SECTION 3B

Home health services

RECOMMENDATION

The Congress should eliminate the update to payment rates for home health care services for calendar year 2008.

COMMISSIONER VOTES: YES 13 • NO 0 • NOT VOTING 1 • ABSENT 3

SECTION 3B

Home health services

Section summary

Our indicators for home health services are positive. Access to care continues to be satisfactory, with more than 99 percent of beneficiaries living in an area served by a home health agency (HHA) in 2006. The number of beneficiaries using HHAs increased from 2.7 million in 2004 to 2.9 million in 2005. The number of HHAs participating in Medicare increased by 6.5 percent in 2006, with growth in the number of HHAs varying among regions. Quality measures also show an improvement. Our projection of the 2007 margin for freestanding agencies is 16.8 percent. Between 2004 and 2005 average cost per episode grew at a rate of 0.7 percent.

The data on access, quality, volume, and financial performance suggest that most agencies should be able to accommodate cost increases in 2008 without an increase in base payments. ■

In this section

The Congress should eliminate the update to payment rates for home health care services for calendar year 2008.

Recommendation 3B

COMMISSIONER VOTES:
YES 13 • NO 0 • NOT VOTING 1 • ABSENT 3

What is home health care and the home health payment system?

Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech-language pathology, aide service, and medical social work that beneficiaries receive 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. Medicare does not require beneficiaries to pay copayments or a deductible for home health services.

Medicare pays for home health service in 60-day units called episodes, which 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 Medicare will pay for it, 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 episode. Payment also is adjusted for differences in local wages with the prefloor, prereclassification hospital wage index.[1] Medicare makes additional adjustments to some episodes under special circumstances:

- A low utilization payment adjustment (LUPA) requires a payment per visit if a patient receives four or fewer visits during an episode.
- An outlier payment can offset some of the excess cost of an episode if the imputed cost for the visits furnished exceeds Medicare's payments by a certain threshold. The per visit rates computed for the LUPA payments are used to calculate the costs of an episode.
- A significant change in condition adjustment can increase—or potentially decrease—the payment for days remaining in the episode after 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.[2]

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 to look less like the medical services of Medicare's other post-acute care benefits (MedPAC 2005b).

The growth in the early 1990s prompted concerns about the medical necessity of some of the services that were provided. Medicare responded with stricter enforcement of integrity standards and refinements to eligibility standards. In addition, the Balanced Budget Act of 1997 required the creation of a prospective payment system (PPS) to replace the cost-based payment system in the mid-1990s. After these changes, beneficiaries received fewer visits, and skilled nursing and therapy accounted for a larger share of services. The number of beneficiaries using home health services fell by about 1 million, and one-third of agencies providing services left the program. Spending decreased by about half. In the current decade, the 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 5.7 percent from 2006 to 2016 (Office of the Actuary 2006).

Assessing these historical trends is difficult because the service lacks clear, practical guidelines for identifying those whose characteristics suggest they would benefit from receiving the service and what services they ought to receive. Suggesting that more home health service is better and less is worse oversimplifies the case (MedPAC 2005a). Home health agencies (HHAs), like other post-acute providers, serve patients with both long-term and short-term needs. The Commission's goal for post-acute care is to move away from payments based on site of care and to base decisions about where beneficiaries receive post-acute care on patient characteristics and resource needs.

Are Medicare payments adequate in 2007?

Our indicators for home health are positive. The number of beneficiaries using HHAs increased by 0.2 million from 2004 to 2005 (from 2.7 million to 2.9 million). Almost all beneficiaries have good access to care; more than 99 percent lived in an area served by a HHA in 2006. Growth in volume of HHAs participating in Medicare varied

TABLE 3B–1

Trends in the provision of home health care

	2002	2003	2004	2005	Average annual percent change 2002–2005	Percent change 2004–2005
Supply of agencies	7,041	7,320	7,776	8,284	5.6%	6.5%
Beneficiaries (in millions)	2.4	2.6	2.7	2.9	5.6	6.1
Number of episodes* (in millions)	3.9	4.2	4.5	4.9	8.1	9.0
Average case mix	1.18	1.20	1.22	1.23	1.4	0.8
Average visits per episode	21.4	21.1	20.9	20.8	–0.9	–0.5
Average days in stay**						
1 episode	30.0	30.6	31.1	31.4	1.5	1.0
2 or more episodes	173.6	175.2	178.0	181.1	1.4	1.7

Note: *Includes low utilization payment adjustment episodes.
**Our previous calculations of average lengths of stay (LOS) for all episodes were biased by an error in data reporting. We addressed the data error this year by imputing the number of times LOS equals exactly 60.

