SECTION 2E

Home health services

RECOMMENDATION

The Congress should eliminate the update to payment rates for home health care services for calendar year 2009.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

SECTION 2E

Home health services

Section summary

Data on home health access, quality, volume, and financial performance suggest that most agencies should be able to accommodate cost increases without increasing base payments. The Commission estimates that agencies will have average margins of 15.4 percent in 2006 and 11.4 percent in 2008.

Access to care and supply of facilities—As in previous years, beneficiaries continue to have widespread access to care. Ninety-nine percent of beneficiaries live in an area served by at least one home health agency (HHA), and 97 percent live in an area served by two or more agencies. The number of HHAs continues to grow, although at a slower pace than in previous years. The number of agencies increased by about 4 percent to about 9,200 agencies for the first 11 months of 2007. Annual growth in agencies continues to exceed the rate of growth in Medicare enrollees.

Volume of services—The share of fee-for-service beneficiaries using the home health benefit continues to increase, reaching 8.1 percent in 2006. The average number of episodes per home health user continues to increase. Episodes with 10 or more therapy visits accounted for most

In this section

of the new episodes in 2006, with much of this increase in volume likely driven by an influx of patients who would have been treated by inpatient rehabilitation facilities in previous years. Chapter 2F provides more detail on this issue.

Quality—Quality trends are mostly unchanged from previous years. There have been slight increases in the number of beneficiaries who show improvement in walking, bathing, pain management, transferring, and medication management. However, the rate of unplanned emergency department use by home health patients has not improved, and the number of patients hospitalized has increased slightly.

Access to capital—The continuing entry of new agencies and the acquisition of existing agencies by national home health companies suggest that agencies have adequate access to capital for growth.

Payments and costs—Average agency margins are projected to be 11.4 percent in 2008. Home health base rates will increase by about 0.25 percent in 2008, the net impact of the 3.0 percent market basket update required by law and a 2.75 percent reduction to the base rate for changes in coding practice. The annual increase in cost growth for 2006 is 2.7 percent, higher than in previous years but still below the rate of cost growth indicated by the home health market basket.

Our evidence suggests that beneficiaries have adequate access to quality home health care. The number of agencies in the program continues to rise, the share of beneficiaries using the benefit continues to increase, and the margins indicate that HHAs' payments significantly exceed their costs. Quality continues to show small improvements for most measures. These factors suggest that most agencies should be able to accommodate cost increases over the coming year without an increase in base payments. ■

Recommendation 2E

COMMISSIONER VOTES:
YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

The Congress should eliminate the update to payment rates for home health care services for calendar year 2009.

What is home health and the home health payment system?

Medicare home health consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide service, 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 (temporary but not indefinite) skilled care to treat their illness or injury and must be unable to leave their homes without considerable effort. Medicare does not require beneficiaries to pay copayments or a deductible for home health services.

Medicare pays for home health care in 60-day episodes. Episodes begin when patients are admitted to home health care. Most patients complete their course of care and are discharged before 60 days have passed. If they do not complete their care within 60 days, another episode begins and Medicare will pay for another episode.

Agencies receive one payment per episode for home health services. Medicare adjusts this payment based on measures of patients' clinical and functional severity and the use of therapy during the home health episode. Medicare also adjusts for differences in local wages using the prefloor, prereclassification hospital wage index. Medicare makes additional adjustments to some episodes under special circumstances:

- An outlier payment is triggered if the cost of an episode exceeds Medicare's payments by a certain threshold.
- A low utilization payment adjustment makes a per visit payment if a patient receives four or fewer visits during an episode.
- A partial episode payment requires the initiating agency to split the payment for a patient who transfers from one agency to another during an episode.

An overview of the home health prospective payment system (PPS) is available online at http://medpac.gov/documents/MedPAC_Payment_Basics_07_HHA.pdf.

How has the home health benefit changed?

In the early 1990s, both the number of users and the amount of services they used grew rapidly. At the same time, the home health benefit increasingly began to resemble long-term care and to look less like the medical services of Medicare's other post-acute care benefits (MedPAC 2005a).

The trends of the early 1990s prompted stricter enforcement of program integrity standards and refinements to benefit eligibility standards and culminated with replacement of the cost-based payment system of the mid-1990s with a PPS in 2000. Between 1997 and 2000, the number of beneficiaries using home health services fell by about one million, and the number of visits fell by 65 percent (Table 2E-1, p. 174). However, after PPS was implemented these trends reversed. The number of users and visits have increased since 2000; for example, the share of users increased from 7.4 percent of fee-for-service beneficiaries to 8.1 percent in 2006.

The amount and type of care provided to beneficiaries shifted under PPS. The average number of visits provided to each beneficiary fell from 73 in 1997 to 34 in 2006 (Table 2E-1). In addition, the mix of care changed. Home health aide visits fell from about 50 percent of total visits in 1997 to about 20 percent in 2006. The share of therapy visits increased. Home health users have fewer visits today and receive a higher skill mix than the services provided before PPS.

Assessing changes in care that occurred after PPS was implemented is difficult because this service lacks clear, practical guidelines to identify beneficiaries whose characteristics suggest they would benefit from receiving the service and what services they ought to receive. Numerous studies have found significant geographic variation in the delivery of health care services (Fisher et al. 2003). Home health spending is consistent with this trend (Figure 2E-1, p. 175). Expenditures in the highest spending regions exceed $1,200 per enrollee, while in the lowest spending regions, expenditures are less than $100 per enrollee.

