

CHAPTER

9

Home health care services

R E C O M M E N D A T I O N

- 9** For calendar year 2021, the Congress should reduce the calendar year 2020 Medicare base payment rate for home health agencies by 7 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Home health care services

Chapter summary

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2018, about 3.4 million Medicare fee-for-service beneficiaries received care, and the program spent \$17.9 billion on home health care services. In that year, over 11,500 HHAs participated in Medicare.

Assessment of payment adequacy

The indicators of payment adequacy for home health care are generally positive.

Beneficiaries' access to care—Access to home health care is adequate: Over 98 percent of beneficiaries lived in a ZIP code where at least one Medicare HHA operated in 2018, and 83 percent lived in a ZIP code with five or more HHAs.

- **Capacity and supply of providers**—Between 2017 and 2018, the number of HHAs declined by 2.4 percent, and the supply of HHAs has declined 8.3 percent since 2013. However, the decline follows a long period of growth in supply. From 2002 to 2013, the number of HHAs increased by over 80 percent. The decline since 2013 was concentrated in areas that experienced sharp increases in supply in prior years.

In this chapter

- Are Medicare payments adequate in 2020?
- How should Medicare payments change in 2021?

- **Volume of services**—Between 2017 and 2018, the number of 60-day episodes declined by 1.2 percent, continuing a slight decline that began in 2011. However, from 2002 to 2011, home health utilization increased substantially, with the number of episodes rising 67 percent and episodes per home health user climbing from 1.6 to 2.0 episodes. In 2018, episodes not preceded by a hospitalization account for 66 percent of episodes. Between 2002 and 2011, the share of home health volume these episodes accounted for increased from about 50 percent to 67 percent in 2011 and has accounted for about two-thirds of annual home health volume since then.
- **Marginal profit**—In 2018, freestanding HHAs’ marginal profit—that is, the rate at which Medicare payments exceed providers’ marginal cost—was 18 percent, suggesting a significant financial incentive for HHAs to increase their volume of Medicare patients.

Quality of care—In 2018, the rate of home health patients who were hospitalized or received treatment in the emergency room did not change significantly, similar to the trend in prior years, while measures of functional status, such as improvement in walking and transferring, increased. However, the functional status measures should be interpreted cautiously because these measures are based on provider-reported data and could be affected by agency coding practices.

Providers’ access to capital—Access to capital is a less important indicator of Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. The major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs.

Medicare payments and providers’ costs—In 2018, Medicare spending for home health care increased by 0.5 percent to \$17.9 billion. For more than a decade, payments under the home health prospective payment system have consistently and substantially exceeded costs. Between 2002 and 2017, spending increased by over 87 percent. In 2018, Medicare margins for freestanding agencies averaged 15.3 percent. The projected margin for 2020 is 17 percent. Two factors have contributed to payments exceeding costs: Agencies have reduced episode costs by decreasing the number of visits provided, and cost growth in recent years has been lower than the annual payment updates for home health care.

How should payments change in 2021?

Our review of payment adequacy for Medicare home health service indicates that access is more than adequate in most areas and that Medicare payments are substantially in excess of costs. On the basis of these findings, the Commission has concluded that home health payments should be reduced by 7 percent in

2021. Home health care can be a high-value benefit when it is appropriately and efficiently delivered. Medicare beneficiaries often prefer to receive care at home instead of in institutional settings, and home health care can be provided at lower costs than institutional care. However, Medicare's payments for home health services are too high, and these overpayments diminish the service's value as a substitute for more costly services.

The Bipartisan Budget Act of 2018 requires that the policy changes implemented in 2020 be budget neutral and provides CMS with the authority to adjust payments from 2020 through 2026 to maintain budget neutrality. For 2020, CMS has projected that HHAs' behavioral responses to the new policies will increase payments by 4.36 percent, and the agency has implemented an offsetting reduction. Although necessary as an offset, this reduction does not reflect any assessment of the adequacy of Medicare's payments. Given the high financial margins of HHAs, as well as the other positive indicators, additional reductions in 2020 would be appropriate to better align Medicare's payments with actual costs. ■

Background

Medicare home health care consists of skilled nursing, 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. In contrast to coverage for skilled nursing facility services, Medicare does not require a preceding hospital stay to qualify for home health care. Also, unlike for most services, Medicare does not require copayments or a deductible for home health services. In 2018, about 3.4 million Medicare beneficiaries received home care, and the program spent \$17.9 billion on home health services.

Medicare requires that a physician certify a patient’s eligibility for home health care and that a patient receiving services be under the care of a physician. In 2011, Medicare implemented a requirement that a beneficiary have a face-to-face encounter with the physician ordering home health care. The encounter must take place in the 90 days preceding or 30 days following the initiation of home health care. An encounter with a nonphysician practitioner or through telehealth services may be used to satisfy the requirement.¹

Historically, Medicare has paid for home health care in 60-day episodes. Payments for an episode were adjusted to account for a patient’s clinical and functional characteristics and the number of therapy visits provided in the episode. In

2020, Medicare implemented major changes to the home health prospective payment system (PPS), including a new 30-day unit of payment (see text box, pp. 256–257). If beneficiaries need additional covered home health services at the end of an initial 30-day episode, another episode commences. The analysis in this chapter relies on data from 2018 and earlier years, reflecting trends under the 60-day unit of payment in effect during this period. (An overview of the home health prospective payment system is available at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_hha_final_sec.pdf?sfvrsn=0.) Coverage for additional episodes generally has the same requirements as the initial episode (i.e., the beneficiary must be homebound and need skilled care).

