Improving the incentives and safeguards for the home health benefit

Evan Christman

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Concerns about the home health benefit

- Variation in agency profitability.
- Concerns about patient selection.
- Payment system rewards additional volume and provision of therapy.
- Payment system with the greatest geographic variation in spending.
- Vulnerable to fraud, waste and abuse.

Review of home health PPS

- Revised system implemented in 2008.
- 60-day episodes.
- 153 payment groups.
  - Combination of clinical conditions, physical/cognitive function, and number of therapy visits.
- Other payment adjusters not included in this analysis (wage index, outliers).

Home health case-mix system relies on the use of therapy predictor for accuracy

- Current case-mix adjuster explains 55 percent of total costs.
  - Therapy costs: 77 percent
  - Non-therapy costs: 0.1 percent
- System explains 7.6 percent of costs when therapy predictors are removed.

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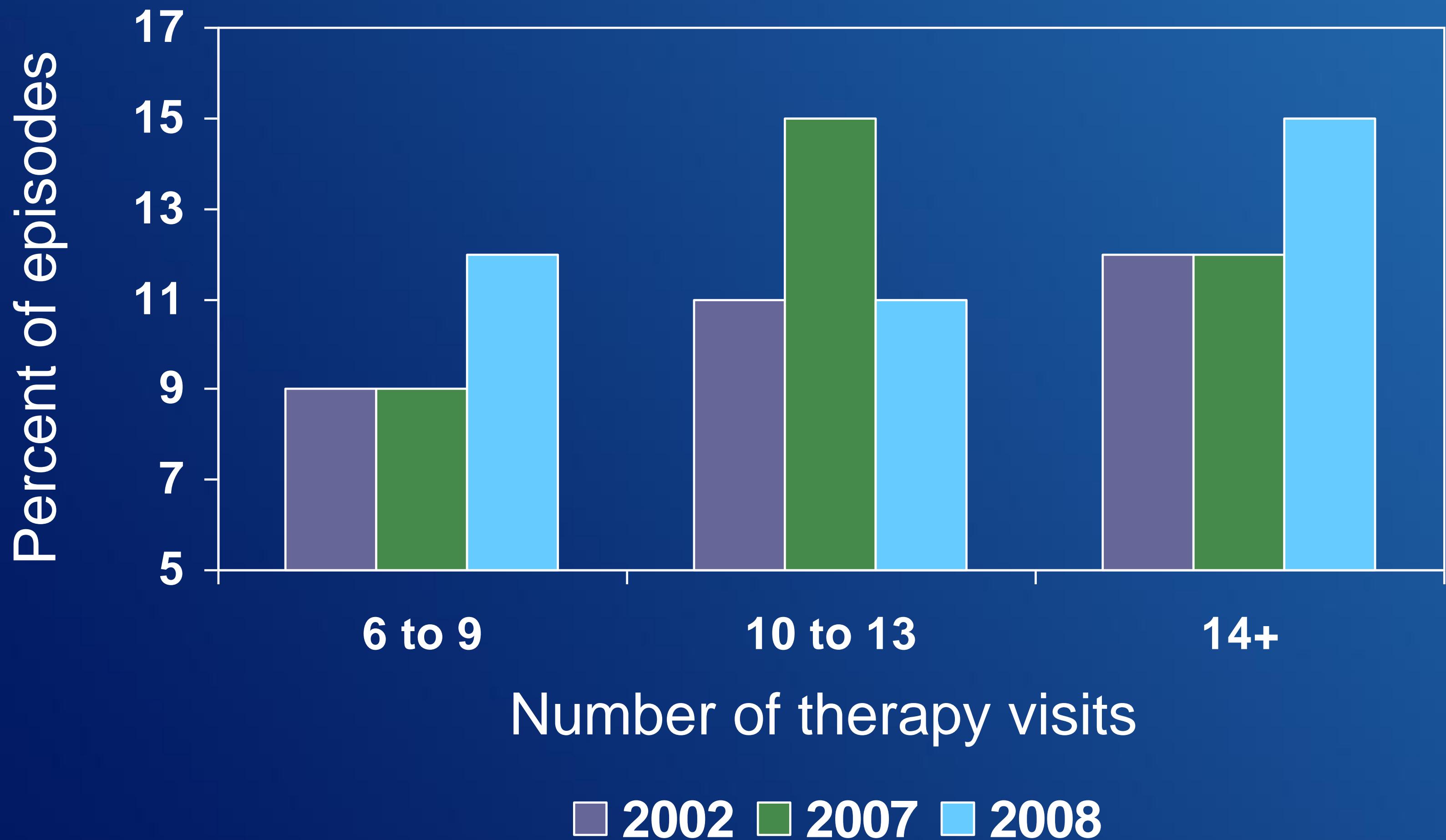
Therapy changes in 2008 reflected payment incentives



