SECTION 3B

Home health services

RECOMMENDATIONS

3B-1 The Congress should eliminate the market basket update for 2011 and direct the Secretary to rebase rates for home health care services to reflect the average cost of providing care.

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

3B-2A 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.

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

3B-2B The Secretary should identify categories of patients who are likely to receive the greatest clinical benefit from home health care and develop outcomes measures that evaluate the quality of care for each category of patient.

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

3B-3 The Congress should direct the Secretary to review home health agencies that exhibit unusual patterns of claims for payment. The Congress should provide the authority to the Secretary to implement safeguards, such as a moratorium on new providers, prior authorization, or suspension of prompt payment requirements, in areas that appear to be high risk.

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

SECTION 3B

Home health services

Section summary

Home health agencies provide services to beneficiaries who are homebound and need skilled care (nursing or therapy). In 2008, about 3.2 million Medicare beneficiaries received home health services from 10,026 home health agencies. Medicare spent $17 billion on home health services in 2008.

Assessment of payment adequacy

The indicators of payment adequacy for home health, discussed below, are mostly positive. Concluding that home health payments need to be reduced significantly, the Commission recommends that the Congress eliminate the market basket update for 2011 and direct the Secretary to rebase rates for home health care services to reflect the average cost of providing care.

Beneficiaries' access to care—Access to home health care is widespread, with 99 percent of beneficiaries living in a ZIP code where a Medicare home health agency operates and 97 percent living in an area with two or more agencies.

- ***Capacity and supply of providers***—The number of agencies continues to increase, with about 500 new ones in 2009. The total number of agencies exceeds 10,400, approaching the peak of 10,917 agencies in 1997. Most new agencies since 2002 are in Texas, Florida, and Michigan. There are

In this section

- Are Medicare payments adequate in 2010?
- How should Medicare payments change in 2011?
- Future refinements to the home health benefit

concerns that growth in certain areas—including Miami–Dade County, Florida—is related to increased fraud and abuse by some providers.

- ***Volume of services***—The volume of services continues to rise. More beneficiaries are receiving home care, and the number of episodes per beneficiary continues to rise.

Quality of care—The Home Health Compare measures for 2009 are similar to those for previous years, showing improvement in the functional measures and mostly unchanged rates of adverse events. However, the Commission has begun to raise concerns about the current measures and believes further study is needed before it can draw definitive conclusions about quality.

Providers' access to capital—Home health agencies are smaller and do not have the capital-intensive needs found in other health care sectors. According to capital market analysts, the major publicly traded for-profit home health companies have access to capital markets for their credit needs. For smaller agencies, the significant number of new agencies in 2009 suggests that they have access to capital necessary for start-up.

Medicare payments and providers' costs—Payments have consistently and substantially exceeded costs in the home health prospective payment system. Medicare margins for freestanding providers in 2008 were 17.4 percent, which is the average for the period 2001–2007. Two factors have contributed to payments exceeding costs: fewer services are delivered than is assumed in Medicare's rates and cost growth has been lower than what is assumed in the market basket. In addition to significantly reduced payments, the Commission calls for strengthening program integrity and quality measurement.

Related issues: Further refinements to the home health benefit

To monitor the effect of recent changes in Medicare payment policy for home health services, the Commission intends to examine several areas that warrant attention. The Commission will examine: (1) the factors driving growth in the length of home health spells—of particular concern as recent policy changes raised payments for spells with multiple episodes; (2) whether payment-related thresholds for therapy services in effect in 2008 have created better incentives for aligning therapy provision with patient needs; (3) the extent to which payment refinements continue to be biased in favor of cases with high resource use while undervaluing cases with low resource use; and (4) the adequacy of current quality measures, the accuracy of risk adjustment, and efforts to develop measures that more directly capture the quality of care provided. We also plan to examine methods for strengthening physician accountability. ■

Background

Medicare home health care 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 skilled care to treat their illnesses or injuries and must be unable to leave their homes without considerable effort. Medicare requires that a physician certify a patient's eligibility for home health care and that a patient receiving service be under the care of a physician. Medicare does not require copayments or a deductible for home health services.

Unlike its coverage for skilled nursing facilities, Medicare does not require a hospital stay to qualify for home health care. The share of beneficiaries admitted from the community compared with admissions after a facility stay has increased significantly since 2000. In 2007, about 39 percent of home health episodes were preceded by a stay in an inpatient or post-acute care facility (acute care hospital, skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital).