Medicare has always overpaid for home health services under the PPS

Payments for home health care have substantially exceeded costs since Medicare established the PPS. In 2001, the first full year of the PPS, average Medicare margins for freestanding HHAs equaled 23 percent.² The high margins in the first year suggest that the PPS established a base rate well in excess of costs. Indeed, the base rate assumed that the average number of visits per episode between 1998 and 2001 would decline about 15 percent; instead, the actual decline was about 32 percent (Table 9-1). Between 2001 and 2017, the number of visits per episode continued to decline, falling an additional 17 percent. The average number of therapy services per episode increased, but this increase was more than offset by the decline in visits per episode for all other service types (nursing, home health aide, and medical social services). In addition, HHAs were able to hold the

**TABLE
9-1**

Medicare visits per episode before and after the implementation of the PPS

	Visits per episode				Percent change in visits per episode		
	1998	2001	2017	2018	1998–2001	2001–2017	2017–2018
Skilled nursing	14.1	10.5	8.4	8.2	–25%	–20%	–2%
Therapy (physical, occupational, and speech–language pathology)	3.8	5.2	7.7	8.0	39	48	4
Home health aide	13.4	5.5	1.6	1.4	–59	–71	–12
Medical social services	0.3	0.2	0.1	0.1	–36	–50	>–0.1
Total	31.6	21.4	17.8	17.8	–32	–17	>0.01

Note: PPS (prospective payment system). The PPS was implemented in October 2000. Data exclude low-utilization episodes. Percent change columns were calculated on unrounded data.

Source: MedPAC analysis of home health standard analytic file from CMS.

Major changes to the home health prospective payment system in 2020

The Bipartisan Budget Act of 2018 requires CMS to implement two major changes to the home health prospective payment system (PPS) in 2020: a new 30-day unit of payment in place of the current 60-day unit and the elimination of the number of therapy visits as a factor in the payment system.³ These changes follow several years of analysis by the Commission and CMS to identify possible reforms to the home health PPS. The elimination of the therapy thresholds is consistent with a recommendation we first made in 2011 and reiterated in subsequent reports (Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2016, Medicare Payment Advisory Commission 2011).

Historically, Medicare's home health payment system had a series of nine payment thresholds that increased payment as the number of therapy visits in an episode increased; in effect, providing more therapy visits increased payments. Such an adjustment encouraged agencies to consider financial incentives when providing therapy services. The Commission has noted that home health agencies (HHAs) appear to adjust their services to maximize financial results under these thresholds (Medicare Payment Advisory Commission 2011). An investigation by the U.S. Senate Committee on Finance found that many agencies were targeting therapy services based on financial incentives, and the committee called for Medicare to move away from using therapy as a payment factor (U.S. Senate Committee on Finance 2011). Eliminating the thresholds mitigates these adverse incentives in the home health PPS.

CMS implemented a new case-mix system, the Patient-Driven Groupings Model (PDGM), in 2020. The PDGM categorizes episodes into 432 payment groups based on the following characteristics:

- **Episode timing**—Newly initiated home health services (those with no prior home health services) are classified as “early,” while episodes that follow an initial 30-day period are classified as “late.” For example, if a beneficiary had 4 consecutive 30-day home health episodes, the first 30-day period is classified as early, while

the 3 subsequent 30-day periods are classified as late 30-day periods. Though the unit of payment moves to a 30-day episode, beneficiaries receiving home health care will continue to be assessed for payment purposes at the beginning of care and at the beginning of each subsequent 60-day period of service. Episodes occurring more than 60 days after the end of a previous home health episode are classified as “early.”

- **Referral source**—This category assigns episodes to payment groups based on the services provided before the beginning of home health care. Early episodes that are preceded by a stay at an inpatient hospital, long-term care hospital, inpatient rehabilitation facility, or skilled nursing facility are classified as “institutional” episodes. Early episodes that are not preceded by these services are classified as community-admitted episodes. Later episodes are classified as institutional if they are preceded by a hospital stay.
- **Clinical category**—The new system creates 12 clinical categories. Five of the categories are based on patients' reported care needs: need for musculoskeletal rehabilitation, neurological/stroke rehabilitation, wound care, behavioral health care, and complex care. The other seven categories focus on providing beneficiaries with medication management, teaching, and assessment for surgical aftercare, for cardiac and circulatory conditions, for endocrine conditions, for infectious diseases, for respiratory conditions, for gastrointestinal and genitourinary conditions, or for other conditions.
- **Functional/cognitive level**—Similar to the existing system, the PDGM classifies patients' cognitive and physical functioning using information from the Outcomes Assessment Information Set (OASIS) home health patient assessment.
- **Presence of comorbidities**—The PDGM adjusts payment for commonly occurring comorbidities in home health care and includes a three-tiered adjustment for selected comorbidities.

(continued next page)

Major changes to the home health prospective payment system in 2020 (cont.)

Similar to the system in effect before 2020, low-use episodes with relatively few visits in an episode will be paid on a per visit basis. The threshold for the low utilization payment adjustment (LUPA) will vary from two to six visits, depending on the payment group to which an episode has been assigned. Episodes at or above the threshold will receive the full case-mix-adjusted 30-day payment under the PDGM. CMS estimated the PDGM's likely impact in the 2020 home health payment rule:

- Payments in 2020 increase by 2.8 percent for nonprofit agencies and 3.7 percent for facility-based HHAs.
- Payments fall by 0.3 percent for freestanding agencies and by 1.1 percent for for-profit HHAs.
- HHAs in urban areas see a 0.5 percent payment decrease, while those in rural areas see a 3.4 percent increase.
- Payments rise for smaller providers and fall for larger providers. For example, payments increase by 1.9 percent for the 2,841 HHAs with fewer than 100 episodes in annual volume and drop 0.2 percent for larger HHAs (those with more than a 1,000 episodes a year).