The lack of definition in the home health benefit may play a role in this variation. Suggesting that more home health service is better and less is worse oversimplifies the case, as we have discussed in previous reports (MedPAC 2005b). Better information about which patients most benefit from home health care would be helpful. This broader perspective on home health policy is consistent with our goal for post-acute care: to base decisions about where beneficiaries receive post-acute care services on patient characteristics and resource needs.

TABLE 2E–1

Changes in home health spending, visits, and users

				Percent change		
	1997	2000	2006	1997–2000	2000–2006	1997–2006
Agencies	10,447	6,881	9,227	–34%	34%	–12%
Total spending (in billions)	$17.7	$8.5	$13.2	–52	55	–26
Users (in millions)	3.6	2.5	2.9	–31	18	–18
Number of visits (in millions)	258	91	98	–65	8	–62
Visit type (percent of total)						
Home health aide	48%	31%	20%	–37	–34	–58
Skilled nursing	41	49	53	20	7	28
Therapy	10	19	26	101	37	176
Medical social services	1	1	1	1	–27	–26
Visits per user	73	37	34	–49	–8	–54
Percent of fee-for-service beneficiaries who used home health	10.5%	7.4%	8.1%	–30.1	10.7	–23

Source: Home health Standard Analytic File; Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 2002; and CMS's Providing Data Quickly database.

How has home health spending changed?

Medicare spending for home health care has fluctuated significantly over the last 10 years, but recent years have seen steady growth. Between 1990 and 1997, spending for home health grew by 24 percent annually, raising concerns about the appropriateness of Medicare's cost-based reimbursement for home health and fraud by some providers. At the peak in 1997, home health expenditures totaled $17.7 billion, and 3.6 million beneficiaries received services (Table 2E-1). The Balanced Budget Act of 1997 (BBA) included several provisions designed to temporarily reduce payment for home health services. These changes had a swift effect on the industry; by 2000, the number of agencies fell by 34 percent to 6,881 and the number of beneficiaries served fell by 31 percent. The BBA also mandated a PPS for the home health benefit, which began operation in October 2000. Under the PPS, payments have risen by about 9 percent a year. Between 2007 and 2016, Medicare home health spending is expected to grow by an average of 6.2 percent annually (OACT 2007).

The home health industry has achieved remarkable financial results under the PPS, even after several reductions to the home health update. In 2001 through 2005, legislative actions reduced the home health update by an average of 1 percent. In 2006, the market basket increase was eliminated entirely. In addition to these reductions, CMS implemented an adjustment required by the BBA that reduced payments by 7 percent in 2003. Despite these reductions, margins remained robust through the period, averaging 16 percent over the 2002–2005 period (Table 2E-2).

TABLE 2E–2

Home health agency margins

	2002	2003	2004	2005	2006
All	17.1%	14.8%	16.8%	17.3%	15.4%

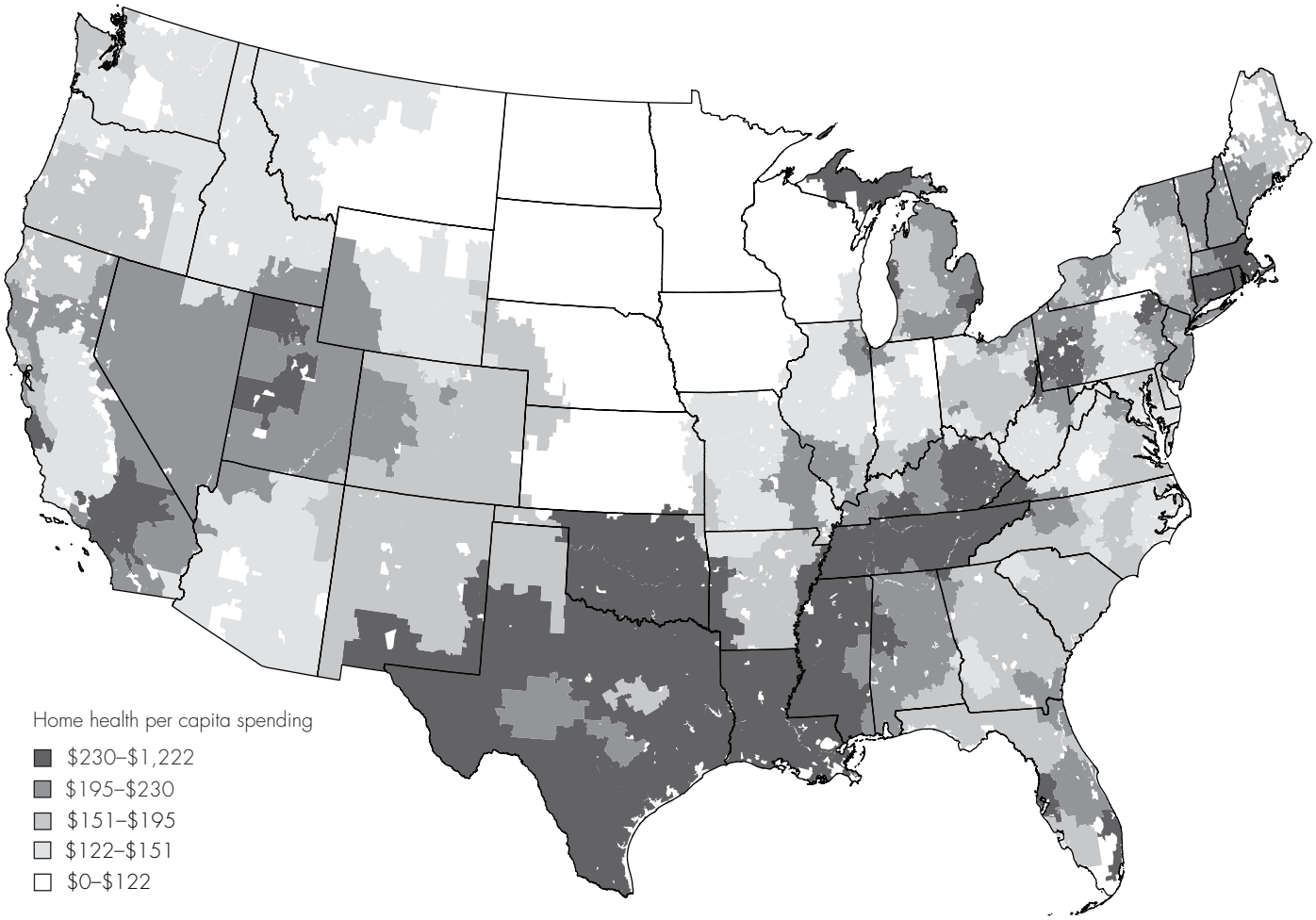
Source: MedPAC analysis of 2002–2006 home health cost reports.