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Source: MedPAC analysis of home health analytic file

Agencies with higher case-mix values and more therapy have better financial performance

- Payment increases faster than increase in providers costs.
- In 2007 agencies with higher Medicare margins had higher average case-mix values and more therapy.

	Margin group	
	Low	High
Average Medicare Margin	-9%	37%
Therapy episodes as a share of total episodes	25%	30%
Agency case-mix index	1.23	1.32

Source: MedPAC analysis of Datalink file.

Analysis indicates need for revised system

- Very low accuracy for non-therapy services.
- Providers may base therapy delivery on incentives of payment system.
- Case-mix system overpays for higher weighted services (including therapy).

Designing a revised system

- Focus on patient characteristics (do not include therapy visits as a predictor).
- Use characteristics from patient assessment (OASIS).
- Factors included:
  - Activities of daily living/function
  - Several diagnosis (cancers, chronic conditions)
  - Source of admission
  - Demographic factors

Revised system better predicts therapy and non-therapy services

	Therapy	Non-therapy	Total
Revised case-mix system	26.7%	13.9%	14.4%
Current case-mix system (without therapy thresholds)	11.6%	8.2%	7.6%

Source: MedPAC analysis of Datalink file.

- Eliminates financial incentives to provide more therapy.
- Prediction of all costs more accurate.
- Improved prediction of high-cost non-therapy cases.

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Revised system would shift payment from therapy episodes to non-therapy episodes

- Non-therapy payments increase 35 percent; therapy payments decrease 14 percent.
- Raises payments for special populations:
  - Dual eligibles +3 percent.
  - Severely ill patients who need high amounts of nursing and aide services: +42 percent.

