3.4 percent. Increases in the cost of transportation, wages, and other inputs determine the market basket increase.

Evidence regarding the current level or rate of technological advance in this industry is anecdotal and sometimes contradictory. The key technologies that we have identified—point-of-care electronics, new wound treatments, telemonitoring—seem likely to generate their own financial return by reducing the number of visits necessary in an episode. If they are able to provide their own return, additional payment is not necessary to promote their adoption.

RECOMMENDATION 4B

The Congress should eliminate the update to payment rates for home health care services for calendar year 2007.

RATIONALE 4B

Our evidence suggests that access to care is good. Communities across the country have providers and more providers are entering the program. The quality of care continues to improve slightly. The number of users and the amount of service that they use are rising. These factors, along with more than adequate margins,

suggest that agencies should be able to accommodate cost increases over the coming year without an increase in base payments.

IMPLICATIONS 4B

Spending

- This recommendation decreases federal program spending relative to current law by between $200 million and $600 million in one year and between $1 billion and $5 billion over five years.

Beneficiary and provider

- No adverse impacts are expected. This recommendation is not expected to affect providers' ability to provide care to Medicare beneficiaries.

Should the prospective payment system's structure change?

We have noted in several past reports that the change in incentives facing home health agencies after the prospective payment began in 2000 may have changed the relationship between case mix and costs upon which the system was built. If the case-mix system is not accurate, it should be changed; a trio of reports from the Office of Inspector General (OIG) suggests that the therapy threshold could be a part of the problem. The Commission has developed an agenda to further explore the case-mix system.

Evidence continues to grow that the current case-mix system may be inaccurate:

- The current home health product includes fewer visits and a higher proportion of therapy than it did when the system was created.
- The variation in minutes of service within case-mix groups suggests that care within case-mix groups is not homogenous.
- When we explored the correlations of agency characteristics (e.g., size and type of control) and agency margins, we found no evidence of any substantial, strong relationships. However, we found that agencies' average case mix had a small but statistically significant relationship with HHA margins. Ideally agencies' case mix and margin would be unrelated because the case-mix adjustment would accurately match payments to costs on average.

The weights in the current case-mix system are based on the relationship between care provided and patient characteristics that appeared in data collected in 1997 and 1998. At that time, agencies had an incentive to provide as many visits as the home health intermediary would approve. Both patterns of care and patient characteristics have changed since then.

At the end of 1998, the incentives changed as CMS introduced an interim payment system that was intended as a bridge between the cost-based system and the prospective system. Under the interim system, agencies had a financial incentive to reduce visits wherever possible. Medicare coverage for patients whose only skilled care need was the drawing of blood was eliminated. Also, greater oversight provided an incentive for agencies to limit use that might be inappropriate. Research suggests that the smallest declines in use of home health occurred among the types of beneficiaries who usually use home health; beneficiaries whose diagnosis was related to infrequent use of home health experienced larger declines in use (MedPAC 2004). High-use states had greater declines than low-use ones.

The current PPS also has incentives to reduce the number of visits provided during an episode. Case-mix groups with many visits, and thus high weights and high payments, could have offered the greatest scope to reduce visits. On average, the number of visits per episode has remained about the same under the PPS; we will explore whether certain case-mix groups lost a greater proportion of visits than others. To the extent that greater percentage reductions in care occurred in highly weighted case-mix groups, a positive relationship between case mix and margin would be expected to emerge.

Our examination of the average number of minutes of care per episode by case-mix group (MedPAC 2005b) also found indications that this system may need refinement. In that work, we found large variation in the minutes of service per episode provided to patients in the same case-mix group. If the number of minutes are related to the cost of the episode, then the variation in minutes within case-mix groups could suggest that the system is not accurately predicting costs.

Even more recently, the Congress asked the Commission to investigate the relationship between home health agencies' case mix and their margin of profit or loss on Medicare patients (MedPAC 2005a). We found that neither case mix nor other key variables explain much

of the variation in margins among HHAs. However, we also found evidence of a small but statistically significant relationship between margin and case mix. The presence of a statistically significant relationship, in a predictive model that is weak, suggests further research is needed.

Some change in the home health product is good. The intent behind changing the home health payment from a cost-based system to a prospective payment system is to provide an incentive for providers to reach good outcomes with more efficient use of resources. However, three reports from the Office of Inspector General indicate some agencies are providing more therapy than is medically necessary (OIG 2005a, 2005b, 2005c). The OIG selected an agency each from Florida, California, and Connecticut for a review of claims that just met the 10-visit threshold for higher payments based on therapy service provision. At two agencies, the therapy provided failed a record review for medical necessity of services (64 out of 74 claims failed in one case; 19 out of 40 claims failed in the other). In the third case, all of the 100 claims sampled met the test for medical necessity.[2] The third case proves that overuse of therapy is not universal; however, the first two cases suggest that overuse of therapy may be an issue.

Overuse of therapy is consistent with the incentives of the payment system. Episodes with 10 or more visits for physical therapy, occupational therapy, or speech pathology (therapy) satisfy the 10-visit threshold for increased payments under the PPS. Medicare pays about $2,500 more for an episode that meets the therapy threshold than for a similar episode with nine or fewer therapy visits. We see relatively more episodes that just meet the therapy threshold and fewer episodes with eight or nine therapy visits (Wardwell and Thompson 2005).

The OIG reports suggest that rethinking the therapy threshold could be a good place to start restructuring this system. The Commission plans to explore the relationship between case mix and cost at the episode level. Work at the episode level could point the way toward refinements of the case-mix system if we identify a subset of resource groups that are particularly misaligned. For example, we might find that payments for episodes that meet the therapy threshold are particularly misaligned with costs, which would suggest that the therapy threshold policy should be refined. CMS is also pursuing work in this area, researching case-mix models that could predict therapy costs instead of relying on a threshold. A case-mix system with multiple, graduated thresholds might be more accurate than a single-threshold system; a case-mix system without any thresholds could perform even better if therapy could be predicted accurately.

In our work on outliers last year, we found that some patient characteristics that were not included in the payment system appeared to be related to the frequency of very high cost episodes. Those characteristics were:

- unable to self-administer injectable medications
- manages self-injectable medication if prompted
- history of rehospitalization
- lacks informal support
- behavioral problems

Although we suspected these characteristics could in fact cause patients to be systematically less profitable because these characteristics are not accounted for in case mix, our research did not find such a relationship. If behavioral problems, for example, made care more costly but did not generate higher payments, then agencies with caseloads that included more beneficiaries with behavioral problems should have lower profit margins, all else equal. We tested these beneficiary characteristics in the regression model we used to respond to the Congressionally mandated study. Using the regression model allowed us to compare agencies with caseloads that included larger than average numbers of beneficiaries with these characteristics and hold other agency characteristics equal. However, we found that none of these beneficiary characteristics was associated with margin to a statistically significant degree. This finding in a weak model does not lead us to a definite conclusion.

At a broader level, we plan to continue our examination of alternatives to the prospective payment system. Perhaps a single payment system is not suited to the task of paying accurately for both short-stay and long-stay care. ■

Endnotes

1 Of all beneficiaries surveyed in 2004, 8.8 percent indicated that they needed home health.

2 Out of 100 claims, 22 claims failed other federal requirements not related to medical necessity, such as proper authorization for therapy, services not provided as ordered, or medical records incomplete.

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