Changes to payment policy in 2008

Medicare will implement significant refinements to the home health PPS in 2008. The proposed changes are designed to make payments under the home health PPS more accurate. The home health benefit has changed

FIGURE 2E–1

Significant variation in Medicare spending for home health



Source: Dartmouth Atlas of Health Care. http://www.dartmouthatlas.org.

significantly since the advent of PPS, but the payment system's resource groups and relative weights are based on data from 1997 and 1998. The changes include several major revisions. The new payment system:

- Revises and expands the patient classification system (home health resource groups (HHRGs)). CMS replaces the system of 80 HHRGs with a new system of 153 HHRGs. The new system bases payments on therapy use and an episode's timing in a sequence of consecutive episodes. The HHRG–153 provides higher payments for third and subsequent episodes in a sequence of consecutive episodes; the higher payments for later episodes reflect the higher average number of visits these patients receive.
- Replaces the 10-visit therapy threshold. The new system eliminates the current threshold, which increases payments for episodes that have 10 or more therapy visits and will make gradual payment increases with more therapy visits. The HHRG–153 splits the range of therapy visits from 0 to 20 visits into nine thresholds and provides smaller increases among the thresholds.

These refinements modestly improve the accuracy of the PPS (see text box, p. 176).

How will the home health resource group 153 change payment accuracy?

MedPAC analyzed the accuracy of the new home health resource group (HHRG) 153 system in two ways: by examining the ratio of payments to costs and by examining the variation in the amount of services used by patients in the same HHRG.[1] Payment-to-cost ratios that are close to or equal to 1.0 indicate that payments for an episode are near or equal to costs. However, we note that payment-to-cost ratios for home health care are generally much higher than 1.0 because home health payments substantially exceed costs.

The new HHRG–153 system will result in a more even distribution of payments relative to costs. We compared the payments for episodes with similar therapy visits and episode timing under the new and old systems. MedPAC computed the average payment and cost for each episode under the HHRG–80 and the new HHRG–153 system. Under the current system, the payment-to-cost ratios for episodes with similar service use range from 1.02 to 1.73. Under the new system, the range between the ratios is narrowed to 1.14 to 1.40. More uniform ratios reduce the differences in financial returns among different types of patients and reduce the provider's financial incentive to favor some patients.

Reviewing variation in service use among the episodes within an HHRG allows us to determine whether episodes are appropriately grouped. The episodes assigned to an HHRG should have similar levels of resource use and should be similar in the number of visits provided. In prior reports, the Commission noted that service use varies widely within HHRGs. The Commission has expressed concern that the degree of within-group variation suggests the payment system is inappropriately grouping dissimilar episodes in the same resource group, which creates the potential for agencies to favor profitable patients within a group. To measure this variation, the Commission compared the coefficient of variation for the number of visits per episode, a measure of how episodes in an HHRG differ from the average episode. A lower coefficient indicates that the episodes within an HHRG are homogeneous—that is, they are relatively similar in the number of visits provided.

Analysis of the coefficient of variation found that the new system establishes a more internally homogeneous set of HHRGs. The new system has more resource groups and uses two dimensions of service use—the number of therapy visits provided and an episode sequence in a spell of consecutive home health episodes—to classify episodes. Consequently, it has less within-group variation in the number of visits provided. The average coefficient of variation for visits has fallen from 0.81 in the current system to 0.75 for the proposed system of HHRGs. The reduction in variation means the new resource groups are better at grouping episodes with similar resource use than the current system. The reduction in within-group variation reduces the potential for providers to select the least costly patients in a resource group.

The changes for therapy payments under the HHRG–153 will lead to a more appropriate distribution of payments. Under the previous system, Medicare made fixed additional payments for episodes that included 10 or more therapy visits. As the number of therapy visits varies significantly among episodes, a single threshold did not capture the incremental costs of therapy in many episodes. Also, this payment "notch" created a significant financial incentive for agencies to provide 10 visits, even if the beneficiary's condition warranted more or less therapy. The new system implements a more gradual payment increase by dividing the range of therapy visits between 0 and 20 visits into 9 separate payment thresholds. These new thresholds redistribute funds from the episodes that are most profitable under the previous system, those with 10–13 therapy visits, to those that were less profitable under the original single-therapy threshold. ■

Are Medicare payments adequate in 2008?

Beneficiary access to care

In this section, we assess two questions:

- Do communities have providers?
- Do beneficiaries obtain care?

Most communities have more than one home health agency (HHA). In the 12 months preceding June 2007, 99 percent of all Medicare beneficiaries lived in an area served by at least one HHA; 97 percent of beneficiaries lived in areas served by two or more HHAs. These numbers suggest that no substantially populated areas of the country lack HHAs.