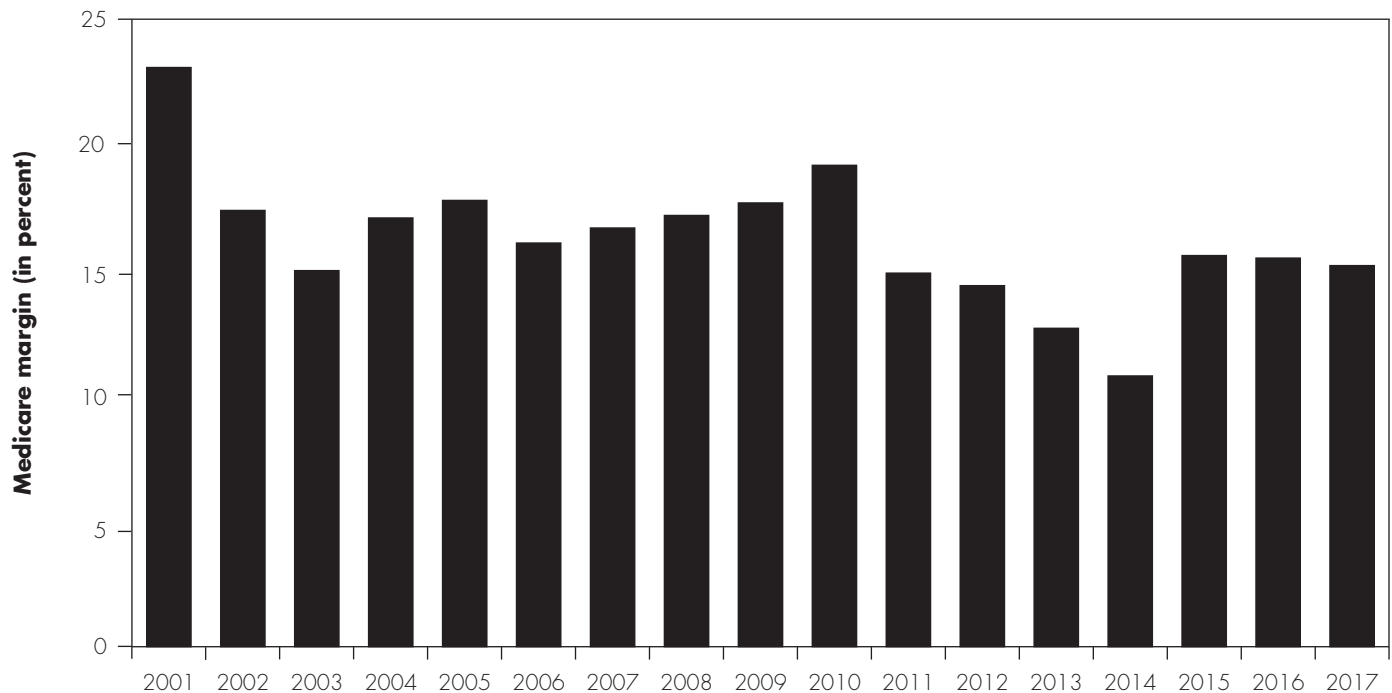
For beneficiaries, the new system increases payments for episodes that need relatively more nursing care and decreases payments for episodes with relatively more therapy visits. Other elements, such as the new system's clinical groupings, also redistribute payment across cases. For a given agency, the mix of patients across these different categories determines the PDGM's overall impact. The estimates listed above reflect CMS's estimate of the net impact of all the PDGM changes by provider characteristics.

These estimates assume that the number of visits and the types of visits beneficiaries receive do not change. However, the experience of past payment changes suggests that HHAs will alter at least some of the services they provide as a result of the PDGM. For example, in 2008, CMS implemented revisions to the case-mix system that increased payments for two classes of episodes: those with fewer than 10 therapy visits and episodes with more than 13 therapy visits. The new system also lowered payments for episodes with 10 to 13 therapy visits in an episode. In the first year of the change, the share of therapy episodes with 10 to 13 therapy visits dropped by about one-third. Conversely, the share of episodes with six to nine visits increased by 30 percent in 2008. Episodes with 14 or more therapy visits increased by 27 percent. In effect, episodes with higher payment under the revision significantly increased in volume, while those with lower payment decreased. The immediate change in utilization demonstrates that home health providers can quickly adjust services when Medicare modifies its payment systems.

Under the PDGM, agencies that provide high numbers of therapy visits will have an incentive to reduce these services since the model lowers payment for many of these episodes. Conversely, HHAs will receive relatively higher payments for patients who require mostly nursing services and could increase services provided for these episodes. CMS's payment policy for 2020 assumes that HHAs will increase the number of visits for episodes that are close to a LUPA threshold, raising aggregate payments. Ensuring that Medicare beneficiaries have access to needed care will continue to be a priority, and the Commission will monitor these changes to understand their impact on access for beneficiaries and the quality of care. ■

rate of episode cost growth below 1 percent in many years, lower than the rate of inflation assumed in the home health payment update. Consequently, HHAs were able to garner extremely high average payments relative to the cost of services provided. Between 2001 and 2017, freestanding HHA margins averaged 16.3 percent (Figure 9-1, p. 258).

In 2010, the Commission recommended that Medicare lower home health payments to make them more consistent with costs, a policy referred to as payment rebasing. The Affordable Care Act of 2010 (ACA) included a rebasing policy intended to lower payments from 2014 to 2017. However, the ACA offset the annual

**FIGURE
9-1****Medicare margins of freestanding home health agencies
remained high between 2001 and 2017**

Source: Medicare cost reports.

rebasement adjustment by the market basket-based payment update for each. As a result, rebasing did not significantly lower home health payment rates. The average payment per episode in 2017, the final year of the ACA rebasing policy, was 5 percent higher than the average payment per episode for 2013, the year before the rebasing adjustments were implemented. Home health margins throughout this period exceeded 10 percent.

