

DECEMBER 2014

REPORT TO THE CONGRESS

Impact of Home Health
Payment Rebasing on
Beneficiary Access to
and Quality of Care

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Payment Rebasing on
Beneficiary Access to
and Quality of Care**

MEDPAC Medicare
Payment Advisory
Commission

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Acknowledgments

The Commission benefited from the individuals who generously offered their time and knowledge. Our thanks to the following: Mara Benner, William Dombi, Tracey Moorhead, and Laurence Wilson. The Commission would also like to thank Hannah Fein and Melissa Lux for their help editing this report.

Executive summary

Executive summary

In 2014, pursuant to the Patient Protection and Affordable Care Act (PPACA), Medicare implemented the first of four years of base-payment reductions in its home health prospective payment system (PPS). This “rebasings” is intended to address the overpayments for home health services Medicare has paid since the home health PPS began operation in 2000. PPACA also required the Medicare Payment Advisory Commission (MedPAC, or “the Commission”) to assess the impact of these payment changes on quality of and beneficiary access to home health care. As part of this assessment, the statute required the Commission to consider the impact on care delivered by rural, urban, nonprofit, and for-profit home health agencies.

In 2010, the Commission recommended that Medicare lower home health payments to make them more consistent with costs. Medicare margins of home health agencies averaged 17.2 percent annually from 2001 through 2012, equaling 14.4 percent in 2012. The PPACA rebasing provision lowers payments from 2014 through 2017, but it differs from the Commission’s recommendation. The PPACA rebasing adjustment is phased in over four years and offset by the annual payment update, which varies from 2.2 percent to 2.5 percent per year (these updates include productivity reductions in PPACA that lower the update beginning in 2015). The Commission’s recommendation did not offset the rebasing with updates and had a shorter implementation period.

In 2013, CMS promulgated regulations detailing how the PPACA rebasing provision would be implemented. CMS announced that the per episode base rate would be reduced by \$81 for each of the statutorily specified four years. (Medicare’s average payment for a home health care episode in 2012 was \$2,900.) These reductions will be partially offset by the payment update each year, which will add back \$66 on average each year, resulting in a net payment reduction ranging from 0.4 percent to 0.6 percent in each year of the transition. Across all four years, the cumulative net reduction equals 2 percent, or about \$58 per episode. This reduction is small by historical standards; at different points in the past, the home health base rate has been reduced by 3 percent per year or more, without a noticeable effect on beneficiary access and quality of care, or on home health agencies’ financial performance under Medicare. The estimate does not include the effects of budget-neutrality adjustments for changes to the wage index and case-mix weights that will raise the base rate in 2015—policies separate from rebasing. With these adjustments, the base rate in 2017 will be higher than the base rate in effect before rebasing began.

This mandated report is due before claims or quality data will be available to allow us to directly assess the impact of rebasing. Therefore, we examined data from 2001 through 2012 to assess whether past changes in the average payment per home health episode had an effect on quality and access for beneficiaries. A review of access measures indicates that past payment reductions did not have a significant impact on access to care. Over 99 percent of beneficiaries lived in a ZIP code that had at least one active home health agency (HHA) in 2012, and the number of agencies doubled between 2001 and 2012 (the increase was mostly in for-profit agencies). Aggregate volume of home health services more than doubled between 2001 and 2012. From 2001

through 2010, episode volume for urban, rural, for-profit, and nonprofit providers grew on a per beneficiary basis. These increases in utilization occurred in years in which the average episode payment decreased as well as years in which the average payment increased. In 2011 and 2012, episodes per 100 beneficiaries declined slightly, as did average payment per episode. However, these declines in utilization came after aggregate home health volume more than doubled from 2001 through 2010. In addition, the slowdown on a per beneficiary basis coincided with an economy-wide slowdown in health care spending (including other public and private programs); a decline in Medicare inpatient hospital admissions, which create demand for post-acute home health care; and Medicare's tightening of program integrity controls. Even if these factors do not affect home health care use in the future, the size of the remaining rebasing adjustments are modest enough that their impact on utilization between 2016 and 2017 is likely to be small.

From 2003 through 2012, trends for three quality measures suggest that payment changes during this period did not have a significant effect on quality; these findings were consistent across ownership categories (for profit and nonprofit) and geographic areas (rural and urban). Nonprofit agencies performed slightly better on the quality measures. During this period, HHAs' overall rate of unexpected hospitalization during the home health episode—an indicator of poor quality—remained steady at about 28 percent, while average payment per episode increased in most years. This finding suggests that hospitalization rates were not sensitive to changes in payments—that is, the higher payments to HHAs did not lead to fewer hospitalizations. Also during this period, performance on two measures of functional outcomes for HHA patients—the share of patients demonstrating improvement in walking and the share of patients demonstrating improvement in transferring (such as moving themselves from a bed to a chair)—generally increased. These increases in quality occurred in years in which the average payment per episode decreased as well as years in which the average payment per episode increased, suggesting that changes in payment have little direct relationship to rates of functional improvement.

In short, the payment reductions that occurred in selected years between 2001 and 2012 did not have a negative effect on home health quality or beneficiary access to care. This finding is consistent with our prior work. The Commission's annual payment adequacy reviews during this period generally concluded that access to care and quality of care were adequate, and payments were more than adequate in most years. Empirical data on the effects of the payment rebasing called for by PPACA do not yet exist, and the Commission will continue to review access to care and quality as data for additional years become available. However, experience suggests that the small PPACA rebasing reductions will not change average episode payments significantly. Home health agency margins are likely to remain high under the current rebasing policy, and quality of care and beneficiary access to care are unlikely to be negatively affected. ■

**Impact of home health payment
rebased on beneficiary access to
and quality of care**

Introduction

In 2014, pursuant to the Patient Protection and Affordable Care Act (PPACA), Medicare implemented the first of four years of base payment reductions in its home health prospective payment system (PPS). This “rebasement” is intended to address the high payments for home health services since the home health PPS began in 2000. PPACA also required the Medicare Payment Advisory Commission (MedPAC, or “the Commission”) to assess, by January 1, 2015, the impact of these payment changes on quality of and beneficiary access to home health care. As part of this assessment, the statute required the Commission to consider the impact on care delivered by rural, urban, nonprofit, and for-profit home health agencies.

Medicare home health care comprises skilled nursing services, physical therapy, occupational therapy, speech therapy, aide services, and 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 skilled care to treat their illnesses or injuries and must be unable to leave their homes without considerable effort. Medicare requires that a physician certify a patient’s eligibility for home health care and that a patient receiving service be under the care of a physician. In contrast to coverage for skilled nursing facility services, Medicare does not require a preceding hospital stay to qualify for home health care.

Medicare pays for home health care in units of 60-day episodes. Payments for an episode are adjusted for patient severity based on patients’ clinical and functional characteristics and some of the services they use. If beneficiaries need additional covered home health services at the end of the initial 60-day episode, another episode commences and Medicare pays for an additional episode. Coverage for additional episodes generally has the same requirements (e.g., the beneficiary must be homebound and need skilled care) as the initial episode. Payments for episodes in rural areas receive a 3 percent payment increase in 2010 through 2015.

Home health margins—essentially the difference between providers’ costs for providing care and Medicare’s payments to providers—have been very high for freestanding home health agencies (HHAs) since the PPS was implemented in 2000; between 2001 and 2012, Medicare margins averaged 17.2 percent. These high margins likely have encouraged the entry of new HHAs into the program; supply has increased by an average of over 500 HHAs per year since 2002. The high margins have led the Commission to recommend that home health rates be lowered to a level consistent with costs (Medicare Payment Advisory Commission 2014).

Margins may be even higher than the Commission has reported. The margins used in reports by the Commission rely on cost and payment information reported by HHAs on their Medicare cost reports. CMS stopped routinely auditing these cost reports when the PPS was implemented in 2001, but it recently conducted an audit of a sample of HHA cost reports for 2011. The audit found that costs for that year were overstated by an average of 8 percent. Because costs were overstated, the profit margin of 15 percent reported by the Commission for 2011 was likely understated, and actual margins could have been significantly higher. Similarly, if reported costs in earlier years were overstated, the margins for these years could have been significantly higher.

Program integrity has long been a significant concern for the home health benefit, and recent developments indicate that fraud is once again a significant problem. Federal authorities have

Table 1**Impact of PPACA rebasing on home health payments for 60-day episodes**

	2014	2015	2016	2017	Cumulative change
Rebasing adjustment	-2.8%	-2.8%	-2.8%	-2.8%	-11.6%
Statutory payment update (includes impact of productivity adjustments in 2015 and later years)	2.3	2.2	2.5	2.4	9.6
Net annual payment reduction	-0.6	-0.6	-0.4	-0.4	-2
Assuming the sequester is in effect					-4*
Annual net dollar reduction to base rate	-\$16	-\$18	-\$11	-\$13	-\$58

Note: PPACA (Patient Protection and Affordable Care Act of 2010). Payment update estimates are based on the second quarter 2014 forecast of home health market basket. Effects of payment changes are multiplicative.