Our measure of access is based on data collected and maintained as part of CMS's Home Health Compare database as of October 2007. The service areas listed in the database are postal ZIP codes where an agency provided service in the past 12 months. This definition may overestimate access because agencies need not serve the entire ZIP code to be counted as serving it. On the other hand, this definition may underestimate access if HHAs are willing to serve certain ZIPs but did not receive any requests from those areas in the preceding 12 months.

The Office of Inspector General and Agency for Healthcare Research and Quality, through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, have previously studied access to home health care (OIG 2006). Those studies generally found that most beneficiaries did not have difficulty accessing home health care. However, these agencies have not conducted recent studies of access to home health care. For example, the last CAHPS survey that included home health was for 2004. Updated studies would be useful to follow any changes in access.

Changes in the volume of services

The share of fee-for-service beneficiaries using home health care has increased since 2002. The total number of users decreased in 2006, but this is largely due to a significant number of beneficiaries moving to Medicare Advantage. The number of users grew at a rate of 5.6 percent annually from 2002 to 2005, but fell by 0.4 percent in 2006 (Table 2E-3, p. 178). However, the total number of fee-for-service beneficiaries declined by 2.5 percent in 2006 as more beneficiaries enrolled in Medicare Advantage. As a result, the share of beneficiaries in fee-for-service who used home health care actually increased from 8.0 percent in 2005 to 8.1 percent in 2006.

Despite a decrease in the total number of users due to shifts to Medicare Advantage, the rate of fee-for-service beneficiaries using home health care and their episode volume have continued to increase. The number of episodes per fee-for-service beneficiary increased by 4 percent and the episodes per user increased by about 2 percent in 2006. Home health episode growth slowed in 2006, again consistent with the shift of beneficiaries to Medicare Advantage plans. Between 2002 and 2005, the number of episodes grew by about 8 percent a year. This growth fell to 1.7 percent in 2006.

The total number of home health visits has started to increase over the last several years. At the peak in 1997, agencies furnished 73 visits per beneficiary using home health care (Table 2E-1, p. 174). This number declined to a low of 30 visits per user in 2002 but has grown to 34 visits in 2006. The two drivers of this recent increase in visits are growth in the number of visits per episode and growth in the number of episodes per user.

Volume under the PPS has shifted to include a higher share of episodes with 10 or more rehabilitation visits, with the share of these cases rising from 24 percent in 2002 to 28 percent in 2006. The Commission noted in the past that episodes that meet the threshold for additional payment for therapy services—episodes with 10 or more visits—are paid significantly more than nontherapy episodes and are more profitable for providers (MedPAC 2007). Between 2002 and 2005, these types of episodes grew at about 13 percent annually, twice the rate of episodes with fewer than 10 therapy visits.

The difference in the growth rate became even more significant in 2006, and for the first time therapy-intensive episodes constituted the majority of new episodes. The annual growth of episodes with 10 or more visits was 4.2 percent in 2006, six times the rate of growth for episodes that were not therapy intensive. Because of this higher rate of growth, therapy-intensive episodes constituted about 70 percent of new episodes.

The growth in the number of therapy-intensive patients coincides with changes in the types of patients served by inpatient rehabilitation facilities (IRFs). The overall impact on patient severity from the response to changes in IRF policy is small. In 2004, the threshold for qualifying as an IRF was tightened, and to comply, IRFs have changed

TABLE 2E–3

Trends in home health volume and payment, 2002–2006

						Average annual percent change	
	2002	2003	2004	2005	2006	2002–2005	2005–2006
FFS beneficiaries (in millions)	34.9	35.8	36.3	36.6	35.7	1.6%	–2.5%
Home health users (in millions)	2.5	2.6	2.8	2.9	2.9	5.6	–0.4
Share of FFS beneficiaries who used home health	7.1%	7.3%	7.6%	8.0%	8.1%	3.9	2.1
Total spending (in billions)	$9.3	$9.7	$11.0	$12.5	$13.2	10.2	5.7
Payments per:							
FFS beneficiary	$267	$272	$303	$340	$369	8.4	8.4
Home health user	$3,753	$3,704	$3,975	$4,266	$4,527	4.4	6.1
Episodes by type: (in millions)	3.1	3.2	3.4	3.7	3.7	6.2	0.7
Less than 10 therapy visits	1.0	1.1	1.2	1.4	1.4	12.9	4.2
10 or more therapy visits	4.0	4.3	4.7	5.1	5.1	7.9	1.7
Total							
Episodes per:							
FFS beneficiary	0.12	0.12	0.13	0.14	0.14	6.2	4.2
Home health user	1.62	1.64	1.68	1.73	1.76	2.2	2.0
Average payment per episode	$2,317	$2,256	$2,361	$2,470	$2,569	2.2	4.0
Share of episodes with 10 or more therapy visits	24%	25%	26%	27%	28%	4.7	2.5

Note: FFS (fee-for-service).

Source: MedPAC analysis of home health Standard Analytic File.

the types of patients they serve. Apparently, many patients previously served by IRFs now use home health care instead (see Chapter 2F on IRFs). However, all new home health therapy episodes constituted only 1.1 percent of volume in 2006.

Changes in quality

Medicare uses the Outcome and Assessment Information Set (OASIS) to measure patients' clinical severity and functional limitations at the beginning and end of an episode of home health care. This assessment tool allows HHAs to track their patients' outcomes and to change their use of resources, care planning, and other processes to improve their services. CMS also uses OASIS to produce reports for agencies' quality improvement efforts and publishes OASIS-based quality information to help consumers choose high-quality providers.