Ensuring appropriate use of home health care is challenging

Policymakers have long struggled to define the role of the home health benefit in Medicare (Benjamin 1993). From the outset, there was a concern that setting a narrow policy could result in beneficiaries using other, more expensive services, while a policy that was too broad could lead to wasteful or ineffective use of the home health benefit (Feder and Lambrew 1996). Medicare relies on the skilled care and homebound requirements as primary determinants of home health eligibility, but these broad coverage criteria permit beneficiaries to receive services

in the home even though they are capable of leaving home for medical care, which most home health users do (Wolff et al. 2008). Medicare requires that home health services be delivered under a plan of care established by a physician, but it is not clear how engaged physicians are in the delivery of home health care. Medicare does not provide any incentives for beneficiaries or providers to consider alternatives to home health care, such as outpatient services. Beneficiaries who meet program coverage requirements can receive an unlimited number of home health episodes and face no cost sharing. In addition, the program relies on HHAs and physicians to follow program requirements for determining beneficiary needs, but evidence from prior years suggests that they do not consistently follow Medicare's standards (Cheh et al. 2007, Department of Health and Human Services 2018, Office of Inspector General 2001). Concerns about ensuring the appropriate use of home health episodes not preceded by a hospitalization led the Commission to recommend a copayment for these episodes (Medicare Payment Advisory Commission 2011).

**TABLE
9-2**

Number of participating home health agencies has increased significantly since 2002

	2002	2013	2017	2018	Percent change		
					2002-2013	2013-2018	2017-2018
Active home health agencies	7,011	12,613	11,844	11,556	80.0%	-8.3%	-2.4%
Number of home health agencies per 10,000 FFS beneficiaries	2.0	3.3	3.1	3.0	67.1	-10.6	-2.2

Note: FFS (fee-for-service). "Active home health agencies" includes all agencies operating during a year, including agencies that closed or opened at some point during the year. Percent change columns were calculated on unrounded data.

Source: MedPAC analysis of CMS's Provider of Service file and 2019 annual report of the Boards of Trustees of the Medicare trust funds.

Program integrity is a continuing challenge in home health care

In 2010, the Commission made a recommendation to curb wasteful and fraudulent home health services (Medicare Payment Advisory Commission 2010). The recommendation calls on the Health and Human Services Secretary to use the department's authorities under current law to examine providers with aberrant patterns of utilization for possible fraud and abuse. The ACA permits Medicare to implement temporary moratoriums on the enrollment of new HHAs in areas believed to have a high incidence of fraud, and it has used this authority in the past in Florida, Illinois, Michigan, and Texas.

In 2019, Medicare initiated the Review Choice Demonstration (RCD) for home health agencies in Illinois and Ohio. The RCD is a payment review activity that aims to ensure that home health claims meet Medicare's coverage and payment requirements. Under the RCD, HHAs select one of three options for the review of their claims: prepayment review for all claims, postpayment review for all claims, or no review and a 25 percent payment reduction to all claims (providers could still be subject to postpayment reviews). Under the review options, agencies have to submit supporting documentation, such as medical records, in addition to the standard information required for Medicare claims. HHAs that have over 90 percent of their claims approved have the option to select review approaches that reduce the number of claims subject to review. CMS plans to expand the RCD to Texas in 2020 and has indicated that it plans to add Florida and North Carolina in the future.

Are Medicare payments adequate in 2020?

The Commission reviews several indicators to determine the level at which payments are adequate to cover the costs of an efficient provider in 2020. We assess beneficiary access to care by examining the supply of home health providers, annual changes in the volume of services, and marginal profit. The review also examines quality of care, access to capital, and the relationship between Medicare's payments and providers' costs. Overall, the Medicare payment adequacy indicators for HHAs are positive.

Beneficiaries' access to care: Almost all beneficiaries live in an area served by HHAs

Supply and volume indicators show that almost all beneficiaries have access to home health services. In 2018, over 98 percent of beneficiaries lived in a ZIP code served by at least one HHA, 96.5 percent lived in a ZIP code served by two or more HHAs, and 83 percent lived in a ZIP code served by five or more agencies.⁴ These findings are consistent with our prior reviews of access.

Supply of providers: Agency supply remains high despite recent decline

In 2018, the number of HHAs declined by 2.4 percent compared with 2017, and the supply of HHAs declined by 8.3 percent since 2013 (Table 9-2). However, the decline follows a long period of growth in prior years. From 2002 to 2013, the number of HHAs increased by 80 percent.

**TABLE
9-3**

Fee-for-service home health care services have increased significantly since 2002

	2002	2011	2016	2017	2018	Percent change		
						2002-2011	2011-2018	2017-2018
Home health users (in millions)	2.5	3.4	3.5	3.4	3.4	36.9%	-1.9%	-0.6%
Share of beneficiaries using home health care	7.2%	9.4%	8.9%	8.8%	8.8%	31.1	-7.2	-0.4
Episodes (in millions):	4.1	6.8	6.6	6.4	6.3	67.0	-8.2	-1.2
Per home health user	1.6	2.0	1.9	1.9	1.9	22.0	-6.4	-0.6
Per FFS beneficiary	0.12	0.19	0.17	0.16	0.16	60.0	-13.2	-0.9
Payments (in billions)	\$9.5	\$18.3	\$18.1	\$17.8	\$17.9	92.3	-2.2	0.5
Per home health user	3,783	5,312	5,234	5,242	5,303	40.5	-0.2	1.2
Per home health episode	2,645	2,916	2,996	3,039	3,089	10.3	5.9	1.6

Note: FFS (fee-for-service). Percent change is calculated on numbers that have not been rounded; payment per episode excludes low-utilization payment adjustment cases.