*Cumulative payment decline would be 4 percent in 2017 if the sequester were in effect.

Source: MedPAC analysis based on data provided by CMS.

investigated or prosecuted home health–related fraud cases for a range of alleged offenses, including billing for services not provided, attempting to bribe federal officials, and paying kickbacks to recruit patients (Department of Health and Human Services and Department of Justice 2011). The number of agencies and utilization has increased dramatically in California, Texas, and Florida—states that have documented program integrity concerns in the past. In 2013, Medicare implemented a moratorium prohibiting new agencies from entering the program in the Miami, Chicago, Dallas, Houston, and Detroit metropolitan areas.

The home health benefit provides a valuable service to beneficiaries and the Medicare program, particularly when it is an element of an efficient and coordinated care delivery system. However, the current home health payment system rewards the volume of services provided, and not the efficient use of home health care or reductions in avoidable hospitalizations. These perverse financial incentives might be addressed if the payment for and delivery of home health care in traditional fee-for-service (FFS) Medicare were more closely integrated with other sources of medical care typically provided during an episode. Payers are seeking to achieve this integration through accountable care organizations or bundled payments that link acute care (e.g., hospitalizations) and post-acute care payment.

Relative to FFS Medicare, Medicare managed care plans typically supervise home health care more closely to ensure appropriate use. For example, plans may use prior authorization to ensure that the number of visits provided during an episode is not excessive or an episode is no longer than medically necessary. Patients with unusually high home health care needs may be transitioned to a plan’s case management benefit or other intensive intervention, as opposed to remaining solely in home health care for an extended period. Plans can also be more selective about the HHAs with which they contract, narrowing their networks to focus on HHAs with better quality and other desirable characteristics. FFS Medicare lacks statutory authority to use many of the oversight tools available to private plans.

Estimated impact of rebasing on margins in 2017

CMS recently projected that the number of home health agencies (HHAs) with negative margins would increase from about 30 percent in 2011 to 43 percent in 2017 (Centers for Medicare & Medicaid Services 2013). Some industry analysts have used this projection to suggest that Medicare beneficiaries' access to home health care could worsen as a result of rebasing. However, several mitigating factors suggest that the impact will likely not be as severe as this projection or industry comments suggest.

As CMS notes, over 80 percent of the HHAs that are projected to have negative margins in 2017 already had negative margins in 2011, suggesting that rebasing is not the cause of the poor financial performance for many HHAs, and that many of them find a way to remain in operation despite reporting poor margins. Further, these projections are based on data that are known to overstate HHA costs. An audit of a sample of 2011 HHA cost reports

(continued next page)

Overview of home health care rebasing policy

PPACA includes a rebasing provision that lowered the home health base rate beginning in 2014, but it differed in several respects from the Commission's recommendation on rebasing (Medicare Payment Advisory Commission 2014). The Commission's recommendation intended rebasing to be implemented in a relatively short period (no more than two years) and eliminated the market basket payment update during the rebasing period. In contrast, PPACA phased in rebasing over four years and limited the extent to which rebasing could lower payments: The dollar amount of the reduction could not be greater than 3.5 percent of the base rate in effect for 2010. Finally, PPACA offset the rebasing adjustment in each year by continuing the market basket payment update, which varies from 2.2 percent to 2.5 percent per year (Table 1).

In 2013, CMS promulgated regulations for the PPACA rebasing provision. CMS reduced the per episode base rate by \$81 per episode in each of the statutorily specified four years. (Medicare's average payment for a full home health care episode in 2012 was \$2,900.) These reductions will be partially offset by the payment update in each year, which will add back \$66 a year on average, resulting in a net payment reduction ranging from 0.4 percent to 0.6 percent in each year of the transition. The bulk of the reductions occur in 2014 and 2015.

Across all four years, the cumulative net reduction equals 2 percent, or about \$58 per episode. This reduction is small by historical standards; at different points in the past, the home health base rate has been reduced by 3 percent per year or more, without a noticeable impact on beneficiary access and quality of care or on home health agencies' financial performance under Medicare. The estimate does not include the effect of budget neutrality adjustments for changes to the wage index and case-mix weights that raise the base rate in 2015—policies separate from rebasing. With these adjustments, the base rate in 2017 will be higher than the base rate in effect before rebasing began. While one analysis suggested that these changes are likely to significantly increase the share of agencies with negative margins, several offsetting factors suggest this may not be the case (see text box).

Estimated impact of rebasing on margins in 2017 (cont.)

found that they overstated their costs by an average of 8 percent (Morefield et al. 2013). If the margin estimates were adjusted for these errors, the share of agencies with negative margins in 2011 and 2017 would likely be significantly lower.

Other factors also would lower the share of HHAs with negative margins. As noted elsewhere in this report, agencies have been successful in raising their Medicare payments through increasing the case mix of their admitted patients and by controlling episode costs, with flat or declining costs in many years. Past experience suggests that agencies can continue to find significant efficiencies. For example, between 1998 and 2001, home health agencies reduced the number of visits per episode they provided by one-third. A reduction in cost would only have to be a fraction of this amount to offset the aggregate 2 percent payment reduction that will occur under rebasing. While it is difficult to forecast the operational changes that HHAs will make in response to rebasing, past experience suggests that agencies can and do successfully retool their practices when payments change.

In addition, the projections by CMS assume that the supply of HHAs is fixed, even though new agencies have entered the program on an ongoing basis since at least 2000. Hundreds of new agencies enter the Medicare program every year, though they are not distributed evenly throughout the country. CMS's projections also do not assume that providers with negative margins leave the program. The high levels of access in many parts of the country suggest that many agencies could leave the program without decreasing access to care. Agency turnover has occurred in the past, and access has remained at acceptable levels (Liu et al. 2003). If agencies that enter the program are profitable and agencies with lower margins depart, the share of agencies with negative margins would be lower than projected by CMS.

Current estimates of rebasing rely on assumptions about future changes in home health payments and costs. For these reasons, any projection that estimates margins six years into the future has some uncertainty associated with it. The Commission's annual payment adequacy analyses estimate margins only for the year of the report, generally projecting from cost reports from two years before. The shorter projection window allows the Commission to include the effects of policy and other technical changes that have occurred in the intervening year (2013), thus reducing the uncertainty of our projections. The Commission will continue to assess the effect of rebasing on home health payments in our future reviews of payment adequacy. ■

Framework for assessing the impact of rebasing

This mandated report is due before claims or quality data will be available to allow us to directly assess the impact of rebasing. Therefore, we examined data from 2001 through 2012 to assess whether past changes in the average payment per home health episode had an effect on quality

Table 2**Impact of past changes to the Medicare home health base payment rate and Medicare margins of freestanding home health agencies**

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Market basket reduced	•	•	•	•	•	•					•	•
Adjustment for coding increases unrelated to patient severity								•	•	•	•	
Other			•								•	
Rural add-on payment in effect	•	•	•	•	•	•	•				•	•
Net annual change in base rate	N/A	4%	-5%	2%	2%	0%	3%	-3%	0.1%	2%	-5%	-2%
Average margins for:												
All free-standing home health agencies	23.1%	17.4	15.0	17.1	17.8	16.1	16.7	17.2	17.7	19.2	14.9	14.4
Nonprofit agencies	22.5	15.8	11.9	13.5	13.6	12.1	12.0	12.8	13.7	15.4	12.0	12.0
For-profit agencies	22.5	18.8	17.0	19.2	19.7	17.8	18.6	18.8	19.0	20.4	15.8	15.2
Urban agencies	28.0	17.1	13.4	15.3	17.3	16.8	15.7	15.9	16.9	19.5	15.5	12.8
Rural agencies	21.7	17.6	15.3	16.7	17.0	16.0	17.0	17.5	17.9	19.3	14.9	14.7

Note: N/A (not applicable). "Other" includes a reduction mandated by the Benefits Improvement Act in 2003 and a base-rate reduction required by the Patient Protection and Affordable Care Act in 2011. Some adjustments applied for only a portion of a payment year. The base rate used for annual change calculation is based on the rate in effect on the last day of the payment year; it does not include the impact of rural add-on payments. The net annual change in base rate includes the effects of all administrative and statutory payment policies in effect for that year (except rural add-on payments).

Source: Medicare home health payment regulations for 2001 through 2012; MedPAC analysis of cost reports 2001–2012.

and access for beneficiaries. The Commission will continue to assess the effects of rebasing in future years as additional data become available.