Source: MedPAC analysis of home health Standard Analytic File.

among regions in 2006, with an overall increase of 6.5 percent. Quality measures also have shown improvement.

Beneficiaries' access to care

In this section we ask two questions:

- Do communities have providers?
- Do beneficiaries obtain care?

Most communities have more than one HHA. In the 12 months preceding June 2006, 99 percent of all Medicare beneficiaries lived in an area served by at least one HHA; 97 percent of beneficiaries lived in an area 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 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 October 2006. 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.[3] 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.

Data from a 2004 survey of fee-for-service beneficiaries provide some information about whether beneficiaries can obtain home health care. Nearly 90 percent of the beneficiaries who responded to the Consumer Assessment of Healthcare Providers and Systems® 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.[4] While updated CAHPS–FFS data are not available for home health services in 2005, the other indicators of beneficiary access, such as number of HHAs and participating beneficiaries, suggest that the factors affecting access to home health services have not deteriorated since the last survey. The older CAHPS–FFS data are useful because they explore two areas the Home Health Compare data did not address—trends for beneficiaries who had access problems and the access experience of rural and urban beneficiaries:

- Beneficiaries who had significant access problems were more than proportionally represented among the beneficiaries who had access difficulties in other areas of health care, including prescription drugs, doctors, and specialists. This pattern might indicate

that the significant problems some beneficiaries faced in accessing home health care are not unique to home health care but are symptomatic of more general access difficulties. Ensuring adequate access to quality care is important, but systemic access problems cannot be addressed efficiently by adjusting home health payments.

- CAHPS–FFS also allows us to compare rural and urban beneficiaries' experiences. As was the case in 2003, rural beneficiaries in 2004 reported better access to care than their urban counterparts: 82 percent of rural beneficiaries had no problem with access, compared with 77 percent of urban beneficiaries.[5]

A review of beneficiary access in 2004 by the Office of Inspector General (OIG) suggests that access to care remains adequate (OIG 2006). The OIG reported that 79 percent of hospital discharge planners had no difficulty placing beneficiaries; those with the most common conditions requiring home health services did not experience access problems. The OIG did not report the impact on the length of the stay in the hospital for beneficiaries who were difficult to place in home health care. However, the OIG found that patients who needed drug therapies or rehabilitation or who were clinically complex were more difficult for discharge planners to place. Some of these findings suggest the need for system refinements.

The finding on rehabilitation, however, is inconsistent with an incentive in the home health PPS that substantially increases payments for therapy cases; it is also inconsistent with other audits by the OIG that have suggested an overuse of therapy.[6] The OIG reviewed claims that just met the threshold for higher payments based on therapy service provision for three different agencies in 2005 (OIG 2005a, 2005b, 2005c). At two agencies, the therapy provided failed a record review for medical necessity of services (64 of 74 claims failed in one case; 19 of 40 claims failed in the other case). In the third case, all 100 claims sampled met the test for medical necessity.

Changes in the volume of services

We considered three measures of volume: the number of beneficiaries using home health care, the number of episodes provided, and the amount of care beneficiaries received. Table 3B-1 shows increases in the number of users and episodes since 2002.

- Nearly 2.9 million beneficiaries used home health care in 2005—a 6.1 percent increase from 2004. This growth rate is higher than the 1.6 percent growth in the number of Medicare beneficiaries.
- Over the same period, the number of episodes rose from 4.5 million to 4.9 million (about 9 percent).
- Case mix has not changed significantly over the period, rising by less than 1 percent to 1.23 in 2005.

To capture the total care beneficiaries receive, we measure the intensity and duration of each stay. Between 2004 and 2005, the intensity of care provided over the 60-day episode fell slightly, though the average length of stay increased slightly. The number of visits within an episode, the intensity indicator, has been about 21 since 2002. We look at both indicators of volume because caring for patients at home requires home care agencies to monitor and support beneficiaries over a period of time with periodic, in-person visits.

Table 3B-1 shows that in 2005 the average duration of home health stays that are one episode long was about 31.4 days, a 1 percent increase from 2004. Seventy-six percent of all stays have one episode, but some beneficiaries use several consecutive episodes of home health care. For stays with 2 or more episodes, the average length of stay in 2005 was about 181 days, or three episodes long. This is also a small increase from 2004.

The average number of episodes per beneficiary in 2005 shows that, even after adjusting for the larger number of beneficiaries, more users required a second episode of home health care. The average number of episodes per beneficiary in 2005 was 1.7, while in 2002 the average was 1.6.