The quality measures in Table 2E-4 are the items Medicare reports from OASIS to the public. The first five rows show the percent of patients who improved as a percentage of the total number who were admitted with some level of limitation for each time period; increases indicate improving quality. The final two rows display the percentage of patients who used the hospital or the emergency room while under the care of an HHA. For these measures, lower scores suggest better care.

These quality indicators are risk adjusted to account for patients' diagnoses, comorbidities, and functional limitations.[2] Thus, to the extent possible, the improvements reflect small increases in the quality of care from HHAs rather than changes in patient characteristics. While there have been slight gains in quality for most measures, there have been no decreases in the rate at which beneficiaries visit the emergency room and there was a 1 point increase in the rate of hospital admissions in 2007.

TABLE 2E–4 **Share of patients achieving positive outcomes continues to increase**

	2003	2004	2005	2006	2007
Functional/Pain measures (higher is better)					
Improvements in:					
Walking	34%	36%	38%	40%	42%
Getting out of bed	49	51	52	52	53
Bathing	57	60	61	63	64
Managing oral medications	35	38	39	41	42
Patients have less pain	57	59	61	62	63
Adverse event measures (lower is better)					
Any hospital admission	28	28	28	28	29
Any unplanned emergency room use	21	21	21	21	21

Source: MedPAC analysis of CMS Home Health Compare data.

In 2006, we convened an expert panel to consider process measures of home health quality. We determined that additional measures for wound care and falls in the home would contribute to quality measurement. CMS will add a measure for wound care in 2008 and is developing a measure for falls. These new measures will provide useful information for conditions that are common among home health users. In 2008, CMS implemented a demonstration to test a pay-for-performance incentive (see text box, p. 180).

Changes in the supply of agencies

The number of agencies has increased significantly since PPS was implemented in 2001 (Table 2E-5). In 2002, 6,878 agencies participated in Medicare; by 2006, the number of agencies had increased by about 30 percent to 8,868. This growth was faster than the growth in the number of beneficiaries. For example, for every 10,000 beneficiaries in 2002 there were 1.9 HHAs, and by 2006 there were 2.4 agencies for every 10,000 beneficiaries, an increase of 22 percent.

Trends in provider growth reflect patterns in the entry and exit of providers, or the net growth. Variation among states in this net growth is significant, with some states seeing little or no change and others experiencing significant increases or decreases in the number of agencies. Between 2002 and 2006, 60 percent of the gain in the number of agencies occurred in Florida and Texas. Between 2002 and 2005, the six fastest growing states gained an average of 272 providers (MedPAC 2007). However, not all states experienced growth during this period. For example, Minnesota and Montana experienced declines. The number of agencies in Montana fell by 25 percent, while the number in Minnesota declined by 6 percent. It

TABLE 2E–5 **The number of home health agencies continues to grow**

						Average annual percent change	
	2002	2003	2004	2005	2006	2002–2006	2005–2006
Number of agencies	6,878	7,223	7,710	8,218	8,868	6.1%	8.1%
Number of agencies per 10,000 beneficiaries	1.9	2.0	2.1	2.2	2.4	4.2	8.0

Note: 2007 count will be added after year closes.

Source: CMS's Providing Data Quickly database.

Home health pay-for-performance demonstration

Medicare started a home health pay-for-performance demonstration in January 2008. Providers in seven states will have the option of participating in the demonstration. They will be evaluated on seven measures from the Home Health Compare measure set. Agencies that volunteer will be assigned to an experimental group or a control group. For those assigned to the experimental group, agencies in the top 20 percent of performance and 10 percent of improvement will be eligible for an incentive payment. The control group will serve as a comparison to allow CMS to compare differences in cost and quality between agencies that are and are not eligible for the incentive.

MedPAC has recommended that Medicare implement a home health pay-for-performance program, and in our June 2007 report we offered an example of a possible framework. The Commission noted that a pay-for-performance program should include the following elements:

- Reward providers for achieving high quality and also reward those who significantly improve in the quality they deliver. This principle seeks to encourage as many providers as possible to improve, regardless of their overall level of improvement.
- The incentive should be a small portion of the current payment, 1 percent or 2 percent. The Commission determined that the purpose of the reward is to change the incentives in the payment system and not to increase the overall level of reimbursement. As the program gains more experience with performance incentives, the size of the incentive should increase.
- Distribute all payments that are set aside for performance incentives.
- The pay-for-performance system should be designed in collaboration with other purchasers and apply the lessons learned from the program and other health care payers. The program should be evaluated regularly and incorporate new information about health care quality and the program's effectiveness.
- Pay-for-performance incentives should not increase total spending. The goal should be to shift the incentives for payment and not to increase payment amounts.

CMS's demonstration is an interim step in the development of a pay-for-performance system for home health care. In several aspects, the demonstration is consistent with the elements of the Commission principles. For example, the demonstration will reward both attainment and improvement. In addition, the demonstration relies on measures that providers already use and report.