Our analysis focuses on the most frequently occurring type of home health episode: the case-mix-adjusted 60-day payment episode with 5 or more home health visits. These episodes account for about 96 percent of home health episodes. The other 4 percent include outlier episodes and low-utilization payment adjustment (LUPA) episodes, which are episodes with four or fewer visits. The former are paid based on a percentage of costs incurred, and the latter are paid on a per visit basis.¹

Table 2 provides a summary of the legislative and administrative changes to the home health PPS base payment that occurred from 2001 through 2012. The market basket, which is the inflation index used to set the annual payment update, has been reduced below its statutory amount or eliminated entirely in 8 of the 12 years in this period. In addition, there have been legislative or administrative reductions in many years for efficiency and changes in coding unrelated to patient severity. Since 2011, the base rate has largely been declining because of PPACA reductions

and administrative reductions to correct increases resulting from diagnostic coding that did not reflect greater patient severity. The cumulative size of the four-year PPACA rebasing reduction is smaller than some of the single-year reductions in prior years. For example, the one-year base rate reductions in 2003, 2008, 2011, and 2012 all were larger than the aggregate four-year PPACA rebasing reduction of 2 percent. Despite these reductions, Medicare margins for freestanding HHAs averaged over 17 percent throughout this period. Across every ownership category (for profit, nonprofit, urban, and rural), HHAs had margins in these years greater than 11 percent.

The Commission's analysis of home health financial performance focuses on freestanding providers because hospital-based HHAs have costs that are obscured under hospitals' cost allocation practices and because hospitals can use their affiliated HHAs to lower their inpatient costs by discharging patients to them.

About 10 percent of episode volume is delivered by hospital-based HHAs. Hospital-based HHAs' margins have generally been lower than those of freestanding HHAs, equal to -15 percent in 2012. The lower margins of hospital-based HHAs are chiefly due to their higher costs. For example, in 2012, the average cost per skilled nursing visit was \$129 for freestanding HHAs and \$202 for hospital-based HHAs. However, the lower inpatient costs due to shorter hospital stays may more than offset any losses from hospitals operating hospital-based HHAs.

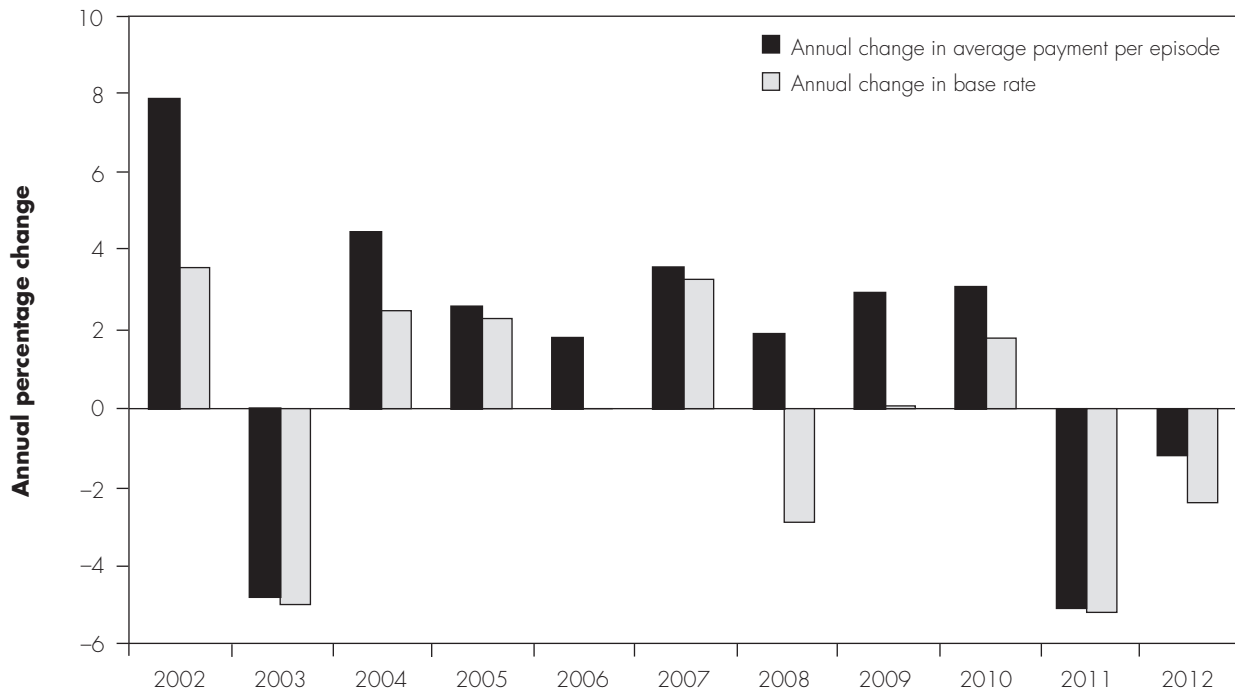
While rebasing will be implemented as a series of base-rate reductions, these reductions do not always result in a reduction to the average episode payment. In many years, increases in patient case mix and rural payment add-ons offset declines in the base rate. The average payment per episode increased in most years through 2012 (Figure 1, p. 9). For years when the base rate increased, the increase in average episode payment was generally greater than the increase in the base rate. In years when the base rate declined, the decrease in average episode payment was generally less than the decrease in the base rate.

Growth in the average episode case mix likely explains much of this trend. Across this period, the average reported case-mix relative weight increased by an average of 1.2 percent per year. In years in which the base rate increased, an increase in case mix compounded this growth and resulted in an increase to the average episode payment that was higher than the base rate increase. For example, in 2004, the base rate increased by 2.3 percent and the average episode payment increased 4.5 percent. For years in which the base rate decreased, the increase in case mix offset the base rate decrease. For example, in 2008, the base rate declined by 3 percent and the average episode payment increased by 1.9 percent.

An increase in case mix usually would be expected to reflect an increase in HHAs' costs of providing care to patients due to their higher clinical severity. However, CMS reviewed the case-mix change that occurred during this period and concluded that over 90 percent of the increase in case mix was due to changes in agency coding practices and did not reflect an actual increase in patient severity (White et al. 2009). This finding suggests that the higher payments for increased case mix were not compensating agencies for an increase in costs associated with increases in patients' severity of illness, but instead offset reductions to the base rate. In recent years, CMS has implemented payment reductions to adjust for the unwarranted growth in patient case mix,

Figure 1

Annual changes in Medicare home health base payment rate and average payment per episode



Source: Home health standard analytic files 2001 through 2012; Medicare home health prospective payment system payment regulations for payment years 2001 through 2012.

but even with these reductions, freestanding HHAs in 2011 and 2012 had Medicare margins averaging 14.9 percent and 14.4 percent, respectively.

The past experience of base rate reductions suggests that the small declines in payments that will occur under the PPACA rebasing may be mitigated by future increases in the case-mix index. Agencies can affect their patient case mix two ways: by coding more diagnostic conditions or increasing the number of therapy visits provided. In 2010, CMS implemented restrictions intended to make it more difficult to increase therapy visits, but the percentage of episodes that included therapy visits continued to rise. In our March 2011 report to the Congress, the Commission recommended that Medicare eliminate the number of therapy visits provided in an episode as a factor in determining payment for that episode and base payment solely on patient characteristics. The ICD-10 coding system, when implemented, may provide additional opportunities for an increase in coded severity. Even a modest increase in case mix would offset the small PPACA payment reductions.

Most studies of the impact of payment changes on quality of and access to home health care have focused on payment reductions implemented in the 1997 Balanced Budget Act (BBA). As a bridge to the establishment of the home health PPS in October 2000, the BBA included an interim payment system (IPS) that set strict per beneficiary limits on spending, which began in October

1997. These limits had a significant and immediate effect on spending: By the second year of IPS, in 1999, spending had fallen by 50 percent to about \$8.5 billion. Between 1997 and 2000, the number of users dropped by 1 million beneficiaries, and the number of visits declined from 258 million to 90 million. However, these declines should be seen in the context of the problematic utilization trends that preceded the IPS. Between 1990 and 1995, the number of users increased by 75 percent and the number of visits more than tripled. Between 1990 and 1995, spending increased over 30 percent annually, from \$3.7 billion to \$15.4 billion. As the rates of use and lengths of stay increased, there was concern that the benefit was serving more as a long-term care benefit rather than the intended post-acute care benefit (Government Accountability Office 1996). Given the spike in utilization rates during these years, it is not surprising that the IPS resulted in widespread home health utilization declines but did not disproportionately affect select groups (Brookhart et al. 2010, Liu et al. 2003, McCall et al. 2003).

Studies also found that utilization declines resulting from IPS payment reductions did not adversely affect the quality of care beneficiaries received (Medicare Payment Advisory Commission 2004). Findings from surveys of patient satisfaction with home health services in this period were mostly unchanged relative to pre-IPS surveys (McCall et al. 2003, McCall et al. 2004). An analysis of all the BBA changes related to post-acute care, including the home health IPS and changes for other post-acute care sectors, concluded that the rate of adverse events generally improved or did not worsen when the IPS was in effect (McCall et al. 2003). This experience with reduced home health payments suggests that the small declines in payment from current PPACA rebasing provisions may not significantly affect quality.