Since 2002, rural beneficiaries have used more episodes per beneficiary than urban users; this trend has persisted as the number of episodes per beneficiary in both categories has increased. Between 2002 and 2005, rural episodes per beneficiary increased from 1.5 to 1.7, and urban use increased from 1.4 to 1.5. However, the ratio of rural to urban episodes per beneficiary has been nearly constant over the four years, which suggests that rural add-on payments made in 2002 and 2004 did not increase the average number of episodes rural beneficiaries used relative to their urban counterparts.

TABLE 3B–2 **Share of patients achieving positive outcomes continues to increase**

Measure	2003	2004	2005	2006
Improvement in:				
Walking	34%	36%	38%	40%
Getting out of bed	49	51	52	52
Bathing	57	60	61	63
Managing oral medications	35	38	39	41
Patients have less pain	57	59	61	62
Any hospital admission	28	28	28	28
Any unplanned ER use	21	21	21	21

Note: ER (emergency room).

Source: MedPAC analysis of CMS Home Health Compare data.

Changes in quality

Medicare uses the Outcome and Assessment Information Set (OASIS) to measure patients' clinical severity and functional limitations at the beginning and end of an episode of home health care. It allows HHAs to track their patients' outcomes and to change their use of resources, care planning, and other processes to improve service. CMS also uses OASIS to produce reports for agencies and publishes OASIS-based quality information to guide consumers to choose high-quality providers.

The quality measures in Table 3B-2 are the items from OASIS that Medicare reports to the public. The first five rows represent the patients who improved as a percentage of the total number who were admitted with some level of limitation for each time period; increases in these percentages indicate improving or stable quality. The final two rows represent the percentage of patients who used the hospital or the emergency room (ER) while under the care of a HHA. For these measures, lower scores suggest better care. The rate of hospital admission or unplanned ER use has not changed in the last four years.

These quality indicators are risk adjusted to account for patients' diagnoses, comorbidities, and functional limitations. Thus, the improvements over time should measure small increases in the quality of care from HHAs rather than changes in patient characteristics. There have been small annual gains in quality in several categories but no decreases in the rate at which beneficiaries are hospitalized or have to visit the ER.

Medicare's payment systems need to change to encourage quality care, and in 2005 the Commission recommended that Medicare introduce a pay-for-performance program into the home health payment system. Medicare already uses nonfinancial incentives and other tools for improving quality, but generally the current payment system fails to financially reward plans or providers who improve quality. We developed the following criteria for pay-for-performance measures:

- Measures must be evidence based, broadly understood, and accepted.
- Most providers and plans must be able to improve on the measures; otherwise, only a few beneficiaries may receive improved care.
- Incentives should not discourage providers from taking higher risk or more complex patients.
- Information to measure the quality of a plan or provider should be collected in a standardized format without excessively burdening the parties involved.

Along with our recommendation to start pay for performance in home health care, the Commission also recommended that process measures be developed. In 2006, we convened an expert panel as a step toward adding process measures to the home health set. The panel collected data on best practices in fall prevention and wound care and gauged the expert consensus on the link between these processes of care and improved patient outcomes. These practices could be developed into good quality measures that satisfy the Commission's criteria. MedPAC will issue a report in June 2007 that addresses the design of a pay-for-performance program for home health care.

Changes in the supply of agencies

It is difficult to determine how changes in the number of providers can affect beneficiaries. On the one hand, a decrease in the number of agencies may be the result of mergers or consolidations that does not reflect a decrease in the capacity available to serve beneficiaries. On the other hand, it is difficult to gauge how new agencies affect local capacity, as some of them may be small and have small staffs or limited services.

Over the past 10 years, the number of HHAs in the Medicare 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, almost 11,000 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.

There were 7,041 agencies in 2002; since then, the number has increased by about 5.6 percent a year. In 2005, there were 8,284 agencies in the program, and in 2006 there were 8,802. This growth represents a 6.3 percent increase (compared with only about a 1.5 percent increase in the size of the beneficiary population) and a 25 percent increase in the total number of agencies since 2002.

Both the entry and exit of providers drive trends in net growth. The variation in this net growth among states is significant, with some states seeing little or no change and others experiencing significant increases or decreases in the number of agencies. California and Texas, two of the six states with the highest net growth over the last four years, accounted for 67 percent of the gain in agencies. These states grew by an average of 272 providers per state; 25 states or territories experienced growth of 1 to 31 agencies, an average growth of 9 agencies; and 18 states experienced an average decline of about 5 agencies.