Under a prospective payment system (PPS) implemented in 2000, Medicare pays for home health care in 60-day episodes. Patients who complete their course of care before 60 days have passed are discharged and Medicare pays for the episode. Payments for an episode are adjusted for patient severity by a case mix that is based on patients' clinical and functional characteristics and some of the services they use. If they need additional covered home health services at the end of the initial 60-day episode, another episode commences and Medicare pays for an additional episode. Beneficiaries may receive an unlimited number of consecutive home health episodes as long as they meet the eligibility standards for the benefit.

Medicare implemented significant refinements to the home health PPS in 2008 (Medicare Payment Advisory Commission 2007). The revised system sets payments based on the number of therapy visits and an episode's timing in a sequence of consecutive episodes in addition to the patient's clinical and functional characteristics. The Commission's analysis of the changes is discussed in our March 2008 report. (An overview of the home health PPS is available at http://medpac.gov/documents/MedPAC_Payment_Basics_09_HHA.pdf.)

Medicare spending for home health fluctuated in the 1990s but has increased rapidly since 2000

The home health benefit has changed substantially since the 1980s. Implementation of the inpatient PPS in 1983 led to increased use of home health services as hospital lengths of stay decreased. Medicare tightened coverage of some services, but the courts overturned these curbs in 1988. After this change, the number of agencies, users, and services expanded rapidly in the early 1990s. Between 1990 and 1995, the number of annual users increased by 75 percent and the number of visits more than tripled to about 250 million a year. Spending increased from $3.7 billion in 1990 to $15.4 billion in 1995. As the rates of use and lengths of stay increased, there was concern that the benefit was serving more as a long-term care benefit (Government Accountability Office 1996). Further, many of the services provided were believed to be inappropriate or improper; for example, in one analysis of 1995–1996 data the Office of Inspector General (OIG) found that about 40 percent of the Medicare home health claims paid did not meet Medicare requirements for reimbursement (Office of Inspector General 1997).

The trends of the early 1990s prompted increased program integrity actions, refinements to eligibility standards, and replacement of the cost-based payment system with a PPS in 2000. The first initiative was Operation Restore Trust, which reviewed payments of home health agencies (HHAs) and other providers to recover inappropriate or fraudulent payments. The second major change was implementation of the interim payment system (IPS) in October 1997, which cut reimbursement levels significantly. Between 1997 and 2000, the number of beneficiaries using home health services fell by about 1 million, and the number of visits fell by 65 percent (Table 3B-1, p. 202). Total spending for home health services declined by 52 percent. IPS also had a swift effect on the supply of agencies, and by 2000 the number of agencies had fallen by 31 percent.

In October 2000, CMS implemented a PPS, and the composition of the services provided under the benefit changed significantly. Between 2000 and 2008, home health aide visits fell from about 30 percent to about 18 percent of total visits. In addition, the share of therapy visits increased from about 19 percent in 2000 to 26 percent in 2008.

The steep declines in services under the IPS do not appear to have adversely affected the quality of care beneficiaries

TABLE 3B–1

Changes in home health utilization

	1997	2000	2008	Percent change 1997–2000	Percent change 2000–2008
Agencies	10,917	7,528	10,026	–31%	33%
Total spending (in billions)	$17.7	$8.5	$16.9	–52	99
Users (in millions)	3.6	2.5	3.2	–31	28
Number of visits (in millions)	258.2	90.6	117.8	–65	30
Visit type (percent of total)					
Skilled nursing	41%	49%	55%	20	12
Home health aide	48	31	18	–37	–41
Therapy	10	19	26	101	11
Medical social services	1	1	1	1	–30
Visits per user	73	37	37	–49	1
Percent of FFS beneficiaries who used home health	10.5%	7.4%	9.1%	–30	24

Note: FFS (fee-for-service).

