Assessing payment adequacy: home health care services and steps toward broad post-acute care payment reforms

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Home health policies for the 2014 Report to Congress

- Review of payment adequacy
- Home health readmissions reduction policy

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Home health summary 2012

- $18 billion total expenditures
- Over 12,300 agencies
- 6.7 million episodes for 3.4 million beneficiaries

Payment adequacy indicators are positive, similar to results from prior years

- Access generally adequate
  - Number of HHAs continues to grow
  - Share of users and volume of episodes steady after several years of rapid increases
- Most quality measurements steady or small improvement
- Access to capital is adequate
- Margin for 2012: 14.4 percent
- Estimated margin for 2014: 12.6 percent

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Commission policy: Reprint recommendations from 2011 and 2012

- Reduce payments through a full rebasing that adequately addresses excessive payments
- Rebalance payments so agencies do not favor therapy services over non-therapy services
- Expand fraud and abuse efforts to address regions with aberrant patterns of home health utilization
- Establish co-pay for certain episodes to encourage appropriate utilization

Establishing a readmissions reduction policy for home health to align provider incentives

- Reducing readmissions is a priority for the Medicare program
  - Hospital Readmissions Reduction Program (HRRP)
  - New models of care (ACO, PCMH)
- Home health care is a common site of service for many post-hospital beneficiaries in these models
- About 29 percent of post-hospital home health stays result in readmissions

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Readmission rates vary widely and suggest opportunity for some providers to improve

- Readmissions rates for the worst quartile of agencies averaged 58 percent – compared to 26 percent for all other agencies
- Readmission rates were 38 percent for the four highest states: Texas, Louisiana, Oklahoma and Mississippi
- Lower performing providers may present an opportunity for improvement that would benefit beneficiaries and potentially lower program costs

Financial elements of a readmissions reduction policy for home health care

- Agency performance compared to a fixed target (i.e., 40th percentile of index year)
  - Risk-adjusted readmission rate for each agency
- Agencies with readmissions over the target would incur a penalty
  - Penalty would equal payments for home health episodes attributed to readmissions
  - Cap on maximum penalty size
  - Penalty would be collected through a reduction to following year's payments
- Providers can avoid any penalty by maintaining/lowering their rate below the target

Elements of a potential readmissions reduction policy for home health care

- Protect access for low-income beneficiaries by comparing providers to a peer group that serves a similar share of these beneficiaries
- Include all of home health stay and a 30-day follow-on period; post-hospital home health cases only
- Clinical conditions included in measures could follow “all conditions-potentially preventable readmissions” approach Commission suggested for HRRP

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Impact of an illustrative readmissions reduction policy

- Modeled a policy based on 2010 performance
- Agencies above the 40th percentile for their peer group would be subject to a payment reduction
- Agencies would likely act to lower rates, but did not model this behavioral response – actual share of agencies subject to penalty would likely be lower

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Share of agencies above benchmark by characteristic

- Nationally 60 percent of agencies would be above the benchmark
- 65 percent of profit agencies compared to 44 percent of non-profit agencies
- 61 percent of free-standing providers compared to 46 percent facility-based
- No significant difference between rural and urban agencies in the rate above the benchmark (60%)
- About 74% of agencies in the states with the highest rates of readmission and utilization were above the benchmark (TX, LA, OK, MS)

Financial impact would depend on size of incentive and agency reaction

- Penalty would be applied to each readmission an agency had above the target
- Amount could be tied to Medicare's payments for home health services provided prior to readmission
- Stop-loss would protect agencies from high losses

Stop loss	Penalties incurred for all agencies	Percent of agencies subject to the stop-loss
3 percent	$86 million	5%
10 percent	$87 million	0%

- Penalties would equal about 0.5 percent of home health spending in 2010.

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Benefits of establishing a home health readmissions reduction policy

- Align incentives of home health providers with other entities seeking to reduce readmissions
- Encourage providers with high readmission rates to improve performance
- Recognize that avoiding readmissions is a primary goal of home health care

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Background on patient assessments required by Medicare

- Medicare requires SNF, IRF and home health to use different patient assessment tools; no tool required for LTCH
- Each tool uses different definitions, scales, time periods, and method of assessment
- CMS successfully developed, validated, and tested a common assessment tool
- CMS has no timetable for implementing a common tool or set of items across settings

Benefits of having common patient assessment items across PAC settings

- Facilitate comparisons of patients, outcomes, and costs across PAC settings
- Compare settings and providers when selecting PAC providers
- Narrow prices between settings for similar patients and, in the longer term, consolidate the PAC payment systems