The framework in our June 2007 report differed in several key aspects (MedPAC 2007):

- ***Use of composite measures.*** CMS's demonstration will evaluate agencies on each of seven different measures. Our analysis found that composite measures, which can aggregate a multitude of performance measures across a patient or an agency, provide a more complete picture of agency performance. Any single measure of quality will apply to only a subset of providers, patients, and quality traits. Aggregating performance measures into a composite score ensures that the quality measures are broadly applicable for a range of patients and agencies.
- ***Risk adjustment.*** CMS is relying on the risk adjustment used for Home Health Compare to

is important to remember that the number of providers, or the change in the number of providers, in an area may not be an accurate measure of the capacity available to beneficiaries. HHAs vary significantly in their patient capacity. HHAs in the lowest quintile of volume delivered fewer than 140 episodes while some of the largest agencies provided more than 1,100 episodes in 2006. Also, because home health care is not facility based, agencies have the flexibility to adjust their service areas and staffing as local conditions change. Even the number of employees is not

Home health pay-for-performance demonstration (cont.)

adjust the differences in patient severity among home health agencies. However, our analysis found that this risk adjustment did not always adequately control for differences in patient severity among agencies. Our report demonstrated an alternative form of risk adjustment that used clinical stratification, which divides patients into similar groups of risk based on their primary diagnosis, to identify patients with similar levels of health risk.

- ***Statistical variation in agency performance.*** CMS's method for measuring quality will not address statistical variations in agency performance. As a result agencies may score in the top 10 percent due to chance. Treating each agency's reported score as given—without accounting for the size of an agency's caseload or the standard deviation of scores within an agency's caseload—makes substantial distinctions among small agencies with widely variable scores and makes very little distinction among larger agencies with more stable scores. Under CMS's approach, small agencies that fall in the top 10 percent or 20 percent could receive the incentive, even if the statistical variation in their score indicates the agencies could fall outside the reward threshold. Conversely, large agencies with relatively less variability in their scores could be denied an incentive payment because a smaller agency, without accounting for the variability in its quality scores, outranked it on the quality measures. An alternative approach is to use a method that accounts for the statistical fluctuations in agency performance when measuring differences in quality among agencies.

- ***Size of the bonus payment.*** Another concern is that high-performing agencies cannot be certain they will receive a bonus. To maintain budget neutrality, the funds for the incentive payments will be based on any savings attributable to lower cost growth for the agencies in the experimental group. If the experimental group achieves a lower rate of cost growth, the dollar value of the lower cost growth will be distributed to the agencies in the experimental group that meet the thresholds set for attainment and improvement. Funding the bonus pool from savings will keep the demonstration from raising costs, but it creates uncertainty about the size of the incentive. It is possible that no incentive would be paid if the experimental group does not achieve lower cost growth, or the incentive could be small if the difference in cost growth is modest. Uncertainty about the size of an incentive payment could discourage agencies from making new investments to improve quality or it could discourage them from participating at all.

- ***No penalty for low-performing agencies.*** CMS is relying only on the incentive of a bonus payment to encourage quality; agencies that perform poorly in the CMS demonstration will not see their payments reduced. While the absence of a penalty makes the demonstration more attractive to low-performing agencies, it also limits the degree to which payments under the demonstration reflect agency performance. The demonstration will test only the incentive presented by potential increases in payment and not the effectiveness of penalties.

- ***Participation is voluntary.*** Agencies have the option of not participating in the demonstration. This makes it more likely that agencies that believe they will qualify for an incentive will participate, and agencies that do not believe they will qualify will forgo participation. Agencies that do not believe they will qualify may be those most in need of improvement. MedPAC's framework calls for pay for performance to be a compulsory element that should apply to all providers who choose to serve Medicare beneficiaries. ■

a capacity measure because many HHAs use contracted therapists, aides, and nurses to meet their patients' needs. The total number of agencies provides some indication about the availability of home health services but must be considered with other factors that describe access such as the number of beneficiaries served or episodes delivered.

Concerns about the rapid growth in home health in certain areas led CMS to launch a demonstration to identify fraudulent providers in October 2007. Agencies in Los Angeles, California, and Houston, Texas, will be subject to additional review, including submitting ownership information and a special survey of their operations by

state regulators. CMS selected these areas after observing significant increases in the number of agencies and spending there. CMS will conduct the demonstration for two years, and if the techniques succeed in identifying fraudulent providers, the demonstration may expand to other areas.

How did agency participation change in 2007?

The growth in HHAs in 2007 was smaller than in prior years, with a net gain of about 410 new agencies—or a growth of about 4.6 percent.[3] Policy changes for survey and certification and payments may play a role, but even with this slowdown the total number of agencies reached 9,289 in 2007.

Most agencies use the Medicare survey and certification process to gain the accreditation necessary to participate in Medicare. Under this process, state survey agencies visit a new agency to determine whether it meets Medicare's conditions of participation. Once an agency has satisfactorily completed this process and met state licensing requirements, it may begin to receive payment from Medicare. The increase in new providers has strained resources available to the states for certifying new agencies and some have fallen behind in the recertifications of existing agencies they must also conduct. CMS has instructed agencies to focus their efforts on responding to complaints and recertifications; consequently, some states, including Texas, are not certifying new agencies. Agencies that wish to be certified have an alternative to the state process; they may use one of the independent certification agencies such as the Joint Commission or the Community Health Accreditation Program.

Implementation of the new HHRG–153 system and the adjustment for coding improvements (discussed later) may have slowed the number of new entrants. These policies will change the distribution and level of payments for agencies. Some providers may wish to see the effects of these changes before they decide to begin offering Medicare services. It is also possible that the decrease in the number of fee-for-service beneficiaries may be a factor slowing the entry of new agencies, as the home health industry contends that reimbursement for beneficiaries enrolled in Medicare Advantage plans is inadequate.

Home health agencies' access to capital

Few HHAs access capital through publicly traded shares or public debt. 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. Investor analyses of the leading publicly traded companies are limited indicators of the general industry. Medicare home health care has a small share of the entire "home care" market that investors analyze, which includes nonskilled Medicaid and private duty nursing, nurse staffing services, home infusion, and home oxygen services. Also, publicly traded companies are a small portion of the total number of agencies in the industry.