Source: Home health standard analytical file; Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 2002; and Office of the Actuary, CMS.

received; one analysis found that patient satisfaction with home health services was mostly unchanged in this period (McCall et al. 2004). An analysis of all the Balanced Budget Act of 1997 (BBA) changes related to post-acute care, including the home health IPS and changes for other post-acute care sectors, concluded that the rate of adverse events generally improved or did not worsen when IPS was in effect (McCall et al. 2003). A study by the Commission also concluded that the quality of care had not declined between IPS and PPS (Medicare Payment Advisory Commission 2004). The similarity in quality of care under IPS and PPS, despite the substantial decline in visits per beneficiary, suggests that the payment reductions in the BBA led agencies to reduce costs without compromising patient care.

Although the changes in the BBA addressed some of the program integrity problems in the home health benefit, payments under the PPS have generally been more than adequate. Margins averaged 17.4 percent between 2001 and 2007. This consistent pattern of high margins indicates that Medicare payments have been well in excess of costs, even in years when the annual payment update has been reduced or eliminated (Figure 3B-1).

Setting policy to define the home health benefit is challenging

Policymakers have always struggled to define the role of the home health benefit in Medicare (Benjamin 1993). From the outset, there was a concern that setting too narrow a policy could result in beneficiaries using other, more expensive, services, while a policy that was too broad could lead to wasteful or ineffective use of home health care (Feder and Lambrew 1996). Medicare relies on the skilled care and homebound requirements as primary determinants of home health eligibility, but these requirements provide limited guidance.

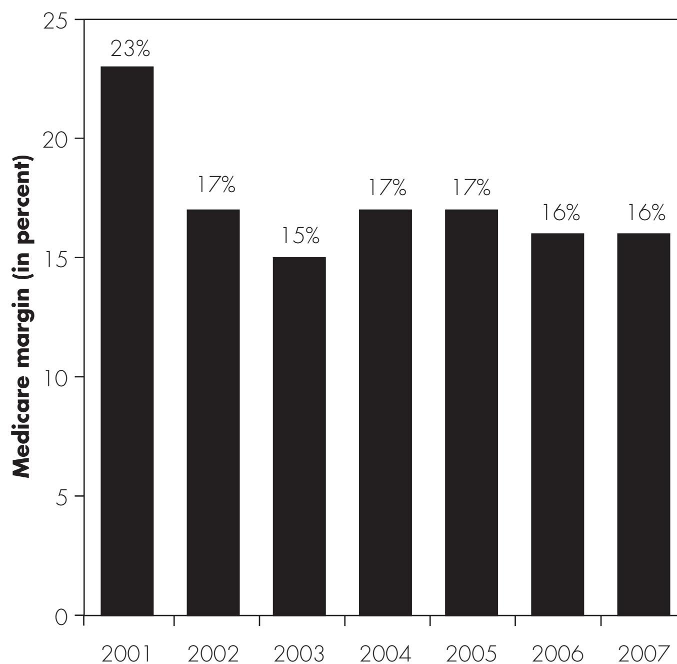
An additional challenge is the variability in services home health patients receive. Past experience indicates that home health providers respond swiftly to incentives in the payment system, as evidenced by the changes in utilization between 1997 and 2000. The fact that payment policy is such a significant factor underscores the Commission's concerns that the home health benefit is ill defined. Understanding which services provide the most benefit would permit development of payment incentives that encourage use of appropriate types of care.

The current benefit relies on the patient's physician to determine appropriateness. However, providers may not always have the information they need to make the best decision. There is overlap in the types of patients and services provided by home health and other post-acute care providers, and it is not always clear which patients belong in home health or another setting. In addition, the benefit's coverage standards are considered ambiguous even by home health practitioners, and agencies appear to be inconsistent in how they apply them (Brega et al. 2002, Cheh et al. 2007). Improved guidelines that more specifically identify the patients most appropriate for home health care would ease administrative confusion and facilitate more appropriate use of the benefit.

Better guidelines might also address some of the regional variation in home health care the Commission has identified in past work (Medicare Payment Advisory Commission 2009). The broad regional variations suggest that local health care systems have different approaches to home health utilization and raise the possibility that some approaches may be more effective than others. Identifying the patients who most benefit from home health care and the services they would benefit from could help to bring more uniformity to use of the benefit.

FIGURE 3B–1

Medicare has paid home health agencies significantly more than cost under PPS



Note: PPS (prospective payment system).

Source: MedPAC analysis of home health cost reports, 2001–2008.