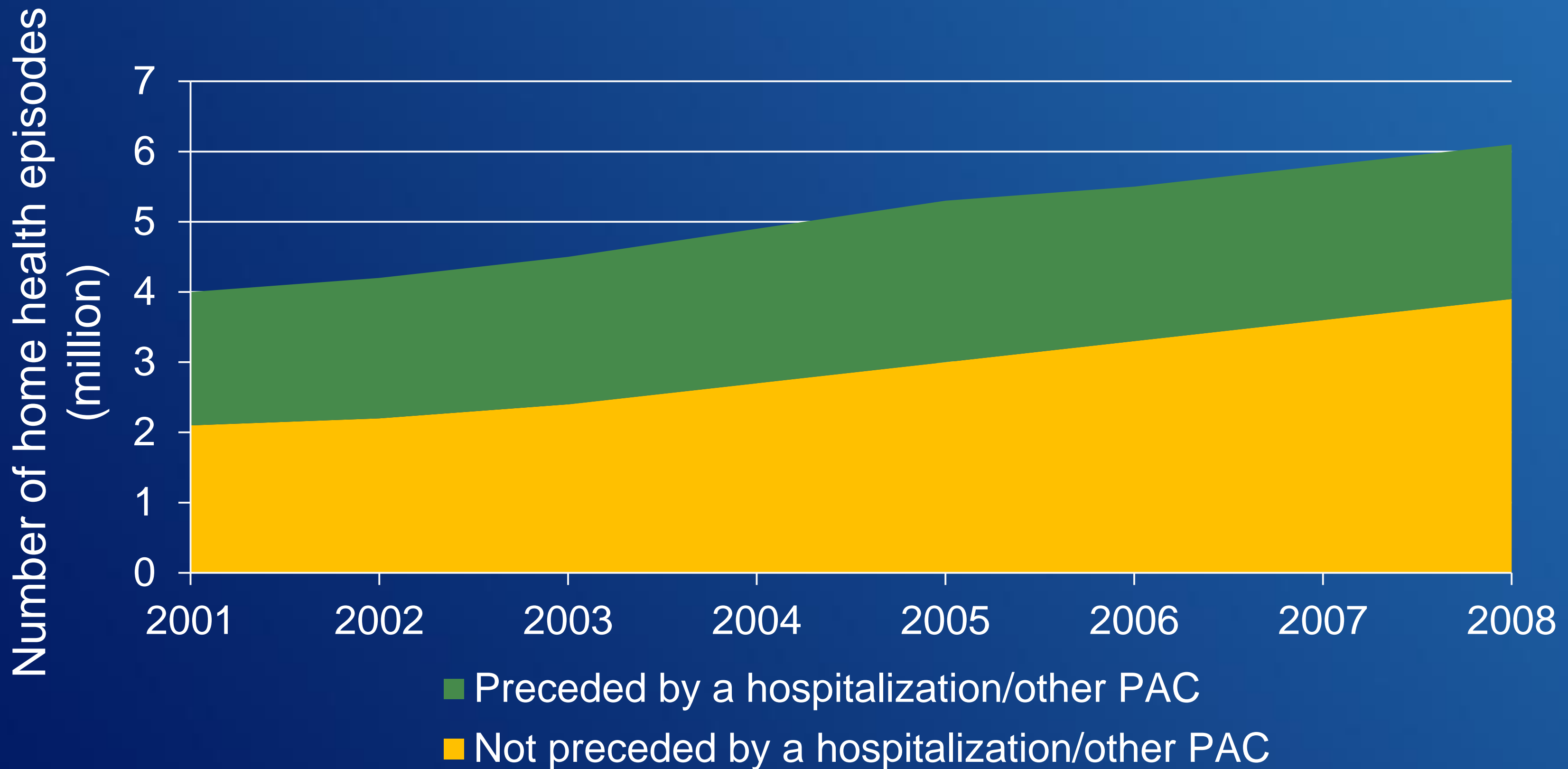
Payment changes for provider categories

Providers with higher payments	
Type	Payment change (%)
Non-profit	+6
Hospital-based	+7
Rural	+4
Providers with high share of non-therapy episodes	+25
Providers that deliver more services in non-therapy episodes	+6

Providers with lower payments	
Type	Payment change (%)
For-profit	-3
Free-standing	-1
Urban	-1
Providers with high share of therapy episodes	-23
Providers that deliver fewer services in non-therapy episodes	-7

Source: Urban Institute analysis of Datalink file.

Majority of volume growth attributable to rise in episodes not preceded by a hospitalization



Source: MedPAC analysis of Datalink file.

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Growth in home health episodes not preceded by a hospitalization or PAC, 2001-2008

- First episodes (no prior home health in last 60 days):
  - Community-admitted episodes increased 48 percent.
  - Post-hospital/PAC episodes increased 14 percent.
- Number of subsequent episodes (2nd or later episodes in a consecutive spell of home health) doubled.
- Number of hospitalizations flat; rising supply of agencies.

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Weak policies for ensuring appropriate use

- Home health agencies and physicians responsible for determining eligibility.
- Limited administrative review by CMS.
- No beneficiary incentive to decline care of negligible value or consider alternatives.

Considerations for home health cost sharing

- Lack of cost sharing makes home health an exception.
- Beneficiaries can influence demand for health care services.
- Cost sharing will reduce utilization – both effective and ineffective care.
- Design needs to set appropriate incentives.
  - Should not drive beneficiaries to other high-cost settings.
  - Minimize negative impact for high-need and low-income patients.

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Targeted design could mitigate impact for vulnerable populations

- Fixed per episode amount.
- Only for episodes not preceded by a prior hospitalization or PAC use.
- Exclude episodes with few visits.
- Exempt low-income/Medicaid.
- 32 percent of episodes subject to cost sharing with these exceptions.

Further efforts necessary to combat home health fraud

- Number of agencies continues to rise in areas considered high fraud risk (Los Angeles, Miami).
- Aberrant patterns of utilization in many counties suggest need for further investigation.

Options for expanded effort to combat home health fraud

- CMS has new powers under the PPACA.
  - Moratoriums on new providers
  - Suspension of billing privileges
  - Stop payment for services considered high risk
- Home health could serve as a test case for these new powers.
  - CMS/IG would need to identify areas of significant fraud risk.

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Next steps

- Refine policy options for:
  - Improving payments for non-therapy services and addressing incentives that favor therapy.
  - Implementing the new PPACA authority to combat health care fraud.
  - Cost sharing to improve program incentives.