Since most new HHAs are not owned by publicly traded companies, the data on provider entry provides insight on the access to capital for the privately held agencies. In 2007, about 520 new HHAs entered the program and about 95 percent of them are for profit. The entry of new for-profit agencies suggests that the home health industry has access to capital.

While most HHAs are independently operated or part of a small chain of local or regional agencies, many of the larger publicly traded companies are acquiring established agencies. Purchasing established agencies allows firms to enter new markets with an established referral base in the local market as well as the staffing and other infrastructure for delivering services. One estimate suggests that three of the largest publicly traded Medicare home health companies—Gentiva, Amedisys, and LHC—acquired 165 agencies in 2006 (Deutsche Bank 2007). Consolidation activity is expected to continue, as currently the largest publicly traded firms own less than 10 percent of the HHAs participating in Medicare. Like the overall growth in agencies, these acquisitions suggest that publicly traded firms have adequate access to capital.

Payments and costs for 2008

In addressing payment adequacy, the Commission also considers the relationship between Medicare payments and costs in 2008. MedPAC evaluates provider financial performance by examining the cost information reported by HHAs on Medicare cost reports. The Commission's goal is for payments to be adequate for efficient providers. In making our update recommendation, we focus on the freestanding providers because they are the majority of providers and because they do not reflect the impact of the allocation of overhead costs from the hospital. Our model of HHA margins is based on data from about 4,840 freestanding HHAs.

Our estimated margin for freestanding HHAs is 15.4 percent in 2006. Like previous years, margins generally

vary depending on the number of episodes provided. Agencies in the highest volume quintile had an average margin of 9.2 percent, while those in the lowest had an average margin of 16.7 percent (Table 2E-6).

Hospital-based HHAs have higher costs in part because hospitals allocate hospital-wide overhead costs to the home health provider; if this cost allocation did not exist, the hospital-based margin would be higher. Furthermore, no patient or other economic characteristics of hospital-based HHAs explain these higher costs. Hospital-based providers report higher costs per episode but provide fewer visits per episode than freestanding providers. Hospital-based providers also have a lower case mix, which suggests that they serve less costly patients.[4] Finally, hospital-based and freestanding providers deliver care in the same setting—the beneficiary's home—so the differences we see in costs are not due to different settings. Hospital-based HHAs had a margin of –4.9 percent in 2006.[5]

TABLE 2E–6 **Margins for freestanding home health agencies**

	2005	2006	Percent of agencies (2006)
All	17.3%	15.4%	100%
Geography			
Urban	16.5	14.6	62
Mixed	18.7	17.2	21
Rural	14.1	14.3	17
Type of control			
For profit	19.2	17.4	77
Nonprofit	13.8	11.6	15
Government	8.5	3.6	8
Volume quintile			
First	12.7	9.2	20
Second	13.5	11.0	20
Third	13.3	10.6	20
Fourth	17.4	15.4	20
Fifth	18.6	16.7	20

Note: Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of 2005–2006 Cost Report files from CMS.

Projecting margins for 2008

In modeling 2008 payments and costs, we incorporate policy changes that went into effect between the year of our most recent data, 2006, and the year of margin projection, 2008, as well as those changes scheduled to be in effect in 2009.[6] The major changes, including those discussed previously, are:

- *Implementation of the revised system of HHRGs.* The new system of resource groups redistributes payments, so it is budget neutral. However, in our modeling of margins for 2008 we assume, consistent with past experience, some changes in agency coding practices that increase payment.
- *Impact of case-mix adjustment.* CMS plans to reduce payments in 2008–2011 to correct for an increase in case mix not attributable to patient severity that occurred between 1999 and 2005 (see discussion in next section). The reduction will lower payments by 2.75 percent in 2008–2010 and by 2.71 percent in 2011. Our modeling assumes planned reductions of 2.75 percent per year in 2008 and 2009.
- *Market basket.* By statute, HHAs will receive a full market basket increase of 3.0 percent in 2008. The net increase will be 0.25 percent with the reduction for the case-mix adjustment.

With these policies and the changes discussed below, we estimate that HHAs will have margins of 11.4 percent in 2008.

Changes in coding practice for 2008 and 2009

The home health PPS, like the other payment systems, relies on the relationship between a patient's conditions and resource use to set payments. For a patient with a range of conditions that do and do not affect payment, PPS creates an incentive for providers to always code those conditions that affect payment and be less detailed with coding conditions that do not affect payment. A consequence of this incentive is that coding practices may change when the conditions that affect payment are modified. These changes in coding practice will likely result in increased reporting of conditions that raise payments; as a result, aggregate payments will increase.

Recent analysis of historical coding trends indicates that changes in coding practice since the PPS was

implemented have increased case mix. CMS analyzed claims from 2000–2005 and found that changes in coding practices increased case mix by 11.78 percentage points. Consequently, the 2005 overall case mix overstated the severity of home health patients. As noted earlier, CMS is lowering payments in 2008 through 2011 to account for the impact of the overstated case mix.

Implementation of the HHRG–153 system presents a substantial opportunity for change in coding in 2008 and subsequent years. For example, the number of diagnostic conditions that affect payment is expanding from 4 categories to 22. CMS has not proposed a payment adjustment for future coding changes, so aggregate payments will likely increase from agencies adjusting to the new system. Consequently, our estimate assumes that agencies will change their coding practices under the new HHRG–153 in 2008. Based on CMS's estimate of coding change that occurred in 2000–2005, we assume that changes in coding practice will raise payments by 1.6 percent in 2008 and 2009.