The growth or decrease relative to the state's overall stock of HHAs also varies. Each category of growth indicated in Table 3B-3 includes both large and small states, except the category with the highest growth, which is dominated by large states. Because of this variation, even states in the categories that experienced a smaller absolute change may have seen a significant change relative to the number of providers. For example, Montana lost 13 agencies, which equals a decline of about 25 percent. In contrast, Minnesota saw a decline of 14 agencies, a decrease of about 6 percent because it has more providers. Trends in beneficiary growth, volume, and episode growth per beneficiary also varied for the states in each category. These variations suggest that there is not always a direct relationship between changes in the beneficiary population and changes in the number of HHAs and that care must be exercised in assessing the implication of the change in agencies for beneficiaries and the Medicare program. Consistent with the national trends in volume, the episode per beneficiary growth is positive for each of the four categories. For example, the category of states with a decrease in agencies had an average annual increase of 4.4 percent in the number of episodes per beneficiary from 2002 through 2005.[7] In fact all categories of states averaged a net increase in the number of episodes per beneficiary. Finally, it is worth noting that in the case of Montana a decline in the number of agencies is coupled with a 1 percent annual decline in episodes per beneficiary. Minnesota had a 3 percent increase in episodes per beneficiary.

TABLE 3B–3

Change in home health agencies varies among states, 2002–2006

	Number of states	Average change
Decrease	18	–5.4
No change	4	0.0
Increase		
Between 1 and 31 agencies	25	9.0
More than 90 agencies	6	272.0

Source: CMS provider certification data.

This analysis of change looks solely at the net change in agencies and does not assess how the supply is changing relative to factors that drive demand. The growth noted in Table 3B-3 may be due to changes in demographics or beneficiary service needs. Further analysis is necessary to understand how the increases in HHAs are related to these factors and the extent to which the number of agencies affects utilization and access.

HHAs vary significantly in their patient capacity, so the number of providers, or the change in the number of providers, in an area may not be an accurate measure of the capacity available to beneficiaries. For example, HHAs in the lowest quintile of volume delivered fewer than 140 episodes, while some of the largest agencies provide more than 1,100 episodes a year. Also, because home health care is not facility based, agencies have the flexibility to adjust their service areas and staffing as local conditions change. Even the number of employees is not a capacity measure because many HHAs use contracted therapists, aides, and nurses to meet their patients' needs.

The growth in the number of providers underscores that Medicare's rules for certifying new agencies are critical for safeguarding the interests of beneficiaries and the Medicare program. A range of factors, such as state regulation, variation in the practice of medicine, and regional differences in reimbursement, could be creating the differences. MedPAC plans to look at the trends and

TABLE 3B–4 **Margins for freestanding home health agencies**

	2004	2005	Percent of agencies (2005)
All	16.0%	16.7%	100%
Geography			
Urban	15.9	16.5	62
Rural	11.8	13.7	12
Mixed	17.0	17.7	25
Type of control			
Nonprofit	12.4	13.3	16
For profit	18.1	18.2	77
Government	8.1	10.7	7
Volume quintile			
First	13.1	16.3	20
Second	10.5	12.0	20
Third	12.9	12.5	20
Fourth	15.9	17.2	20
Fifth	17.5	17.9	20

Note: Analysis includes 4,049 agencies for 2004 and 4,535 agencies for 2005.

Source: MedPAC analysis of 2004–2005 Cost Report files.

Medicare's conditions of participation to better understand the implications for Medicare of the recent growth in the number of agencies.

Home health agencies' access to capital

Few HHAs 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. HHAs are not as capital intensive as other providers because they do not require extensive physical infrastructure. Investor analyses of the leading publicly traded companies are unreliable indicators of the general industry for two reasons. First, Medicare home health care has a small share of the entire home care market that investors 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.

Though financial data for the industry overall are limited, the data on entry into the market by new HHAs can provide some insight. In 2006, about 722 new HHAs entered the program. More than 95 percent of them are for-profit agencies. The growth rate in 2006, 6.5 percent, exceeds the average growth in HHAs of 5.6 percent from 2002 through 2005. The continued growth in 2006 suggests that the industry has adequate access to capital for expansion and that the payment freeze implemented for 2006 did not substantially diminish the industry's outlook.

Payments and costs for 2007

In addressing payment adequacy, the Commission also considers the relationship between Medicare payments and costs in 2007. Our model of HHA margins is based on data from about 4,500 freestanding HHAs.

Hospital-based agencies are not included in our estimate of the aggregate margin for home health care. In 2005, the aggregate margin for hospital-based agencies was –1.5 percent, lower than the 16.7 percent for freestanding agencies. Previous research suggests that this discrepancy is not attributable to factors that would cause the margins of efficient providers to differ. For example, a review of 2001 data found that hospital-based providers were similar to freestanding ones in several respects, such as case mix, average reimbursement per agency, volume of patients, and average number of visits (MedPAC 2004). These similarities, along with the fact that hospital-based and freestanding providers deliver care in the same setting—the beneficiary's home—suggest that differences in financial performance are due to other factors. The higher costs of hospital providers may reflect the allocation of overhead from the hospital or other differences in cost structure.