Source: MedPAC analysis of home health standard analytical file.

The decline since 2013 was concentrated in areas that experienced sharp increases in supply in prior years.

The decline in 2018 was concentrated in Florida and Texas, states that experienced higher than average increases in supply in prior years. These states have been targeted by a myriad of antifraud measures, including criminal investigations and moratoriums on the entry of new HHAs. The number of HHAs exiting the program has increased in recent years in these states, and moratoriums have likely stopped the entry of new HHAs. Even with declines in these states, however, the supply of HHAs in the two states is more than double the supply of HHAs that were available in 2001, with supply exceeding 3,200 HHAs in 2018. These two states average 6.2 agencies per 10,000 Medicare fee-for-service (FFS) beneficiaries, well above the national average.

The supply of HHAs varies significantly among states. In 2018, Texas averaged 8.4 HHAs per 10,000 FFS beneficiaries, while New Jersey averaged less than one HHA per 10,000 FFS beneficiaries. The extreme variation demonstrates that the number of providers is a limited measure of capacity because HHAs can vary in size. Also, because home health care is not provided in a medical

facility, HHAs can adjust their service areas as local conditions change. Even the number of employees may not be an effective metric because HHAs can use contract staff to meet their patients' needs.

Episode volume declined slightly in 2018

Episode volume in 2018 declined by 1.2 percent (Table 9-3). This decline is part of a trend that began after 2011, but this period of decline was preceded by a period of rapid growth. Between 2002 and 2011, total episodes increased by 67 percent, from 4.1 million episodes to 6.8 million episodes.

The decline in home health utilization since 2011 reflects changes in both the demand for home health services and the supply of HHAs. From 2011 to 2018, the number of hospital discharges, a common source of referrals, declined by 13 percent, suggesting that demand for posthospital care using home health services has not increased in Medicare FFS since 2011. In addition, several actions have been taken to curb fraud, waste, and abuse in Medicare home health care.

The decline in episode volume since 2011 has not been uniform across the country. Since 2011, Florida, Illinois,

**TABLE
9-4**

Home health episodes not preceded by hospitalization or PAC stay increased at a higher rate than other episodes

	Episodes			Cumulative percent change	
	2001	2011	2018	2001-2011	2011-2018
Number of episodes preceded by a hospitalization or PAC stay (in millions)	1.9	2.2	2.1	14.8%	-0.5%
Number of episodes not preceded by a hospitalization or PAC stay (in millions)	2.1	4.6	4.2	127.4	-10.3
Share of episodes not preceded by a hospitalization or PAC stay	53%	67%	66%	26	-2.7
Total (in millions)	3.9	6.8	6.3	74.0	-7.8

Note: PAC (post-acute care). "Episodes preceded by a hospitalization or PAC stay" indicates the episode occurred fewer 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 began. Numbers may not sum to totals due to rounding. Percent change columns were calculated on unrounded data.

Source: Home health standard analytical file and Medicare Provider and Analysis Review file for 2001, 2011, and 2018.

Louisiana, Tennessee, and Texas (the five states with the fastest growing episode volume before 2011) have seen a decline of about 28 percent. However, utilization in these five states had more than doubled between 2002 and 2011, higher than in most other areas. The remaining 44 states experienced aggregate growth of 4.2 percent from 2011 to 2018, though there was a range of increases and declines across these states. This geographic variation emphasizes that many areas continued to see growth despite the overall drop in episode volume since 2011. Among the 44 states, growth in California between 2011 and 2018 accounted for a significant share of the increase, with episode volume rising by 42 percent, or almost 188,000 episodes.

Home health care periods of service have increased in length and shifted in focus to episodes not preceded by a hospitalization

Between 2002 and 2011, the average number of episodes per user increased from 1.6 to 2.0 episodes per user (Table 9-3), though the average number of episodes declined slightly from 2011 to 2018. The increase in episodes in the 2002 to 2011 period coincides with Medicare's PPS incentives that encourage additional volume: The per

episode unit of payment in PPS encourages more service (more episodes per beneficiary). The use of home health care for longer periods raises concerns that home health care, in some instances, serves more as a long-term care benefit. These concerns are similar to those in the mid-1990s that led to major program integrity activities and payment reductions.

The rise in the average number of episodes per home health user since 2002 (which plateaued in 2011) coincides with a relative shift away from home health care admission following a hospitalization or institutional post-acute care (PAC) service. Between 2001 and 2011, episodes not preceded by a hospitalization or institutional PAC stay increased by about 127 percent, while episodes preceded by a prior PAC stay or hospitalization increased by 14.8 percent (Table 9-4). Between 2011 to 2018, the volume of episodes not preceded by a hospital or institutional PAC stay dropped by 10.3 percent, while in the same period, episodes preceded by a hospitalization or PAC stay dropped by less than 1 percent. However, this decrease did not significantly change the share of episodes not preceded by inpatient or institutional PAC, which in 2018 accounted for 66 percent of episodes.

**TABLE
9-5**

Average home health agency performance on select quality measures

	2014	2015	2016	2017	2018
During an episode, the share of an agency's beneficiaries who:					
Used emergency department care	12.0%	12.2%	12.1%	12.7%	12.8%
Had to be admitted to the hospital	15.4	15.5	16.2	15.4	15.4
Share of an agency's beneficiaries who improved in:					
Transferring	55%	59%	65%	72%	77%
Walking	61	63	69	74	77

Note: All data are for fee-for-service beneficiaries only and are risk adjusted for differences in patient condition among home health patients.

Source: MedPAC analysis of data provided by the University of Colorado.