Program integrity issues in the home health care benefit

Similar to the problems that occurred in the 1990s, home health care appears to be experiencing fraud and abuse issues that are significantly increasing spending on home health care. The number of agencies has increased dramatically in areas that have generated program integrity concerns in the past—including the states of California, Texas, and Florida. Officials became suspicious of outlier claims in 2007 when 60 percent of all outlier payments nationwide were made to providers in Miami–Dade County, Florida. However, the concerns about home health fraud and abuse reach beyond Miami–Dade County and outliers. Federal authorities are investigating or prosecuting home-health-related fraud cases in a number of areas for a range of alleged offenses (Department of Health and Human Services and Department of Justice 2009). These cases include billing for services not provided, attempting to bribe federal officials, and paying kickbacks to recruit patients.

So far, CMS has conducted three policy initiatives aimed at home health fraud. First, it required home health providers in Harris County, Texas, and Los Angeles, California, and some counties adjacent to Los Angeles to re-enroll in Medicare. Under this initiative, agencies had to prove that they met Medicare's standards for program enrollment and were visited by a Medicare contractor to verify the establishment's existence. Second, CMS implemented a number of safeguards to curtail fraudulent payments for outlier episodes paid to agencies in Miami–Dade County. Finally, CMS limited outlier payments to no more than 10 percent of an agency's Medicare revenue.

Are Medicare payments adequate in 2010?

To address whether payments for the current year (2010) are adequate to cover the costs efficient providers incur and how much providers' costs should change in the coming year (2011), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries' access to care by examining the capacity and supply of home health providers and changes over time in the

TABLE 3B–2

Number of agencies continues to rise

	2002	2003	2004	2005	2006	2007	2008	2009	Average annual percent change 2002–2008	Average annual percent change 2008–2009
Number of agencies	7,056	7,342	7,803	8,313	8,954	9,403	10,026	10,422	6%	4%
Agencies that opened	399	562	656	693	828	624	763	546	N/A	N/A
Agencies that closed	276	195	183	187	175	140	150	70	N/A	N/A
Number of agencies per 10,000 beneficiaries	2.0	2.0	2.1	2.3	2.5	2.6	2.9	3.0	6%	4%

Note: N/A (not applicable).

Source: CMS's Providing Data Quickly database and 2009 trustees' report.

volume of services provided, quality of care, providers' access to capital, and the relationship between Medicare's payments and providers' costs. Overall, the Medicare payment adequacy indicators for HHAs are mostly positive.

Beneficiaries' access to care: Most beneficiaries have access to two or more HHAs

Supply and volume indicators show that beneficiaries have broad access to home health services. Most beneficiaries live in an area served by home health providers, similar to the Commission's findings in prior years. Nearly all—99 percent—beneficiaries live in a ZIP code served by one HHA and 97 percent live in an area with two or more agencies.

Our measure of access is based on data collected and maintained as part of CMS's Home Health Compare database as of October 2009. 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.

Capacity and supply of providers: Agency participation is approaching its previous high mark

The number of providers has grown significantly under PPS, increasing by about 50 percent since 2002 to 10,422 in 2009 (Table 3B-2). While still below the peak of 10,917 agencies in 1997, the number of agencies has increased by an average of about 480 agencies a year since 2002. Six states account for 90 percent of the increase in agencies since 2002 (Florida, Texas, California, Michigan, Illinois, and Ohio). The top three states (Florida, Texas, and Michigan) account for about 60 percent of new agencies. In addition, most of these new agencies are concentrated within one area or a few areas in each state. For example, most of the new agencies in Florida are in Miami–Dade County. In fact, concerns about fraud in Miami–Dade have become so acute that the state has implemented a moratorium on new HHA licenses, effectively preventing new Medicare agencies from serving the county because state licensure is a Medicare requirement. The state opted for a county-level moratorium because Florida, like most states, does not have a certificate-of-need process for controlling the entry of new HHAs.

