*Advising the Congress on Medicare issues*

# Mandated report: Impact of home health payment rebasing on beneficiary access to and quality of care

Evan Christman

September 12, 2014

MEDPAC

# Mandated report on effects of home health rebasing

- Patient Protection and Affordable Care Act (PPACA) requires Commission to assess impact of home health payment rebasing:
  - Access, supply of agencies, and quality
  - For-profit, nonprofit, urban, and rural agencies
  - Report due January 2015
- Presented preliminary results at April 2014 meeting
- Met with representatives from home health industry
- Intend to transmit report fall 2014

# Overview

- Review rebasing policy for home health payments
- Estimated impact of PPACA rebasing
- Analysis of impact of past payment changes on access and quality

# Issues for Medicare home health care

- Effective service when appropriately targeted
- Broadly defined benefit coverage
- History of program integrity issues
- Provider behavior sensitive to Medicare financial incentives
- Payments too high; do not reflect cost of typical episode

# Home health summary 2012

- Patient must be:
  - Homebound
  - Have a need for nursing or therapy
- $18 billion total expenditures
- Over 12,300 agencies
- 6.7 million episodes for 3.4 million beneficiaries

# Rebasing is necessary to ensure efficient home health payments

- Commission recommended rebasing in 2010
- Medicare margins have averaged 17 percent (all providers) from 2001 through 2012
  - Average margins for urban, rural, for-profit and nonprofit agencies have always exceeded 12 percent
  - Recent audit found that costs were overstated by 8 percent and Medicare margin could be higher
- Rapid growth in volume and number of agencies
- Past payment adjustments have not significantly affected margins, or entry of new providers

# Past reductions to the base rate have been offset by increases in reported case-mix

- Medicare has held payment updates below the rate of the market basket in 11 out of the 12 last years
- Increases in reported case-mix have offset these reductions
- CMS analysis concluded that higher reported case-mix was due to changes in agency diagnostic coding practices

# Overview of PPACA rebasing provision

- PPACA rebasing will be phased in over 4-year period
- Reduction limited to $81 per episode per year
- Payment update to offset reduction (+$66 per year)
- Base rate in 2017 will be 2 percent lower than 2013 due to rebasing (-$58 cumulative)
- Sequester would increase cumulative reduction to 4 percent in 2017 (if still in effect)

# Review historical trends to assess the impact of rebasing

- Report is due before data from first year of rebasing is available
- Examine past changes in episode payment, agency supply, utilization, and quality
- How sensitive have supply, access, and quality been to prior changes in average annual payment per episode?