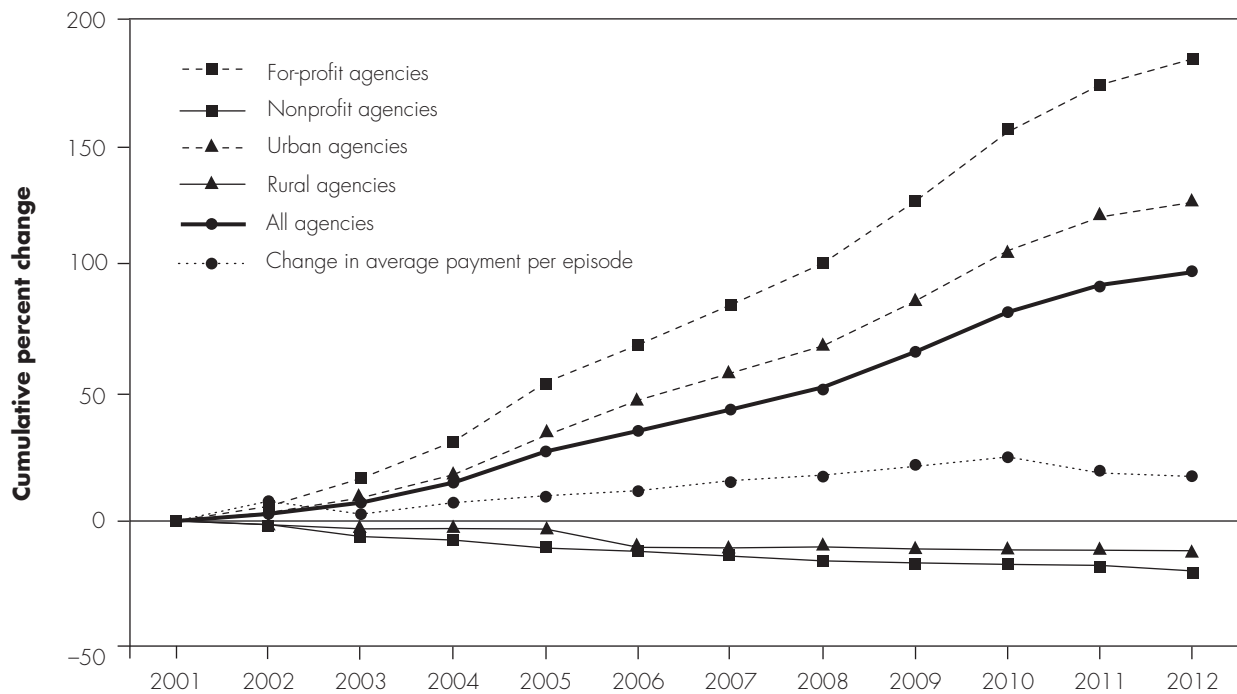
The Commission's past payment adequacy assessments find no impact on beneficiary access or care quality from changes in home health payment under the PPS

The Commission assesses payments, access, and quality of home health care as a part of its annual review of payment adequacy. Since 2001, measures of payment adequacy—supply of agencies, trends in volume of episodes, and quality-improvement trends—have generally been positive for the industry.

Changes in the supply of agencies

The trends in agency supply have been consistent across the years, regardless of the change in average payment per episode (Figure 2). Between 2001 and 2012, the number of for-profit HHAs increased by 184 percent, or by more than 6,200 HHAs. The numbers of nonprofit HHAs declined every year, but the annual increase in the numbers of for-profit HHAs more than offset this decline. The growth in agencies generally has been concentrated in a few areas, with agencies in Texas and Florida accounting for a disproportionate share of new agencies. Overall, access to home health care remained relatively high throughout this period: In every year since 2003, 99 percent of beneficiaries have lived in a ZIP code served by a home health agency, with many living in an area with multiple agencies. For example, 84 percent of beneficiaries lived in a ZIP code served by five or more home health agencies in 2012.

HHAs are unique in that they can serve both urban and rural service areas. For this analysis, we have identified agencies' locations using the county in which their headquarters are located. On

Figure 2**Cumulative change in agency supply and payment, 2001–2012**

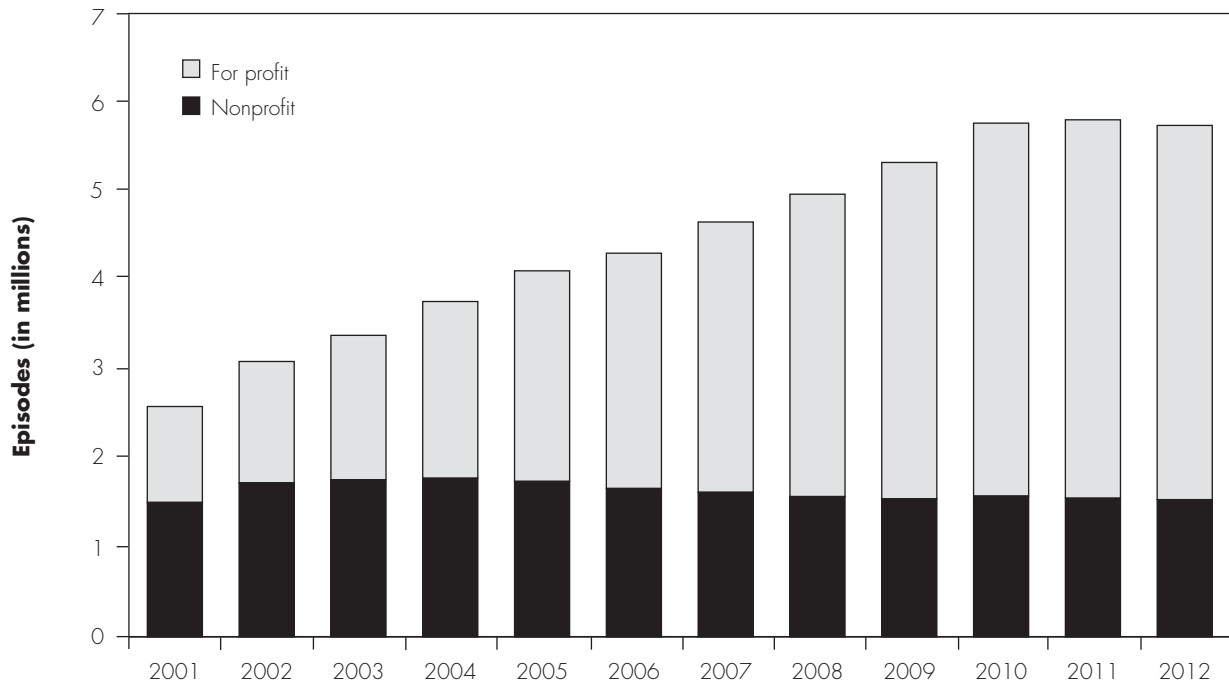
Source: Home health provider of services file and home health standard analytic files 2001–2012.

this basis, the number of HHAs in urban areas has increased while the number in rural areas has decreased. However, many agencies headquartered in urban areas serve adjacent rural areas. For example, freestanding HHAs headquartered in urban counties in 2012 delivered more than 300,000 episodes to beneficiaries residing in adjacent rural counties. During the 2001 through 2012 period, the number of episodes provided in rural areas has more than doubled.

Trends in episode volume

Between 2001 and 2011, total episode volume more than doubled, reaching 5.8 million episodes, with a small decline in 2012 (Figure 3, p. 12).² Almost all of the growth was in episodes delivered by for-profit agencies. Rising utilization reflects a combination of an increase in the number of FFS beneficiaries using home health care and the number of episodes each user received. During this period, the share of FFS beneficiaries receiving home health care increased from 5.1 percent to 7.8 percent, and the average number of episodes per user increased from 1.4 to 1.8.

In 2012, there was a slight decline compared with the prior year in both the number of episodes and the number of beneficiaries using home health, but this decline was concentrated in five states where the number of HHAs has grown substantially in the last 12 years: Florida, Texas,

Figure 3**For-profit episodes grew significantly from 2001 through 2012**

Note: Includes non-low-utilization payment adjustment, non-outlier 60-day home health episodes provided by for-profit and nonprofit agencies.

Source: Home health standard analytic files 2001–2012.

Louisiana, Oklahoma, and Mississippi. Even with this decline, these states averaged 33 episodes per 100 beneficiaries in 2012, nearly double the national average.

Episodes provided by for-profit agencies accounted for most of the growth in home health volume from 2001 through 2012 (Figure 3). The total number of episodes provided by for-profit agencies almost tripled, while the number of episodes provided by nonprofit providers increased from 2001 through 2004 and then declined slightly, for a cumulative increase of 2 percent through 2012 (Table 3, p. 13). Between 2001 and 2012, the share of episodes provided by for-profit HHAs increased from 42 percent to 73 percent, while nonprofit HHAs experienced a corresponding decline from 58 percent of volume to 27 percent. The majority of for-profit HHAs are freestanding, so the for-profit episode growth also shifted volume to freestanding HHAs from facility-based providers; during that period, the share of episodes provided by freestanding HHAs increased from 68 percent to 90 percent.