The number of new agencies has risen more rapidly than the growth in number of beneficiaries. Since 2004, when 99 percent of beneficiaries lived in an area served by a HHA, the number of agencies per 10,000 FFS beneficiaries rose from 2.1 to 2.9 in 2008. Growth has been concentrated in a few areas. For example, in 2008, Texas had 7 agencies per 10,000 beneficiaries, more than double the number in the next highest state. Between 2004 and 2008, 17 states had growth in agencies per beneficiary that exceeded 10 percent, though most new agencies were concentrated in 4 states; 16 states had declines that exceeded 10 percent. However, even many of the states that experienced a decline had a large supply relative to the national average, excluding Texas. Half the states that experienced a reduction of 10 percent or more between

TABLE 3B–3

Share of beneficiaries using home health continues to rise even as enrollment in Medicare fee-for-service declines

	2002	2003	2004	2005	2006	2007	2008	Average annual percent change 2002–2007	Average annual percent change 2007–2008
FFS beneficiaries (in millions)	35.0	35.9	36.5	36.8	36.2	35.5	34.7	0.3%	–2.2%
Home health users (in millions)	2.5	2.7	2.8	3.0	3.0	3.1	3.2	4.3	1.9
Total spending (in billions)	$9.6	$10.1	$11.5	$12.9	$14.0	$15.7	$16.9	10.5	7.1
Episodes (in millions)	4.1	4.5	4.8	5.2	5.5	5.8	6.1	2.8	2.1
Episodes per beneficiary	0.12	0.12	0.13	0.14	0.15	0.16	0.17	6.9	6.4
Episodes per user	1.6	1.7	1.7	1.8	1.8	1.9	1.9	7.2	4.0
Payments per:									
FFS beneficiary	$274	$282	$314	$351	$388	$443	$486	10.1	9.6
Home health user	$3,803	$3,780	$4,053	$4,339	$4,621	$5,076	$5,337	5.9	5.2

Note: FFS (fee-for-service).

Source: MedPAC analysis of home health standard analytical file.

2004 and 2008 still had a rate of agencies per beneficiary that exceeded the national average, excluding Texas, in 2008. However, there can be significant variation in access within a state, as even in high-supply states agencies may be concentrated in certain areas.

HHAs vary significantly in their size (patient caseload), and so the number of providers in an area is not the only measure of capacity. 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 a capacity measure because many HHAs use contracted therapists, aides, and nurses to meet their patients' needs.

Program changes have not significantly curtailed agency entry

Growth in the number of agencies has led CMS to curtail funding for certification of new agencies. In 2007, CMS instructed state survey agencies to prioritize oversight of existing agencies over the certification of new ones. However, this action was not a moratorium on new agencies, as an agency wishing to become a Medicare provider could use an independent certification agency. Medicare accepts accreditation by one of these entities in lieu of a review by a state survey agency. The share of new agencies that are certified through these entities has increased significantly in the last two years. For example, in 2009, about three-quarters of new agencies were certified through the accreditation agencies; in previous years, most new agencies were certified by state survey agencies. The low priority for federal certification of new agencies indicates that CMS is more concerned about other survey and certification activities than about the need to certify new agencies.

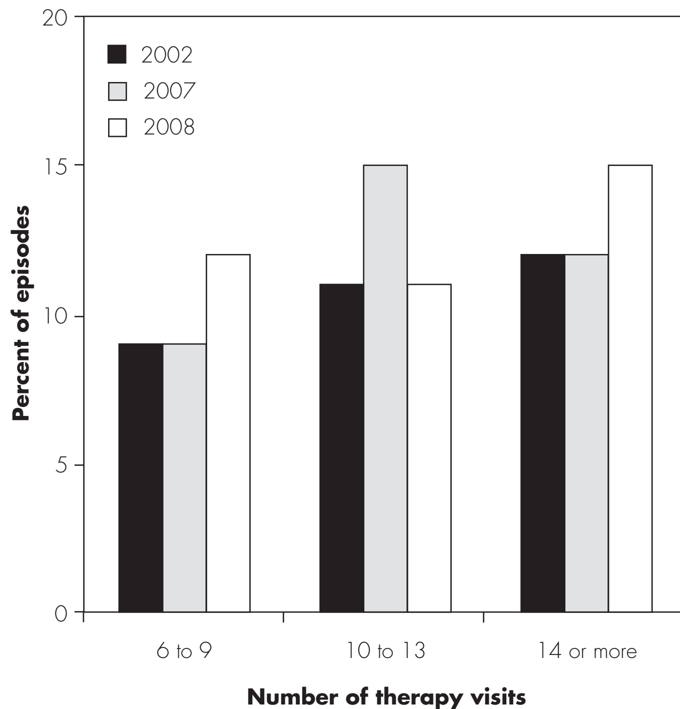
Recent activity indicates that the pace of entry may have slowed slightly in 2009 but also that fewer agencies are leaving the program. In 2009, 546 agencies entered the program, fewer than in the previous year. However, as of November 2009, only 70 agencies had exited, roughly half the number of agencies that left in prior years. The net effect of these two changes is that the total agency count continued to rise to 476 agencies in 2009. This number was lower than the growth in 2008 but continued the trend of significant growth in supply since 2002.