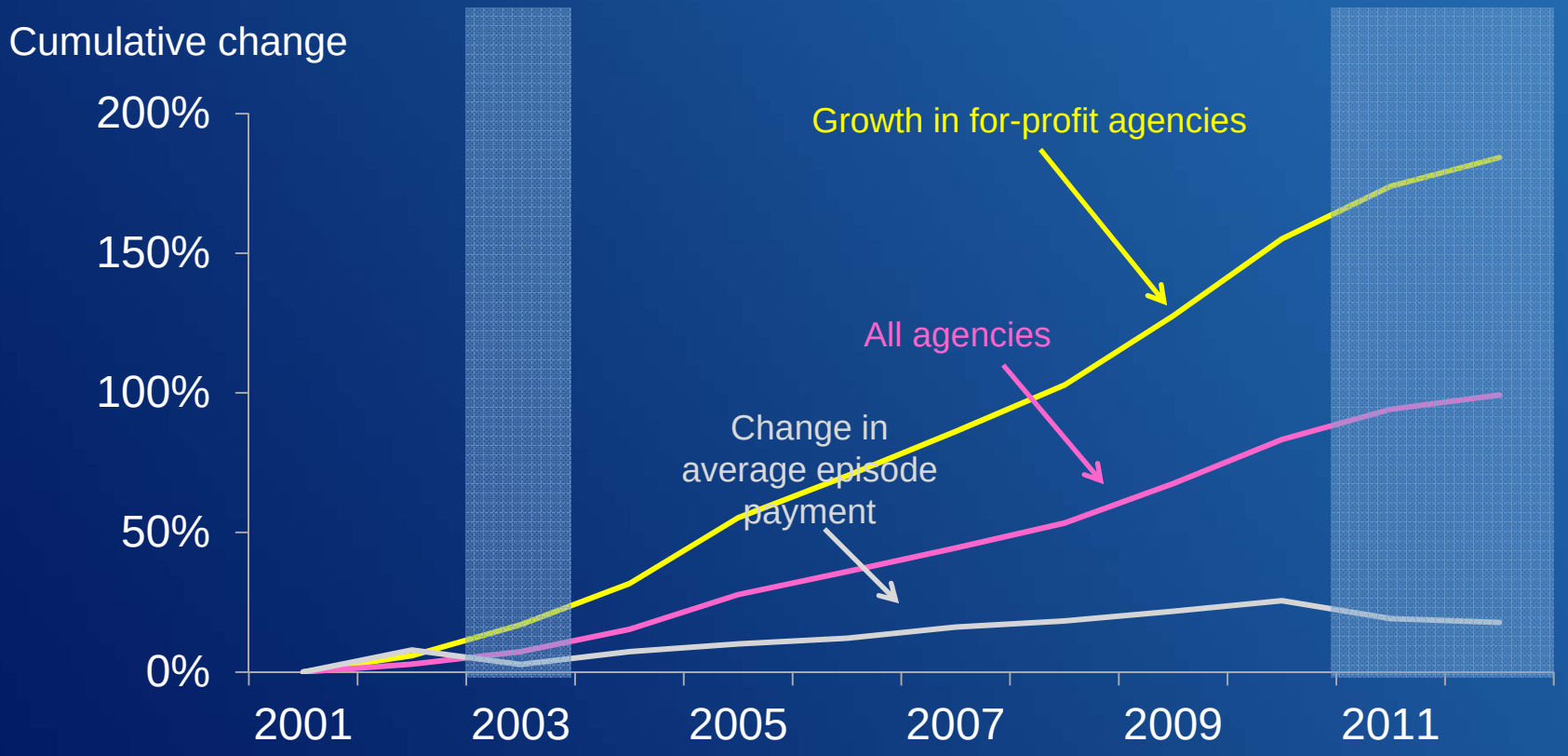
# Medicare payments have increased in most years

| | Annual change in average episode payment | Medicare margins for free-standing agencies |
|---|---|---|
| **2001** | NA | 23.1% |
| **2002** | 7.9% | 17.4 |
| **2003** | -4.8 | 15.0 |
| **2004** | 4.5 | 17.1 |
| **2005** | 2.6 | 17.8 |
| **2006** | 1.8 | 16.1 |
| **2007** | 3.6 | 16.7 |
| **2008** | 1.9 | 17.2 |
| **2009** | 3.0 | 17.7 |
| **2010** | 3.1 | 19.2 |
| **2011** | -5.1 | 14.9 |
| **2012** | -1.2 | 14.4 |