An examination of nonprofit trends by facility type indicates that these providers experienced a similar shift in volume toward freestanding HHAs. From 2001 through 2012, episodes per 100 beneficiaries increased for freestanding nonprofit HHAs by 45 percent; conversely, use of facility-based nonprofit HHAs decreased by 30 percent. During this period, the share of episodes provided by nonprofit freestanding HHAs increased from 50 percent to 67 percent. While overall

Table 3**Change in home health use by area and provider type, 2001–2012**

	2001				
	All	Nonprofit	For profit	Urban	Rural
Total episodes (millions)	2.6	1.5	1.1	1.9	0.6
Episodes per 100 FFS beneficiaries	7.2	4.2	3.0	7.1	6.7
Share of home health users per 100 FFS beneficiaries	5.1%	3.1%	2.0%	5.1%	4.2%
Episodes per user	1.4	1.4	1.6	1.4	1.6
	2012				
Total episodes (millions)	5.8	1.5	4.2	4.5	1.2
Episodes per 100 FFS beneficiaries	14.5	3.9	10.6	14.3	13.8
Share of home health users per 100 FFS beneficiaries	7.8%	2.7%	5.1%	7.8%	6.6%
Episodes per user	1.8	1.4	2.1	1.8	2.0
	Cumulative change (in percent)				
Total episodes (millions)	122%	2%	290%	131%	111%
Episodes per 100 FFS beneficiaries	100	-8	251	101	102
Share of home health users per 100 FFS beneficiaries	53	-13	162	53	55
Episodes per user	30	6	26	31	30

Note: FFS (fee-for-service). Data are for non-low-utilization payment adjustment, non-outlier episodes. The share of home health users per 100 beneficiaries and episodes per user for the urban and rural averages has been calculated using the total number of FFS beneficiaries residing in these areas in a given year. The share of home health users per 100 beneficiaries and episodes per user for the for-profit and nonprofit averages has been calculated using the total number of beneficiaries enrolled in FFS Medicare in a given year.

Source: Home health standard analytic file 2001 and 2012; Medicare Master Beneficiary Record 2001 and 2012.

utilization measured in episodes provided by nonprofit HHAs appears mostly unchanged in this period, episode volume grew significantly for freestanding HHAs, similar to growth experienced by for-profit HHAs.

The growth in the number of beneficiaries using home health care and the number of episodes per user was much higher for for-profit HHAs relative to nonprofit HHAs. For example, between 2001 and 2012, the number of home health care patients per 100 Medicare FFS beneficiaries served by for-profit HHAs increased 162 percent, and the average number of episodes per user provided by these HHAs increased 26 percent (Table 3). Urban and rural areas generally had comparable levels of utilization, and episode volume during this period increased for both areas by more than 100 percent. Urban and rural areas also had similar rates of growth in the share of home health users per 100 FFS beneficiaries and episodes per user.

The rise in episode volume coincides with a shift away from the home health benefit's intended use as a post-acute care (PAC) service. From 2001 through 2011, the number of community-

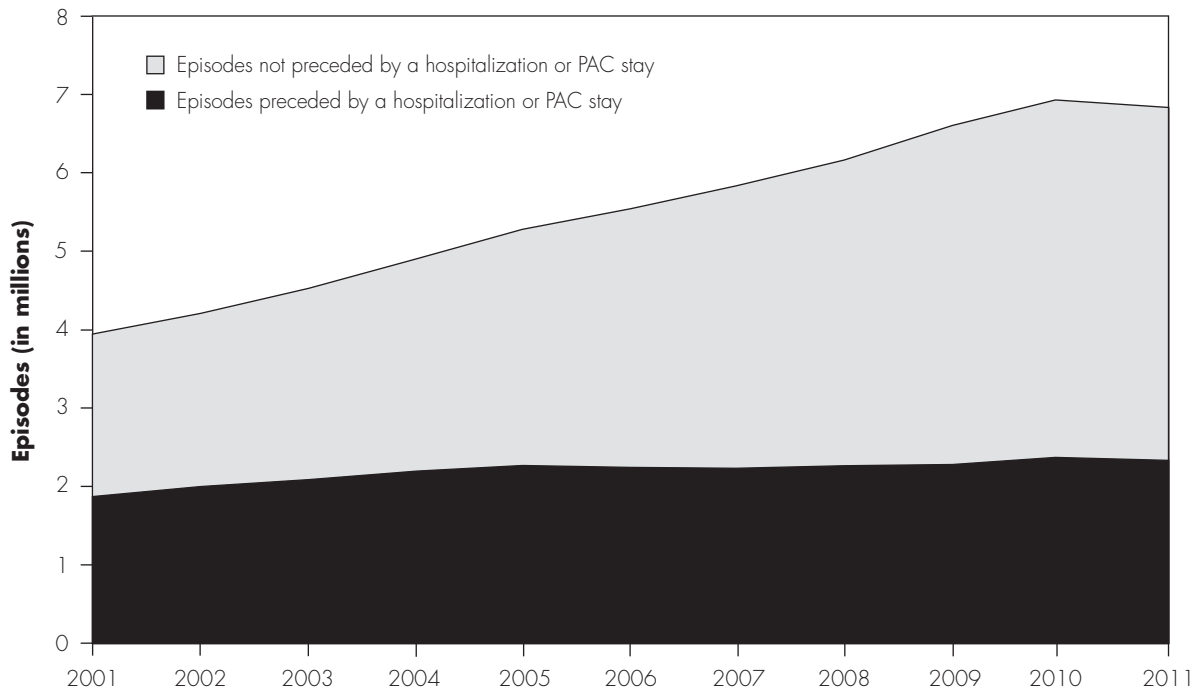
Utilization and clinical attributes of beneficiaries using home health as a post-acute service versus community-admitted beneficiaries

The rapid rise in episodes not immediately preceded by a hospitalization led the Commission to examine the characteristics of beneficiaries based on how they most frequently used home health care (Figure 4). For this analysis, we classified beneficiaries into two user categories: post-acute care (PAC) users, defined as beneficiaries for whom the majority of home health episodes in 2010 were preceded by a hospitalization or other PAC stay, and community-admitted users, defined as beneficiaries for whom the majority of episodes for 2010 were not preceded by a hospital or PAC stay.

The differences between these beneficiary user categories suggest that Medicare's home health benefit serves two distinct populations. In 2010, PAC users averaged 1.4 episodes,

Figure 4

Home health episodes not preceded by a hospitalization or PAC stay account for the majority of volume growth



Note: PAC (post-acute care). "Episodes preceded by a hospitalization or PAC stay" indicates that the episode occurred less than 15 days after a stay in a hospital (including a long-term care hospital), skilled nursing facility, or inpatient rehabilitation facility. "Episodes not preceded by a hospitalization or PAC stay" indicates that there was no hospitalization or PAC stay in the 15 days before the episode started.

Source: 2011 CMS Datalink file.

(continued next page)

Utilization and clinical attributes of beneficiaries using home health as a post-acute service versus community-admitted beneficiaries (cont.)

while community-admitted users averaged 2.6 episodes. About 42 percent of the episodes provided to community-admitted users were for dual-eligible Medicare and Medicaid beneficiaries; in contrast, the comparable share for PAC users was 24 percent. Community-admitted users also had a larger share of episodes with high numbers of visits from home health aides; for example, aide services were the majority of services provided in 11 percent of the episodes for community-admitted users compared with 4 percent for PAC users. Community-admitted users generally had fewer chronic conditions, tended to be older, and had a higher rate of dementia and Alzheimer's disease. The high share of community-admitted users who were also Medicaid eligible suggests that some of this utilization could have been due to state Medicaid programs leveraging the Medicare home health benefit to provide long-term care. Under this practice, states shift the costs of at least some of their long-term care expenses to the Medicare program. ■

admitted episodes (those episodes not preceded by a hospitalization or PAC stay) increased by 117 percent, compared with a 25 percent increase in episodes that were preceded by a hospitalization or PAC stay. During that period, the share of all episodes not preceded by a hospitalization or PAC stay rose from about 53 percent to 66 percent. For-profit episodes accounted for most of the growth in community-admitted episodes. (See text box for discussion of characteristics of community-admitted and post-acute home health patients.)

The starkly higher rates of growth and average levels of service provided by for-profit agencies coincided with a period of rapid growth in the supply of these agencies. The timing of these trends suggests that for-profit agencies facilitated growth primarily through increasing the number of beneficiaries served by home health care, though a growth in the average number of episodes per user also contributed.

The home health industry has shifted from one primarily served by nonprofit providers to one dominated by for-profit HHAs, with a corresponding shift in volume from facility-based providers to freestanding HHAs. In addition, the benefit shifted from primarily providing posthospital episodes to providing mostly community-admitted episodes. Throughout these changes, access appears to have remained high. The supply of HHAs and the number of episodes increased in most years during this period, and the Commission's annual payment adequacy reviews concluded that access to care remained adequate.

