Assessing payment adequacy: home health care services

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Home health summary

- $19 billion total expenditures in 2009
- Over 11,000 agencies in 2010
- Over 6 million episodes for 3 million beneficiaries in 2009

Overview

- Review framework
  - Access to care
  - Quality of care
  - Access to capital
  - Payment and costs
- Advance program integrity
- Improve payment accuracy
- Establish beneficiary incentives

Adequacy indicators for home health are positive

- Access generally adequate
- Number of HHAs continues to grow – over 3,800 new agencies since 2000
- Volume has increased by 50 percent since 2001; share of beneficiaries using home health continues to rise
- Most quality measurements indicate small improvement
- Access to capital is adequate
- Margin for 2009: 17.7 percent

Counties with high shares of beneficiaries using home health also have high episodes per user

ST.	County	Share of FFS beneficiaries using HH	Episodes per user
TX	STARR	35%	4.2
TX	HIDALGO	33%	3.9
TX	DUVAL	33%	4.1
TX	BROOKS	32%	3.9
TX	JIM HOGG	30%	4.5
FL	MIAMI-DADE	26%	3.1
TX	ZAPATA	26%	4.1
TX	CAMERON	25%	3.2
OK	CHOCTAW	25%	4.1
TX	JIM WELLS	25%	4.0
MS	CLAIBORNE	25%	2.9
TX	RED RIVER	24%	4.2
TX	WILLACY	24%	3.1

ST.	County	Share of FFS beneficiaries using HH	Episodes per user
LA	MADISON	24%	4.4
OK	MCCURTAIN	23%	4.3
MS	SHARKEY	23%	4.2
LA	EAST CARROLL	22%	4.3
TX	WEBB	22%	3.8
MS	JEFFERSON	22%	4.2
LA	AVOYELLES	22%	4.0
OK	PUSHMATAHA	22%	3.8
OK	LATIMER	22%	4.2
TN	HANCOCK	21%	3.8
LA	CALDWELL	20%	4.1
LA	WASHINGTON	20%	3.6
National average		**9.0%**	**1.9**

Source: 2008 HH SAF. Data are preliminary and subject to revision.

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More efforts needed to address fraud and abuse

- Several areas have high rates of use that suggest the need for further investigation
- Many new agencies in high risk areas
- CMS has new authorities under the PPACA to address fraud in high-risk areas
  - Moratorium on new providers
  - Payment suspension

PPACA implements a phased re-basing beginning in 2014

- Re-bases to estimated costs over 4 years
- Reduction offset by the payment update in each year
- Reductions limited to no more than 3.5 percent per year
- Delay will reduce impact of re-basing, allow for margins well in excess of cost before and after 2014

Analysis indicates need for revised payment system

- Providers may base therapy delivery on incentives of payment system
- Dependent on the use of therapy services provided as a predictor
- Very low accuracy for non-therapy services

Revised system better predicts therapy and non-therapy services

	Therapy	Non-therapy	Total
Current case-mix system (without therapy thresholds)	11.6%	8.2%	7.6%
Revised case-mix system	27.8%	14.6%	15.3%

Source: Urban Institute analysis of Datalink file.
Estimates are preliminary and subject to revision.

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

Ensuring appropriate use of the home health benefit

- Physicians and agencies make decisions about eligibility and need for home health services
- Cost sharing reduces beneficiary demand for services
- Most FFS services have some cost sharing, but home health is an exception
- Adding a copay would allow beneficiary choice to serve as a brake on volume growth
- Minimize impact for high-need and low income beneficiaries

Setting a home health copayment

- Unit of payment (visit or episode)
- Amount of copayment
- Type of episodes subject to copayment

Per-episode copay would balance provider and beneficiary incentives

- Providers have incentive to limit visits because Medicare pays for care in 60 day episodes
- Per-episode co-pay would encourage beneficiary to assess the need for any home health, but not number of visits
- Keeps beneficiary liability predictable and limited

Cost sharing is appropriate for community admitted home health patients

- Post-hospital patients have higher cost alternatives with little or no cost sharing
- Community-admitted patients face cost sharing for other non-institutional services (20 percent coinsurance)
- Community-admitted episodes growing faster than other episodes (almost double in 2001-2008)

Considerations for setting the copay amount

- Balancing affordability with effectiveness
- Beneficiaries already face 20 percent coinsurance for most services in the community (would equal ~$600 if applied to home health)
- Even a fraction of this amount could have a significant impact on utilization
- $150 copay would equal 5 percent of average episode payment

Illustrative copay design

- Fixed per-episode amount ($150)
- Community-admitted episodes only
- Exclude low-use episodes
- Medicare/Medicaid dual eligible beneficiaries would not pay
- Apply to about one-third of episodes in 2008

Reprint recommendation from March 2010 report

The Congress should direct the Secretary to expeditiously modify the home health payment system to protect beneficiaries from stinting or lower quality of care in response to rebasing. The approaches should include risk corridors and blended payments that mix prospective payment with elements of cost-based reimbursement.

Spending implications: Budget neutral

Beneficiary and provider implications: Should maintain beneficiary access to care and provider willingness to serve beneficiaries