Source: Medicare Home Health Standard Analytic File; home health cost reports

*- Data are preliminary and subject to change -*

# Overall agency supply has increased regardless of changes in average episode payment




Source: Medicare Home Health Standard Analytic File; provider of service file

*- Data are preliminary and subject to change -*

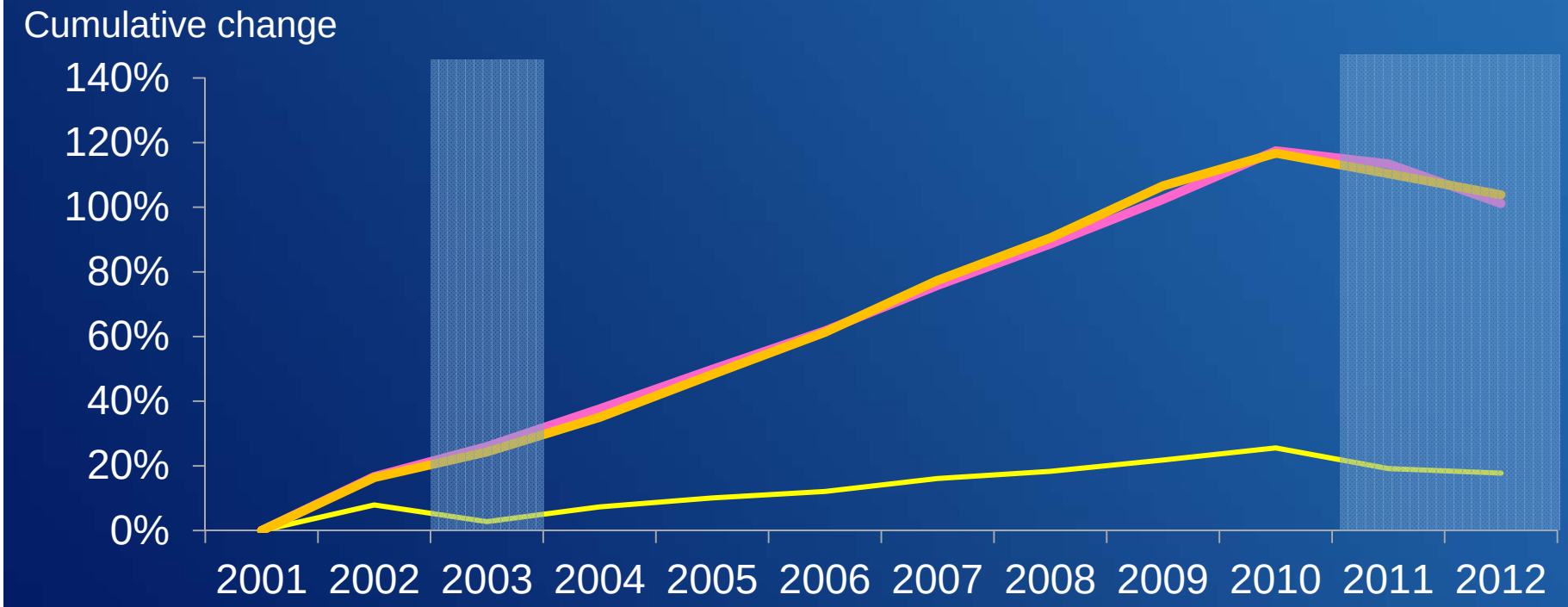
# Trends in agency supply were consistent from 2001 to 2012

- Supply of non-profit agencies declined
- Urban agencies increased in all years; rural agencies declined (urban agencies serve some rural agencies)
- Access did not change significantly
  - 99 percent of beneficiaries have lived in a ZIP code served by home health since 2004 (84 percent live in a ZIP code served by 5 or more agencies in 2012)
- Urban and rural areas have experienced comparable levels of utilization and growth in utilization

# Aggregate utilization of FFS home health care has risen rapidly

- Total episodes more than doubled overall
- Share of beneficiaries using home health increased from 6.2 percent of FFS beneficiaries to 9.6 percent (+54 percent)
- Episodes per home health user increased from 1.4 to 1.8 (+30 percent)
- Episodes per 100 beneficiaries have increased at comparable rates for urban and rural areas

# Per-beneficiary utilization of home health care doubled 2001-2012




Source: Home Health Standard Analytic File; provider of service file

- Change in average payment per episode
- Change in episodes per 100 beneficiaries for urban areas
- Change in episodes per 100 beneficiaries for rural areas