Growth in cost per episode

Since 2001, the average rate of annual cost growth has been significantly lower than the level of inflation indicated by the home health market basket. Between 2002 and 2005, the increase in growth averaged about 1.1 percent a year, significantly lower than the market basket, which averaged 3.3 percent over that period. This phenomenon appears to be diminishing and agencies are beginning to see a rate of cost growth that is higher than in previous years but still lower than most other providers. In 2005, costs increased by 1.6 percent and in 2006 cost growth reached 2.7 percent. Analysis of the cost reports suggests that the costs were increasing across all categories (e.g., labor, transportation) that agencies report and were not attributable to any single area.

How should Medicare payments change in 2009?

The evidence suggests that payments for home health care are adequate to provide access to quality care.

RECOMMENDATION 2E

The Congress should eliminate the update to payment rates for home health care services for calendar year 2009.

RATIONALE 2E

Our evidence suggests that beneficiaries have adequate access to quality home health care. The number of agencies in the program continues to rise, the share of beneficiaries using the benefit continues to increase, and the margins indicate that HHAs' payments significantly exceed their costs. Quality continues to show small improvements for most measures. These factors suggest that most agencies should be able to accommodate cost increases over the coming year without an increase in base payments.

IMPLICATIONS 2E

Spending

- This recommendation decreases federal program spending relative to current law by between $250 million and $750 million in 2009 and between $1 billion and $5 billion over five years.

Beneficiary and provider

- No adverse impacts are expected. This recommendation is not expected to affect beneficiary access to care or providers' ability to provide care.

Future refinements to the home health PPS

The new refinements modestly improve the home health PPS's accuracy, but additional work is needed to improve the accuracy of the system. On average, payments substantially exceed costs for most services, and significant variation exists within resource groups in the new system.

Therapy services have become a major driver of episode volume and payment growth in the PPS. The HHRG–153 will reduce the payment distortions associated with a single threshold, so payment increases for additional therapy visits will now be more gradual. However, it will not address the disparity in payment-to-cost ratios between episodes that receive little or no therapy and episodes that receive significant therapy. Even under the new HHRG–153 system, our modeling indicates that episodes with little or no therapy will be less profitable than those with 6 or more therapy visits. Although the increase is more gradual under the new system, it begins increasing payment for therapy at 6 visits compared with 10 for the current system. The higher payments for therapy-intensive cases, coupled with the lower threshold for additional

payment, suggests that significant incentives for additional therapy visits will remain, if not expand, under the new system. Addressing the disparity in financial margins between therapy and nontherapy patients will make these two classes of patients equally attractive to providers.

The current rate-setting methodology assumes that labor costs for a given discipline are constant across the continuum of patient severity. However, many HHAs employ a range of practitioners with different levels of expertise and wages, from aides to nurses with advanced clinical training. Patients with a higher clinical severity may require more specialized care with higher labor costs than other patients. However, the home health cost report does not collect these data. Expanded information on the home health cost report about the mix of labor that agencies employ would make it possible to analyze differences in skill mix and labor costs among HHAs. Differences in labor mix may account for some of the broad variation we observe in provider costs. Future refinements in the home health PPS should consider how these variations affect cost and total resource use.

MedPAC's statutory mandate requires that it consider the adequacy of Medicare payment for efficient providers. Ensuring that payments are not significantly higher than costs for an efficient provider is critical to the cost discipline of a PPS. If base payments significantly exceed provider costs, improving other aspects of the payment system, such as relative weights, will not resolve this problem. As noted earlier, the home health industry has achieved double-digit margins since the implementation of PPS. The recently announced 11.78 percent reduction for HHAs will significantly reduce these margins, but our analysis for 2008, which includes the policy changes for 2009, suggests that substantial profits remain for this period. If CMS maintains its current policy, and the recent increase in cost trends persists, it is possible that margins may come down to levels that are similar to those of other providers. If so, our future analysis of payment adequacy will capture this trend. ■

Endnotes

1 For this analysis MedPAC used a sample of claims, the Outcome Assessment Information Set, and cost reports for freestanding providers from 2003.

2 MedPAC has noted the risk adjustment for Home Health Compare may not be adequately adjusting for the differences in severity between the caseloads of individual HHAs. The comparison in this chapter focuses on national level data, and in this case the risk adjustment is accounting for aggregate changes in the population.

3 About 521 new agencies entered Medicare in 2007, and about 99 have exited.

4 The home health case-mix system needs improvement and may not always accurately measure patient severity. It is not clear how these inaccuracies bias the comparison of hospital-based and freestanding home health providers. However, the case mix is the indicator of severity the home health PPS relies on and offers insight into how the program views the severity of patients in each setting.

5 The financial performance of hospital-based HHAs is included in MedPAC's assessment of payment adequacy for hospitals (Chapter 2A).

6 MedPAC includes planned policy changes for 2009 to assess their impact on provider margins.

References

Deutsche Bank. 2007. *Home health sector: Initiation of coverage: Home nursing and home respiratory*. New York: Deutsche Bank. January 31.

Fisher, E. S., D. E. Wennberg, T. A. Stukel, et al. 2003. The implications of regional variations in Medicare spending. Part 1: The content, quality and accessibility of care. *Annals of Internal Medicine* 138, no. 4 (February 18): 288–298.

Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2005a. *Report to Congress: Issues in a modernized Medicare program.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2005b. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2004. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2007. *Mid-session review.* Baltimore, MD: OACT.

Office of Inspector General, Department of Health and Human Services. 2006. *Medicare beneficiary access to home health agencies.* OEI–02–04–00260. Washington, DC: OIG. July.