Volume of services: Episodes and rate of use continue to rise

The rate of use and volume of services have risen rapidly for home health services. Between 2002 and 2008, the number of users rose by 3.9 percent a year and the number of episodes per fee-for-service beneficiary rose by 6.8 percent a year.[1] In 2008, about 6 million episodes were provided to 3.2 million beneficiaries (Table 3B-3). About 9 percent of fee-for-service beneficiaries used home

FIGURE 3B–2

Changes in the distribution of therapy visits among home health episodes, 2002–2008



Source: MedPAC analysis of home health standard analytical file.

health in 2008, up from 7.4 percent in 2000 (Table 3B-1, p. 202). The rising volume and rate of use suggest that beneficiaries have adequate access to care.

The number of episodes per user has also increased in recent years, suggesting that beneficiaries are staying in home health longer. Between 2002 and 2008, the number of home health episodes per beneficiary rose from about 1.6 to 1.9.[2] The Commission is concerned about whether longer stays reflect patient needs or incentives that exist under the home health PPS to generate additional episodes.

Under home health PPS, payment incentives historically have influenced the amount of therapy provided The home health PPS uses the number of visits provided, not patient characteristics, to set payment for therapy episodes. Under the PPS implemented in 2000, Medicare paid almost twice as much for episodes with 10 or more therapy visits as for episodes with fewer than 10 therapy visits. In 2002–2007, the share of episodes that qualified for therapy payments increased steadily from 22 percent to 27 percent, with virtually all the growth in therapy episodes concentrated in the range of 10 to 13 therapy visits. For example, between 2002 and 2007, the shares of episodes with 6 to 9 therapy visits and 14 or more therapy visits were mostly unchanged at about 9 percent and 12 percent, respectively (Figure 3B-2). By comparison, the share of episodes with 10 to 13 therapy visits during this time increased from 11 percent to 15 percent. Growth in therapy episodes was a major factor in annual growth in home health volume, accounting for about 40 percent of new episodes in 2007. Clinical or patient characteristics do not explain the pattern of utilization growth. The trend seems to reflect the distortion associated with a single payment threshold.

Changes in therapy in 2008 coincided with payment revisions but more analysis needed to understand impact on quality of care In 2008, CMS implemented revisions for therapy payments that resulted in the swiftest one-year change in therapy utilization since PPS was implemented. In 2008, the share of therapy episodes with decreased payments under the new system—those in the range of 10 to 13 therapy visits—dropped by about one-third, nearing the 2002 level. Conversely, volume increased for therapy episodes that have higher payment under the revisions. For example, in 2008, payment for episodes with six to nine visits increased by 30 percent, and the share of these episodes increased from 9 percent to 12 percent. At the higher end of the visit distribution, payment for episodes with 14 or more therapy visits increased by 26 percent, and the share of these episodes increased from 12 percent to 15 percent. The immediate change in utilization demonstrates that home health providers can quickly adjust services to payment changes in the therapy visit thresholds.

The magnitude of the therapy changes and their correlation with the payment threshold changes suggest that payment incentives continue to influence treatment patterns. This finding is not surprising, as the revised system pays on the basis of services provided, not patient characteristics. The utilization changes in 2008 suggest that the payment system revisions changed but did not eliminate the influence of payment incentives on therapy. More research is needed to determine whether these changes improved patient care.

Quality of care: Measures need further examination

In past reports, the Commission has reported on home health quality measures using the Outcome-Based Quality

TABLE 3B–4

Episode outcomes improve on functional measures though the rate of adverse events is unchanged

	2004	2005	2006	2007	2008	2009
Functional measures (higher is better)						
Improvements in:						
Walking	36%	37%	39%	41%	44%	45%
Transferring	50	51	52	53	53	54
Bathing	59	61	62	63	64	64
Medication management	37	39	40	41	43	43
Patients have less pain	59	61	62	63	64	64
Adverse event measures (lower is better)						
Hospitalization	28	28	28	28	29	29
Emergency care	21	21	21	21	22	22

Source: MedPAC analysis of CMS Home Health Compare data.