Marginal profits

Another factor we consider when evaluating access to care is whether providers have any financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for Medicare beneficiaries.⁵ In 2018, the marginal profit, on average, for freestanding HHAs was 18 percent. This substantial marginal profit indicates that these HHAs have a strong incentive to serve Medicare beneficiaries. While current trends may not indicate rising home health service volume, the high marginal profit in the home health PPS indicates that HHAs have an incentive to serve more patients.

Quality of care: Divergent trends between claims-based and provider-reported measures

Home health quality remained mostly unchanged in 2018 relative to the prior year on two measures of adverse events: The share of patients who utilized emergency care was 12.8 percent, and the share of home health patients hospitalized within 60 days of home health admission was 15.4 percent (Table 9-5). Rates of these events have not changed significantly since 2014. Outcome data for these two adverse event measures are collected from Medicare claims; they do not rely on information collected by HHAs.

The performance of HHAs on these claims-based measures contrasts with the performance on some quality measures derived from HHA-reported data. For example, HHAs report data on patient functional status at admission and discharge from home health care. These data are used to report the share of patients who have improvement in walking and the share of patients with improvement in transferring at the end of their home health stays (Table 9-5). The rates for these measures have improved every year. The disparity between the claims-based measures and the HHA-reported measures raises concern about the accuracy of the latter data.

A comparison of trends between 2014 and 2018 for the claims-based adverse event measures and the agency-reported function measures illustrates these concerns. The rates of patient functional improvement for transferring and walking rose substantially, increasing 22 percentage points and 16 percentage points, respectively, over the five-year period. However, the adverse event rates have not changed significantly. The higher rates of improvement for the functional measures may reflect agency coding practices and should be interpreted cautiously. It is not clear whether the different trends for these two sets of indicators reflect HHAs' improvement in quality or the nature of the data collected.

Notably, functional improvement data are collected only for beneficiaries who do not have their home health care stays terminated by a hospitalization, which means that beneficiaries included in the measure may be healthier and more likely to have positive outcomes. The functional data may not accurately reflect the experience of many patients

because of agency coding practices and the omission of some patients.

In its June 2019 report to the Congress, the Commission reported that broad function levels were associated with other patient characteristics, such as age and patient complexity, giving us some reassurance that, in aggregate, the measures may be reasonable (Medicare Payment Advisory Commission 2019). However, when comparing assessments for individual patients, the work raised serious questions about the accuracy of the provider-reported functional assessments. For beneficiaries transferred from one PAC setting and admitted to another, the functional status recorded at discharge from one setting and at admission to the next were often different, and the differences favored reporting that would raise payments. Further, for the same beneficiaries, a disproportionate share of the levels reported for quality were reported higher than those reported for payment-related items. The Commission concluded that the accuracy of this information needs to be improved before it is used as a risk adjuster in establishing payment, a gauge of provider quality, and a link to quality payment (such as value incentive payments).

Similar questions about the accuracy of the function data were raised in the evaluation of the first year of the home health value-based purchasing (VBP) program. A CMS evaluation contractor described similar trends in performance scores that indicated providers had responded to quality-reporting and VBP incentives (Pozniak et al. 2018). After the introduction of the CMS star ratings program for home health, all HHAs showed improvement in the provider-reported patient assessment-based measures (such as improvements in walking). However, larger improvements were observed among HHAs in states with mandatory participation in the VBP.

The contractor noted that the underlying subjectivity of the patient assessments and the VBP program incentives influence how HHAs assess and record patient status, such that reported “improvements” in quality scores did not necessarily reflect real improvements in quality. The prevalence of patient conditions was relatively stable over time, leading the contractor to conclude that improvements cited in provider-reported outcomes were at least in part due to changes in coding practices. The evaluator acknowledged that providers’ coding could be a combination of increased accuracy (resulting from provider training, for example) and reporting lower patient functional status at admission (recording a patient’s status as worse than it was). The evaluator also found that performance on other measures

not subject to provider coding, including patient experience and Medicare spending and utilization, showed either no or mixed improvement under the VBP program, raising doubts about the assessment-based improvements.

Providers’ access to capital: Access to capital for expansion is adequate

In 2018, the overall (all-payer) margins for freestanding HHAs averaged 4.3 percent, indicating that many HHAs yield positive financial results that should appeal to capital markets. HHAs are not as capital intensive as other providers because they do not require extensive physical infrastructure, and most are too small to attract interest from capital markets. Few HHAs access capital through publicly traded shares or through public debt such as issuance of bonds.

Information on publicly traded home health care companies provides some insight into access to capital, but it has limitations. Publicly traded companies may have other lines of business in addition to Medicare home health care, such as hospice, Medicaid-covered services, and private-duty nursing. Also, publicly traded companies are a small portion of the total number of HHAs in the industry. However, since they are the largest corporate entities in home health care, they can provide some insight about the industry’s financial status.

Analysis of for-profit companies indicates that these companies had adequate access to capital. The largest publicly traded for-profit company, Amedisys Incorporated, acquired several new businesses in 2018 and 2019, including a \$340 million acquisition of a hospice business (Amedisys 2019). Encompass Health added 23 new home health locations in 2018 (Encompass Health 2019). LHC Group acquired seven new home health agencies and a hospice agency in 2018 (LHC Group 2019). These acquisitions or expansions indicate that large for-profit companies have adequate access to capital for both operating costs and acquiring new assets. Anticipation of the implementation of the Patient-Driven Groupings Model (PDGM) in 2020 could slow acquisition efforts because some companies want to observe how this change affects agency financial performance before attempting to acquire additional HHAs.