No correlation found between Medicare payment changes and access changes from 2001 through 2012

Between 2001 and 2012, most agencies exhibited the same trends in the annual change in payment per episode. Average episode payment decreased in three years (2003, 2011, and 2012) and increased in all other years. The exception to these trends was nonprofit agencies, which

Table 4**Change in average payment per episode and episodes per 100 beneficiaries for all home health agencies**

Year	Annual percent change in average payment per episode	Annual percent change in episodes per 100 beneficiaries	Medicare margin for freestanding agencies
2002	7.9%	16.2%	17.4%
2003	-4.8	7.3	15.0
2004	4.5	9.6	17.1
2005	2.6	7.8	17.8
2006	1.8	7.7	16.1
2007	3.6	8.8	16.7
2008	1.9	7.3	17.2
2009	3.0	7.1	17.7
2010	3.1	6.7	19.2
2011	-5.1	-1.8	14.9
2012	-1.2	-3.4	14.4

Note: Data are for non-low-utilization payment adjustment, non-outlier episodes.

Source: Home health standard analytic file 2001 through 2012; Medicare Master Beneficiary Record 2001 through 2012; cost reports 2001 through 2012.

experienced a payment increase in 2012 that was a result of changes in the case-mix relative weights for that year.³

From 2002 through 2010, episodes per 100 beneficiaries increased overall, regardless of whether the average payment per episode increased or decreased, and declined in 2011 and 2012 (Table 4). Though the aggregate declines for all HHAs in episodes per 100 beneficiaries in 2011 and 2012 is coincident with a reduction in average payment per episode, this drop was concentrated in states with the highest utilization rates—Texas, Louisiana, Oklahoma, Mississippi, and Florida. For example, without these five states, the overall change in episodes per 100 beneficiaries in 2012 is only -1.3 percent (compared with -3.4 percent when these areas are included).

It is likely that factors other than payment contributed to the decrease in utilization in 2011 and 2012. Nationwide, spending for all health care (including both public and private payers) slowed during 2011 and 2012, with the rate of increase in economy-wide health care spending lower than the entire U.S. economy's growth rate in both years. In addition, certain factors unique to Medicare home health care may have led to the decline in the average number of episodes per

Table 5**Annual change in average payment per home health episode and episodes per 100 beneficiaries, by ownership**

Year	For profit		Nonprofit	
	Percent change in average payment per episode	Percent change in episodes per 100 beneficiaries	Percent change in average payment per episode	Percent change in episodes per 100 beneficiaries
2002	8.5%	23.0%	7.2%	11.3%
2003	-5.4	16.6	-4.7	-0.1
2004	3.4	20.5	5.0	-0.4
2005	2.2	17.8	2.6	-3.1
2006	1.8	14.9	1.4	-1.9
2007	3.5	15.6	3.3	-2.0
2008	0.6	12.5	4.4	-2.4
2009	3.3	11.2	2.0	-1.6
2010	3.4	9.3	2.0	0.4
2011	-5.1	-1.0	-5.1	-3.9
2012	-2.2	-3.4	1.7	-3.3

Note: Data are for non-low-utilization payment adjustment, non-outlier episodes.

Source: Home health standard analytic file 2001 through 2012; Medicare Master Beneficiary Record 2001 through 2012.

100 beneficiaries in those two years. In 2010, the Department of Justice and other enforcement agencies started new investigative efforts to scrutinize home health care (which included areas in the five states with the highest rates of utilization growth). In 2011, Medicare implemented a PPACA requirement that physicians have a face-to-face examination with a beneficiary before authorizing home health care. Finally, Medicare inpatient hospital discharges, which are an important source of home health care patients, had been declining since 2009 and may account for part of the drop in demand for home health care. These trends may have curbed growth in episodes per 100 beneficiaries in later years.

Comparing trends in access and payment for nonprofit and for-profit HHAs

From 2002 through 2010, episode volume growth on a per beneficiary basis was higher for for-profit HHAs compared with nonprofit HHAs (Table 5). This growth occurred regardless of the direction of the change in average episode payment in a year. In 2011 and 2012, episode volume growth for for-profit HHAs fell by 1 percent and 3.4 percent, respectively, on a per beneficiary basis, but these declines were concentrated in a handful of states. If the five states with the largest drop in episodes in 2012 were removed from the analysis, the declines in episodes per 100

beneficiaries provided by for-profit agencies falls to 0.6 percent in 2011 and 0.9 percent in 2012 for the remaining 45 states.

Episode volume for nonprofit HHAs also did not appear to fluctuate with changes in payment in most years during this period. The trend in episodes per 100 beneficiaries was flat or declined in most years after 2003, regardless of whether average payment per episode increased or decreased. Between 2001 and 2012, the overall episode volume for nonprofit HHAs increased by 2 percent; the per beneficiary rates for nonprofit HHAs declined because the beneficiary population grew by more than 2 percent during this period. Most notably, nonprofit HHAs were the only category to experience an increase in average payment per episode in 2012, and even with this payment increase, both per beneficiary and aggregate volume fell slightly. The declines in 2011 and 2012 were lower if the five states mentioned earlier are excluded, to -3.2 percent and -1.8 percent, respectively.

Comparing trends in access and payment in urban and rural areas

Urban and rural areas generally had the same trends in annual change in episodes per 100 FFS beneficiaries and annual change in average payment per episode. The number of per capita episodes increased every year from 2002 through 2010, regardless of whether average payments per episode increased, decreased, or were flat (Table 6, p. 19). Similarly, urban and rural HHAs both exhibited small declines in these rates after the peak in 2010. As with the ownership results, the magnitude of the decline in the number of episodes per capita in 2012 falls to -1.6 percent for urban and rural areas if the five states with the greatest drop in utilization are removed from the analysis.

To determine whether trends in rural areas with relatively few HHAs differed from trends in other rural areas, our analysis also considered changes in average episode payment and episodes per 100 beneficiaries for rural counties with 3 or fewer HHAs (about 100 counties in any given year in this period). The average annual number of episodes per beneficiary and other measures of utilization were generally lower in these counties, but the annual rates of change in average episode payment and per beneficiary utilization were commensurate with the change in payment for the other counties.

These results suggest that factors other than the PPACA-mandated rebasing likely will have a greater influence on access to care between 2015 and 2017. Even if the nonpayment factors (the recent slowdown in health care spending; efforts to reduce fraud, waste, and abuse; and the decline in Medicare inpatient discharges) do not affect utilization in the future, the size of the rebasing payment reductions is small enough (0.6 percent or less per year) that their impact on utilization between 2015 and 2017 is likely to be minor. Other efforts to expand or reduce the volume of home health services may have a greater impact. For example, for some time the Commission has been concerned about certain areas' high rates of utilization that are suggestive of misuse of the home health benefit. If Medicare expands its program integrity efforts, as the Commission has recommended, inappropriate levels of utilization could be reduced substantially, with no effect on access for legitimate patient need. Similarly, a continued decline in inpatient hospital use, a source of home health utilization, could also result in lower home health care utilization levels that would be unrelated to necessary patient care. Structural health care reforms,

Table 6**Annual change in average payment per episode and episodes per 100 beneficiaries, by geography**

Year	Urban		Rural	
	Percent change in average payment per episode	Percent change in episodes per 100 beneficiaries	Percent change in average payment per episode	Percent change in episodes per 100 beneficiaries
2002	7.2%	16.7%	7.9%	16.4%
2003	-4.1	7.9	-4.8	6.8
2004	4.7	9.3	4.5	8.7
2005	3.0	8.9	2.6	9.8
2006	1.3	7.9	1.8	8.8
2007	4.3	8.7	3.6	10.0
2008	2.3	7.3	1.9	7.4
2009	2.9	7.3	3.0	8.5
2010	2.6	7.4	3.1	4.9
2011	-5.3	-1.9	-5.1	-2.9
2012	-1.2	-5.7	-1.2	-3.1