In modeling 2007 payments and costs, we incorporate policy changes that went into effect between the year of our most recent data (2005) and the year of margin projection (2006) as well as those changes scheduled to be in effect in 2007. These include:

- ***No market basket update for 2006.*** The Deficit Reduction Act (DRA) kept the 2006 base payment at the 2005 level.
- ***The 5 percent rural add-on for services provided to beneficiaries living outside metropolitan areas in 2006.*** The DRA restored the 5 percent rural add-on that expired in April 2005. Like earlier add-ons, the

DRA add-on increased payments to HHAs that served rural beneficiaries in calendar year 2006.

- ***Implementation of new wage areas in 2007.*** The home health PPS will complete the transition to the new labor areas and wage indexes developed after the 2000 U.S. census, already in use by the inpatient PPS. In 2006, the wage index was based on a blend of the previous system and the new system. According to CMS, the new wage areas will result in a slight decrease in payments for HHAs in urban areas and a modest increase in payments in rural areas.

- ***Quality reporting.*** The DRA requires that HHAs report quality measures to Medicare to receive the full market basket update; HHAs that do not report will have 2 percentage points deducted from their update. It is anticipated that few, if any, HHAs will be subject to the reduction. The data HHAs will be submitting to meet the requirement will come from the current OASIS instrument, which HHAs are already required to complete under the Medicare conditions of participation. Because no new information is being collected, the DRA measure will not provide new quality information for measuring provider performance.

The aggregate margin in 2005 for freestanding HHAs was 16.7 percent (Table 3B-4). The distribution of margins in 2005 was similar to that in previous years; about 20 percent of HHAs reported negative margins, the margin was 2.3 percent at the 25th percentile, the median agency margin was 15.0 percent, and the margin was 27.3 percent at the 75th percentile. HHA margins for 2007 are projected to equal 16.8 percent.

The aggregate cost of providing an episode of home health care has increased very little over the past several years. Between 2004 and 2005, the reported average cost per episode grew by about 0.7 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 2002 to 2005—and the average number of visits has remained about the same, the average cost per visit appears to have decreased. Agencies might be reducing the length of visits, reducing overhead costs, or making other changes that reduce the cost of visits.

How should Medicare payments change in 2008?

The evidence suggests that payments for home health care are adequate to provide access to quality care.

Update recommendation

RECOMMENDATION 3B

The Congress should eliminate the update to payment rates for home health care services for calendar year 2008.

RATIONALE 3B

Our evidence suggests that there is adequate access to quality home health care for beneficiaries. The number of agencies in the program continues to rise, the number of beneficiaries using the benefit continues to increase, and the margins indicate that HHAs' payments exceed their costs. For most measures, quality continues to improve. These factors suggest that most agencies should be able to accommodate cost increases over the coming year without an increase in base payments.

IMPLICATIONS 3B

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.

Additional comments

We have noted in several past reports that the change in incentives facing HHAs after the PPS began in 2000 may have changed the relationship between case mix and costs upon which the system was built. The Commission has noted several findings that suggest the need for refinements to the home health PPS:

- 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 on average the case-mix adjustment would accurately match payments to costs.

These findings suggest that the home health PPS needs to be improved to provide appropriate incentives to providers and ensure that the system reflects the current mix of services beneficiaries use. ■

Endnotes

1 The wage index adjusts Medicare payments to reflect the local variation in labor costs. The home health prospective payment system (PPS) uses the hospital wage index values derived from hospital cost reports. Some hospitals, either through an administrative reclassification process or through an exception for urban areas with low wage index values, can be assigned a wage index from another area. The wage index for the home health PPS does not follow these exceptions and is referred to as the prefloor, prereclassified hospital wage index.

2 Partial episode payments are also made when a patient is readmitted to the same agency for a different condition within 60 days of the admission date of the previous episode.

3 An area is considered to be served if only one beneficiary received care.

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

5 The percentages cited here include only beneficiaries who had no difficulty with access, and as a result are lower than the CAHPS–FFS measure cited earlier.

6 The home health PPS increases payment for beneficiaries who need 10 or more therapy visits. These increases range from about $600 to $2,640 per episode.

7 The episode per beneficiary calculations are for a different period, 2002 through 2005, because claims data for 2006 are not yet available.

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