Medicare payments and providers’ costs: Payments rose while cost per episode remained low in 2018

In 2018, average Medicare payments per episode increased by 1.7 percent for freestanding HHAs. Meanwhile, low or

**TABLE
9-6****Medicare margins for freestanding home health agencies, 2017 and 2018**

	Medicare margin		Share of home health agencies, 2018	Share of episodes, 2018
	2017	2018		
All	15.2%	15.3%	100%	100%
Geography				
Majority urban	15.8	15.6	84	84
Majority rural	13.4	13.8	16	16
Type of ownership				
For profit	16.4	16.8	89	80
Nonprofit	10.9	9.9	11	20
Volume quintile				
First (smallest)	7.4	7.8	20	3
Second	9.8	9.3	20	7
Third	11.5	11.9	20	11
Fourth	13.6	13.9	20	19
Fifth (largest)	17.0	17.3	20	60

Note: Home health agencies were classified as majority urban if they provided more than 50 percent of episodes to beneficiaries in urban counties and were classified as majority rural if they provided more than 50 percent of episodes to beneficiaries in rural counties.

Source: MedPAC analysis of home health cost report files from CMS.

no cost growth has been typical for home health care, and in some years, cost per episode has declined. In 2018, the average cost per episode increased by 1 percent, slightly greater than the annual decrease of about 0.5 percent for the last five years. The ability of freestanding HHAs to keep costs low in most years has contributed to their high margins under the Medicare PPS. In 2018, Medicare accounted for about 57 percent of revenue for freestanding HHAs.

Medicare margins for freestanding HHAs remained high in 2018

In 2018, HHA Medicare margins in aggregate were 15.3 percent for freestanding HHAs (Table 9-6).⁶ For these HHAs, the aggregate Medicare margins varied from 1.2 percent for those at the 25th percentile of the margin distribution to 24.0 percent for those at the 75th percentile (not shown in Table 9-6). For-profit HHAs had higher margins than nonprofit HHAs, and urban HHAs had slightly higher margins than rural HHAs. Agencies with higher volume had better financial results, likely reflecting

the economies of scale possible for larger operations. For example, HHAs in the bottom quintile of episode volume had margins of 7.8 percent, while HHAs in the top quintile had margins of 17.3 percent.

The Commission includes hospital-based HHAs in its calculation of acute care hospitals' Medicare margins because these agencies operate in the financial context of hospital operations. In 2018, margins for hospital-based HHAs were -16.6 (data not shown). The lower margins of hospital-based HHAs are attributable chiefly to their higher costs, some of which are a result of overhead costs allocated to the HHA from its parent hospital. Hospital-based HHAs help their parent institutions financially if they can shorten inpatient stays, lowering expenses in the most costly setting.

Relatively efficient HHAs provided similar services compared with other HHAs

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to

**TABLE
9-7**

Performance of relatively efficient home health agencies in 2017

Provider characteristics	All providers in analysis	Relatively efficient providers	All other providers
Number of home health agencies	4,122	295	3,827
Share that are for profit	89%	88%	89%
Median:			
Medicare margin	15.6%	23.1%	15.0%
Hospitalization during first 60 days of stay (percent)	15.5%	14.4%	15.6%
Cost per episode	\$2,427	\$2,122	\$2,457
Patient severity case-mix index*	0.99	1.02	0.99
Visits per episode			
Average visits per episode	16.4	15.3	16.5
Share of visits by type			
Skilled nursing visits	47%	47%	47%
Aide visits	8%	7%	8%
MSS visits	1%	1%	1%
Therapy visits	44%	45%	44%
Number of 60-day episodes			
Median	519	712	511
Mean	942	1,430	905
Share of episodes			
Low-use episode	8%	9%	8%
Outlier episode	3%	3%	3%
Share of episodes provided to rural beneficiaries	23%	15%	24%

Note: MSS (medical social services). Sample includes freestanding agencies with complete data for three consecutive years (2014–2016). A home health agency is classified as relatively efficient if it is in the best third of performance for quality or cost and is not in the bottom third of either measure for three consecutive years. Low-use episodes are those with 4 or fewer visits in a 60-day episode. Outlier episodes are those that receive a very high number of visits and qualify for outlier payments.
*The case-mix model is based on the approach indicated in *Simulation and Analysis of an Alternative Medicare Home Health Payment System Not Based on Number of Therapy Visits*, by Douglas Wissoker and Bowen Garrett of the Urban Institute, August 2015.

Source: Medicare cost reports and standard analytic file.

consider the costs associated with efficient providers. The analysis informs the Commission’s update discussion by examining the adequacy of payments for those providers that perform relatively well on cost and quality measures.

The Commission follows two principles when selecting a set of efficient providers. First, the providers must do relatively well on both cost and quality metrics. Second, performance has to be consistent, meaning that the provider cannot have poor performance on any metric in any of three consecutive years preceding the year under

evaluation. The Commission’s approach is to develop a set of criteria and then examine how many providers meet them. It does not establish a set share (for example, 10 percent) of providers to be considered efficient and then define criteria to meet that pool size.

To identify efficient HHAs, we examined the quality and cost efficiency of freestanding HHAs to identify a cohort that demonstrated better performance on these metrics relative to its peers (Table 9-7). The cost measure was on a per episode basis, adjusted for risk (patient’s health status)

and local wages; the quality measures were risk-adjusted rates of hospitalizations and improvement in walking. Our approach categorized an HHA as relatively efficient if it was in the best performing third on at least one measure (low cost per episode, a low hospitalization rate, or a high rate of beneficiaries showing improvement in walking) and was not in the worst performing third of any of these measures for three consecutive years (2014 to 2016). About 7 percent of freestanding HHAs met these criteria in this period.