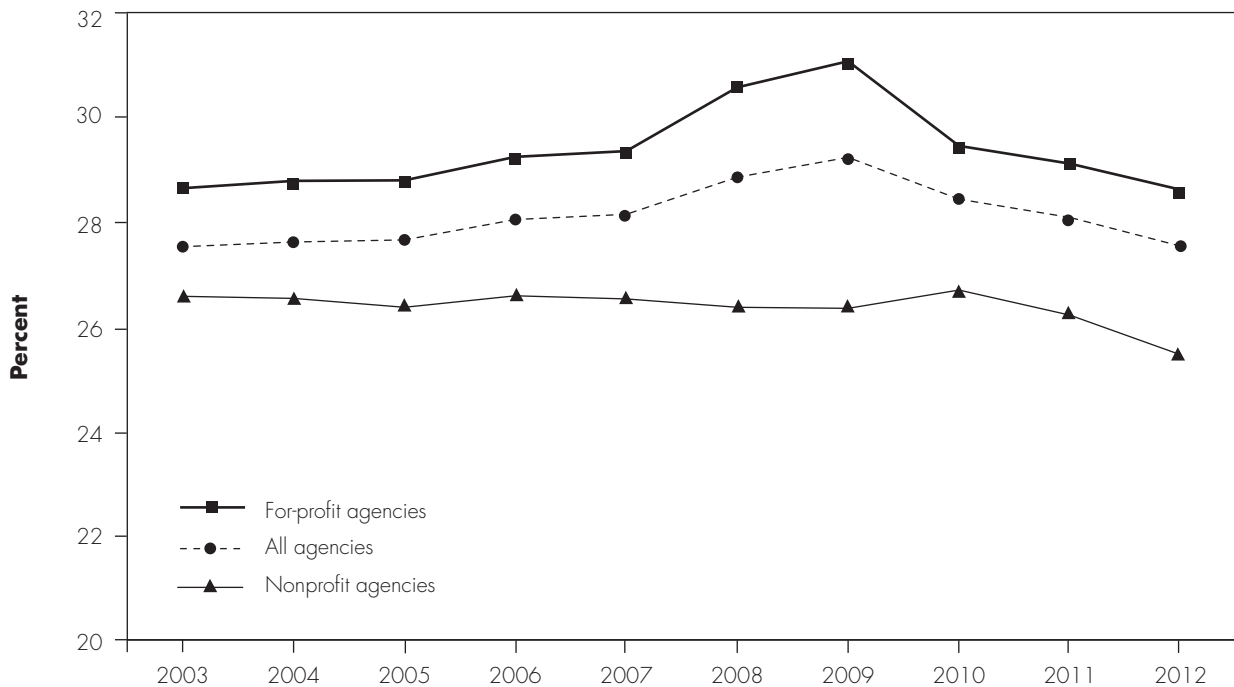
Note: Data are for non-low-utilization payment adjustment, non-outlier episodes. The per beneficiary statistics were computed separately using the number of fee-for-service beneficiaries residing in each geographic classification.

Source: Home health standard analytic file 2001 through 2012; Medicare Master Beneficiary Record 2001 through 2012; cost reports 2001 through 2012.

such as accountable care organizations (ACOs), could also affect Medicare beneficiaries' use of home health care. ACOs have cost and quality targets that encourage them to use services more efficiently while maintaining or increasing quality of care—incentives that HHAs lack under Medicare's FFS payment system. Under an ACO structure, home health use could decline in areas where utilization growth has historically been too high. Alternatively, ACOs could determine that properly targeted home health services could be an effective way to serve beneficiaries residing in the community.

No correlation found between Medicare payment changes and performance on quality measures between 2003 and 2012

If historical home health payment reductions had an effect on quality, we would expect to find a relationship between past payment decreases and Medicare's existing measures of quality. Since 2003, Medicare has reported quality measures for home health care through Home Health Compare. For this analysis, we focused on certain measures to see whether a pattern emerged

Figure 5**Hospitalization rate by home health agency ownership type, 2003–2012**

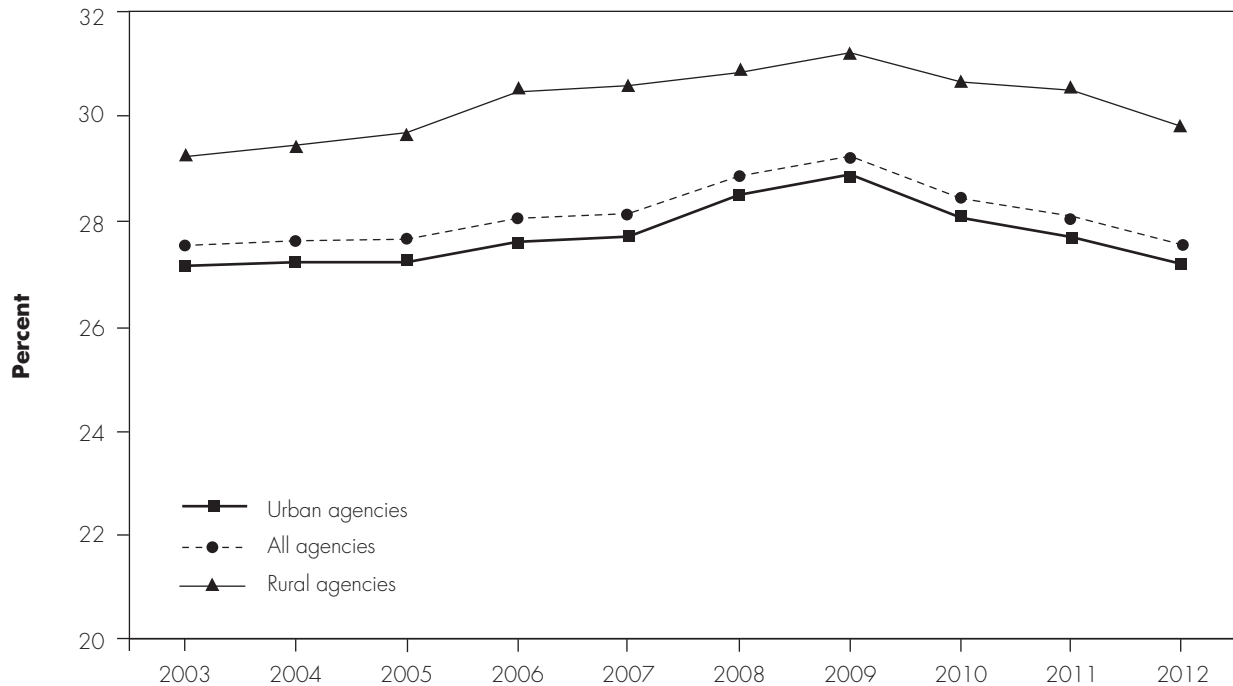
Source: Home Health Compare.

between changes in these measures and changes in payment between 2003 and 2012. The quality measures we examined for this period were:

- hospitalization rates: the share of patients experiencing an unexpected hospitalization while under the care of a home health agency⁴, and
- two functional measures: the share of patients who demonstrated improvements in their ability to walk or transfer (such as getting out of bed).

We adjusted these measures to account for differences in patient demographics and severity of illness.⁵

Between 2003 and 2012, HHAs' overall rate of hospitalizations for Medicare patients under their care was unchanged. Nonprofit agencies performed slightly better and had lower rates of hospitalization.⁶ Coincidentally, hospitalization rates for for-profit HHAs increased in 2008 and 2009—years in which the average payment also increased—and decreased in 2010—a year in which the average payment decreased. By 2012, the hospitalization rate for for-profit HHAs, which experienced the greatest increase in average payment in this period, was unchanged—about equal to the 2003 rate of 28.6 percent. The rate for nonprofit HHAs was unchanged for most of the period, though the rate declined in 2011 and 2012 (Figure 5). Hospitalization rates for urban and rural HHAs peaked in 2009 before dropping back to a level close to the 2003 rate (Figure 6), similar to the pattern exhibited by for-profit HHAs. Across all ownership

Figure 6**Hospitalization rate by home health agency
urban/rural designation, 2003–2012**

Source: Data from the University of Colorado.

categories, changes in the hospitalization rate did not exhibit any clear link to lower payments. The hospitalization rates were steady in many years of payment increases: For-profit HHAs' rate spiked in two years when the average payment increased, and nonprofit HHAs' rate declined in two years when the average payment decreased.

Similarly, for the 2003–2012 period, Medicare's HHA payments and functional measures of quality were not positively correlated (Figure 7, p. 23). The functional measures exhibited small but consistent annual increases in most years (Table 7 and Table 8, p. 22).⁷ Nonprofit HHAs performed modestly better than for-profit HHAs on both functional measures in most years. In the two years in which the average payment per episode declined, 2011 and 2012, the share of patients improving on the functional measures rose for all HHA ownership categories.

These data have some limitations. Due to sample-size issues, they are not available for small HHAs (those billing for fewer than 20 episodes of care in a year). The functional data exclude the 28 percent of cases that ended in hospitalization because in these cases there was no opportunity to assess a patient's functional status at the termination of their episode of care.

These findings are consistent with the finding that the IPS payment reductions, which were much steeper than subsequent statutory and administrative reductions, did not reduce the quality of care. They also suggest that payment has little direct effect on quality and that quality will not

Table 7**Improvement in transferring for home health patients at discharge, 2003–2012**

Year	Share of all patients reporting improvement in transferring				
	All	Urban	Rural	For profit	Nonprofit
2003	49.1%	49.1%	49.0%	47.6%	50.1%
2004	51.1	51.1	51.3	49.6	52.3
2005	51.8	51.7	52.0	49.6	53.8
2006	52.7	52.6	52.9	50.7	54.8
2007	52.8	52.7	53.4	51.0	55.0
2008	52.6	52.7	52.4	51.0	54.8
2009	53.1	53.1	53.1	51.4	55.7
2010	52.8	52.7	53.1	51.3	55.1
2011	53.5	53.4	53.6	51.8	56.4
2012	54.6	54.5	55.1	52.8	57.8

Source: Data from the University of Colorado. In 2010, the scale for measuring the ability to transfer was altered, and the measure is not comparable to prior years.