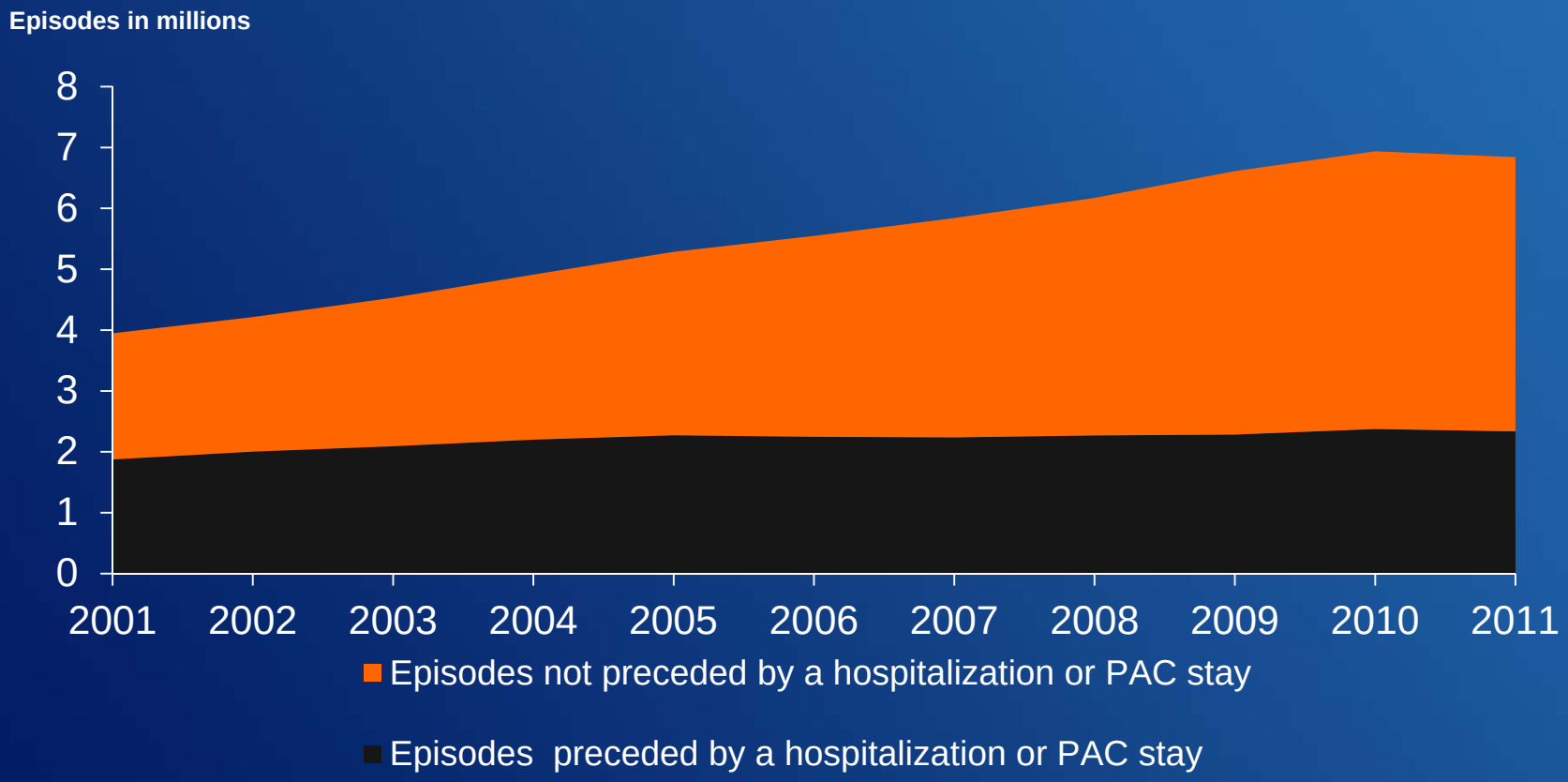
*- Data are preliminary and subject to change -*

MEDPAC

# Small per-beneficiary utilization declines in 2011 and 2012 likely reflect factors other than payment policy

- Per-beneficiary utilization decline is concentrated in 5 states
- Economy-wide (public and private) slowdown in rate of health care spending growth in recent years
- In 2011 Medicare established a requirement for a physician to conduct a face-to-face examination of beneficiaries when ordering home health care
- Expanded efforts to combat fraud, waste and abuse

# Non-post acute episodes account for the majority of episode growth




Source: Home health datalink file

*- Data are preliminary and subject to change -*

MEDPAC

# Impact of rebasing reductions on access likely to be limited

- Small size of rebasing reductions (half-percent or less in each year)
- Rebasing reductions not likely to significantly reduce access
- Utilization near record peak
- Decline in recent years followed rapid growth and likely influenced by factors other than payment policy

# Hospitalization rates have not changed significantly, 2003-2012

| Type of agency | 2003 | 2012 |
|---|---|---|
| For-profit | 28.7% | 28.6% |
| Nonprofit | 26.6 | 25.5 |
| Urban | 27.1 | 27.2 |
| Rural | 29.2 | 29.8 |
| All | 27.5 | 27.5 |

Source: Home health compare

- Average payment per episode increased 18 percent

# Share of patients with improvement in function increased in most years

- Functional measures of quality have improved annually since measures were implemented in 2003
  - 58 percent of patients reported improvement in walking in 2012
  - 53 percent of patients reported improvement in transferring in 2012
- Functional measures increased every year, including years with payment decreases and years with payment increases

# Small changes in payment under PPACA rebasing unlikely to significantly affect quality

- Rebasing cut is small, 2 percent over 4 years (4 percent with sequester)
  - Agencies still receive annual payment update
- Past payment reductions have not had a negative impact on access and quality
  - Utilization and agency supply has more then doubled in 2001 through 2012
  - Functional measures improved while hospitalization was unchanged

# Small changes in payment under PPACA rebasing unlikely to significantly affect quality

- Margins have remained high despite past reductions to base payments
- Higher case-mix has offset past attempts to lower base rate
- Agencies have been successful in controlling costs
- PPACA reductions unlikely to significantly reduce access