In 2017, relatively efficient agencies compared with other HHAs had a median margin that was 8 percentage points higher, a median hospitalization rate that was 1.2 percentage points lower, and a median cost per episode that was 14 percent lower. Relatively efficient HHAs provided more episodes but 1.2 fewer visits per episode. The mix of nursing, therapy, aide, and social services visits did not differ significantly between relatively efficient and other HHAs. Our measure of case-mix severity did not differ significantly between relatively efficient providers and other HHAs. Efficient providers tended to provide a smaller share of episodes in rural areas.

The Commission projects that Medicare margins will remain high in 2020

In modeling 2020 payments and costs, we incorporate policy changes that will go into effect between the year of our most recent data, 2018, and the year for which we are making the margin projection, 2020. The major changes are:

- a 2.2 percent payment update for 2019,
- a 0.1 percent increase in payments due to CMS lowering the outlier payment threshold to increase payments,
- assumed nominal case-mix growth of 0.5 percent in 2019,
- a 1.5 percent payment update for 2020,
- assumed case-mix growth of 4.36 percent for 2020, which is offset by a 4.36 payment reduction CMS has implemented in 2020,
- rural add-on for 2018 and 2019, and
- assumed episode cost growth of 0.75 percent per year.

On the basis of these policies and assumptions, the Commission projects a margin of 17.0 percent in 2020.

CMS has estimated that a combination of coding and utilization changes by HHAs in response to the PDGM will increase payments by 4.36 percent in 2020. Statute requires that the PDGM be implemented in a budget-neutral manner, and consequently CMS has included a payment reduction of 4.36 percent in 2020. Our margin estimate for 2020 assumes that payment increases as CMS expects in 2020. Payment history under the home health PPS demonstrates that HHAs change coding, utilization, and the mix of services provided in reaction to new payment incentives. For example, when CMS implemented revisions to the home health case-mix system in 2008, subsequent analysis found that behavioral responses unrelated to patient severity caused payments to increase by 4 percent in that year—despite having increased only 1 percent per year, on average, between 2001 and 2007. CMS continued to find nominal increases in case mix unrelated to patient severity in later years and reduced payments by an average of 1.8 percent a year from 2008 through 2017 to account for this trend. CMS’s projected increase in payments of 4.36 percent due to the PDGM is consistent with this prior experience, and we include it in our margin estimate for 2020.

How should Medicare payments change in 2021?

Our review of payment adequacy for Medicare home health service indicates that access is more than adequate in most areas and that Medicare payments are substantially in excess of costs. On the basis of these findings, the Commission has concluded that home health payments should be significantly reduced.

Home health care can be a high-value benefit when it is appropriately and efficiently delivered. Medicare beneficiaries often prefer to receive care at home instead of in institutional settings, and home health care can be provided at lower costs than institutional care. However, Medicare’s payments for home health services are too high, and these overpayments diminish the service’s value as a substitute for more costly services. There are also indications that utilization under fee-for-service Medicare is not always efficient, as suggested by the broad geographic variation in the use of the benefit. In another example, a recent analysis of home health care utilization in the Medicare’s Shared Savings Program found that the volume of community-admitted home health episodes

increased at a lower rate for accountable care organization (ACO) beneficiaries relative to a matched comparison group (McWilliams et al. 2017). The lower rate of volume growth suggests that ACOs reduced the utilization of these services relative to the non-ACO population.

The Bipartisan Budget Act of 2018 requires that the policy changes implemented in 2020 be budget neutral and provides CMS with the authority to adjust payments from 2020 through 2026 to maintain budget neutrality. For 2020, CMS has projected that HHAs' behavioral responses to the new policies will increase payments by 4.36 percent, and the agency implemented an offsetting reduction. Although necessary as an offset, this reduction does not reflect any assessment of the adequacy of Medicare's payments. In fact, further reductions are necessary to better align payments with the costs of services.

RECOMMENDATION 9

For calendar year 2021, the Congress should reduce the calendar year 2020 Medicare base payment rate for home health agencies by 7 percent.

RATIONALE 9

An immediate reduction of 7 percent in 2021 would represent a significant action to address the magnitude of

the overpayments embedded in Medicare's rates. However, this reduction would likely be inadequate to align Medicare payments with providers' actual costs. In past years, the Commission has recommended that payments be rebased in the year after a 5 percent reduction, but this recommendation is complicated by the changes to home health payment set for 2021. The mix of services and number of visits provided in an episode will likely change under these policies, and the payment rate set under a rebasing policy should reflect the mix and level of services HHAs provide under the new payment policies.

IMPLICATIONS 9

Spending

- The payment reductions would lower payments relative to current law by \$750 million to \$2 billion in 2021 and by over \$10 billion over five years.

Beneficiary and provider

- Beneficiaries' access to care should not be affected. Lowering payments should not affect providers' willingness to deliver appropriate home health care. ■

Endnotes

- 1 The requirement may also be satisfied by an encounter with a nurse practitioner, certified nurse midwife, or physician assistant.
- 2 Freestanding providers accounted for about 90 percent of the episodes provided in 2018.
- 3 Prior to 2020, Medicare paid for home health care in 60-day episodes.
- 4 As of November 2019, our measure of access is based on data collected and maintained as part of CMS's Home Health Compare database. The service areas listed are postal ZIP codes where an HHA has provided services in the past 12 months. This definition may overestimate access because HHAs need not serve the entire ZIP code to be counted as serving it. At the same time, the definition may understate access if HHAs are willing to serve a ZIP code but did not receive a request in the previous 12 months. The analysis excludes beneficiaries with unknown ZIP codes.
- 5 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:

$$\text{Marginal profit} = (\text{Medicare payments} - (\text{total Medicare costs} - \text{fixed costs})) / \text{Medicare payment}$$

This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 6 Freestanding agencies accounted for about 90 percent of home health episodes in 2018.

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