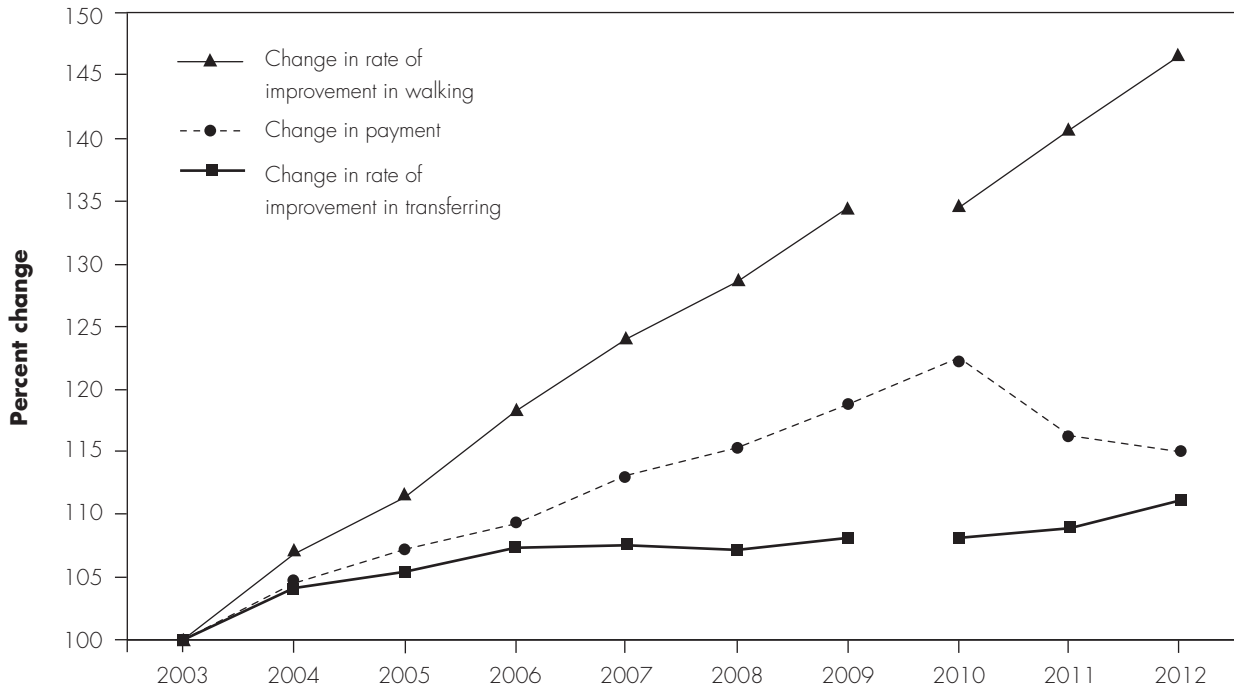
Table 8**Improvement in walking for home health patients at discharge, 2003–2012**

Year	Share of all patients reporting improvement in walking				
	All	Urban	Rural	For profit	Nonprofit
2003	34.8%	34.8%	34.9%	34.7%	34.9%
2004	37.2	37.2	37.4	37.1	37.3
2005	38.8	38.7	39.0	38.3	39.3
2006	41.2	41.1	41.4	41.0	41.5
2007	43.2	43.1	43.4	43.0	43.4
2008	44.8	44.8	44.5	44.9	44.8
2009	46.8	46.9	46.6	46.9	46.9
2010	53.5	53.3	54.6	52.6	55.0
2011	55.9	55.8	56.8	54.9	57.8
2012	58.3	58.1	59.5	57.3	60.2

Source: Data from the University of Colorado.

Figure 7

Change in rates of improvement transferring and walking relative to payment for all agencies



Note: The Outcome and Assessment Information Set items measuring improvement in walking and improvement in transferring were changed in 2010, and the values for 2010 and later years reflect items that are more sensitive to certain elements of functional improvement. For these reasons, the 2010 quality data reported above is not directly comparable to the 2009 data.

Source: Data from the University of Colorado.

be substantially reduced by the small PPACA changes to home health payments. Medicare has not established a value-based purchasing incentive for home health care, so the lack of a clear connection should not be surprising. In the March 2014 report to the Congress, the Commission recommended that Medicare establish a readmissions payment policy that would lower payments for HHAs with high rates of hospital readmission (Medicare Payment Advisory Commission 2014).

Conclusion

This mandated report is due before claims or quality data permit a direct examination of the impact of rebasing, but the experience under Medicare’s home health PPS suggests that access to care and quality of care will not change significantly as a result of rebasing. During the period covered by our historical analysis, the supply of HHAs continued to grow, even in years when average payment per episode and total payments fell. Utilization rates of home health services increased significantly through 2010. The growth in episodes per 100 beneficiaries appears to

have abated in 2011 and 2012, but this slowdown was likely influenced by many nonpayment factors. The rates of hospitalization of HHA patients have not changed significantly from 2003 through 2012, even though payments increased significantly in this period. The share of patients showing improvement on functional quality measures has increased during this period, which included both increases and decreases in average payment per episode.

The home health benefit is valuable when appropriately targeted. Home health care can substitute for a higher level of post-acute care or work with other community providers to help a community-dwelling beneficiary avoid hospitalization. However, even high-value services can be overpaid if rates are set inaccurately, and excessive payments increase the cost of these benefits of home health care to the beneficiaries and the federal taxpayer.

The net reduction to the base rate from rebasing, –2 percent through 2017, is small relative to past reductions in home health payments. The possibility that these reductions could be offset by increases in reported case mix, either through coding improvements or the provision of more therapy, further suggests that the impact of rebasing will not be significant. With an estimated average margin of 11.4 percent in 2014, it appears likely that HHAs will retain significant Medicare margins once rebasing is completed. In future years, data that permit a more direct examination of the impact of rebasing will become available, and the Commission will review these data as a part of our annual review of payment adequacy for home health care. Future data will permit us to assess the utilization trends for the different populations served by home health care and the impact on the different categories of providers in this report. ■

Endnotes

- 1 LUPA payments were found to be too low, and payments were increased by CMS.
- 2 The utilization statistics used in this report may differ from those in previous Commission reports because they exclude LUPA and outlier episodes.
- 3 In 2012, CMS implemented changes to the home health case-mix system that had the effect of raising payments for nontherapy episodes and lowering payments for therapy episodes. Nonprofit agencies, which generally provide fewer therapy services, benefited from this change.
- 4 The rate excludes hospitalizations that were not planned in advance or part of a normal course of treatment (for instance, organ transplant).
- 5 The measures use the risk-adjustment approach that CMS follows when it reports these measures on Home Health Compare and in agency outcomes-based quality management reports.
- 6 Nonprofit agencies had a hospitalization rate of 28.6 percent in 2012, compared with 25.6 percent for for-profit agencies. Some of this difference in performance is likely due to factors other than ownership status. For example, longer lengths of stay, regardless of ownership status, are correlated with higher hospitalization rates. For-profit agencies generally have higher average lengths of home health stays compared with other agencies, which is one factor that probably contributes to their higher hospitalization rate relative to nonprofit agencies.
- 7 The assessment items for functional status were modified in 2010, and therefore the rates for 2010 and later years are not comparable to the rates in previous periods. In each period, 2003 through 2009 and 2010 through 2013, the rates of improvement increased in most years.

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A P P E N D I X

A

Mandate for report

Mandate for report

Addendum A. Section 3301 of the Patient Protection and Affordable Care Act (Mandated report requirement to assess the impact of rebasing on home health)

(2) MEDPAC STUDY AND REPORT.—

(A) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the implementation of the amendments made by paragraph (1). Such study shall include an analysis of the impact of such amendments

on—

(i) access to care;

(ii) quality outcomes;

(iii) the number of home health agencies; and

(iv) rural agencies, urban agencies, for-profit agencies, and nonprofit agencies.

(B) REPORT.—Not later than January 1, 2015, the Medicare Payment Advisory Commission shall submit to Congress a report on the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

About MedPAC

The Commission

The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare’s traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

The Commission’s 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the Comptroller General and serve part time. Appointments are staggered; the terms of five or six Commissioners expire each year. The Commission is supported by an executive director and a staff of analysts who typically have backgrounds in economics, health policy, and public health.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress. In the course of these meetings, Commissioners consider the results of staff research, presentations by policy experts, and comments from interested parties. (Meeting transcripts are available at www.medpac.gov.) Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the Centers for Medicare & Medicaid Services (CMS), health care researchers, health care providers, and beneficiary advocates.

Two reports—issued in March and June each year—are the primary outlets for Commission recommendations. In addition to annual reports and occasional reports on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

The Commission’s goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and health plans in a manner that is fair and rewards efficiency and quality, and spends tax dollars responsibly.

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