Monitoring (OBQM) data set. These measures, collected through the Outcome and Assessment Information Set, examine patients' clinical severity and functional limitations at the beginning and end of an episode. In prior years, the Commission reported that scores for the five functional measures improved, while the adverse event measures (hospitalization and emergent care use) were unchanged. The data for 2009, reported in Table 3B-4, follow a similar pattern. However, the Commission has concerns that these data may not appropriately depict the quality provided in the home health setting.

The nationally reported OBQMs are challenging to interpret because they focus mostly on activities of daily living and instrumental activities of daily living, and they do not directly capture the specific diagnoses or clinical conditions that were the primary reason for use of home health care. For example, the OBQM functional measures reflect the improvement in function for all patients, not just those who received therapy services. Given the volume of therapy provided under the home health benefit, it would be useful to measure the gains in function specifically for patients who use the home health benefit for a primary therapy need (e.g., for therapy involving the upper body or the lower body).

The OBQMs are reported for all episodes with valid data, without concern about the episode's appropriateness for home health given the patient's needs and conditions. Measures for more specific populations and conditions would provide a better assessment of home health quality and more clinically homogeneous groups for comparison among providers or time periods.

Another concern is the apparent inconsistency between functional measures and adverse event rates. For several years, OBQMs have indicated improvement in the functional measures, which suggests patients are healthier at the end of their home health spell, and we might expect adverse events to decline as functional abilities improve. However, the flat trend for hospitalizations and emergency room services suggests that is not the case. These divergent trends raise questions about the validity of the measures.

Some research has indicated that the measures may not properly adjust for changes in the characteristics of the home health population. One study found that the OBQM risk adjustment may disadvantage agencies that take patients with longer stays and more chronic conditions (Murtaugh et al. 2008). Though our analysis compares among years and not agencies, it is possible that some of the problems found in the agency-level analysis could affect the national comparison. If that is the case, it could result in measures misstating the quality of care. For example, the concentrated growth in number of providers raises the possibility that, in some saturated markets, agencies may be taking patients with less severe conditions. If the OBQM risk adjustment overstates the risk for this population, the improvements in the quality measures could reflect better outcomes achieved through taking healthier patients and not the quality of care provided.

TABLE 3B–5

Medicare margins for freestanding agencies, 2006–2008

	2006	2007	2008	Percent of agencies	Percent of episodes
All	15.9%	16.5%	17.4%	100%	100%
Geography					
Majority urban	16.5	16.7	17.8	81.5	81.4
Majority rural	15.8	15.4	15.7	18.5	18.5
Type of control					
For profit	19.2	18.3	18.5	86	78
Nonprofit	13.9	12.0	14.3	14	21
Government*	N/A	N/A	N/A	N/A	N/A
Volume quintile					
First	13.5	8.4	7.9	20	3
Second	13.6	11.7	9.2	20	7
Third	13.7	13.0	13.1	20	11
Fourth	17.7	16.8	16.1	20	20
Fifth	18.6	17.5	19.5	20	59

Note: N/A (not available).
*Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of home health Cost Report files from CMS.

Though the OBQMs for 2009 suggest that quality is adequate, the Commission believes revised measures are necessary given the issues listed above. The Commission plans to examine the strengths and weaknesses of the OBQM measures and explore alternative measures that may capture clinically relevant outcomes for patients who the evidence suggests are appropriate for home health care.

Providers' access to capital: Adequate access to capital for expansion

Few HHAs access capital through publicly traded shares or public debt like issuing bonds. 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. Information on publicly traded home health companies can provide some insight into access to capital but has limitations. Publicly traded companies may have businesses in addition to Medicare home health, such as 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.

Analysis of the for-profit companies indicates that they have adequate access to capital. In recent years, the major chains have been buying existing agencies to expand their businesses, though this activity stalled in 2009. The slowdown in 2009 is attributable to uncertainty about the impact of regulatory changes regarding change of ownership requirements and concerns about the impact of proposed legislative changes on home health payment. According to financial analysts interviewed by the Commission, the major publicly traded for-profit firms are considered to have access to capital markets necessary to make additional acquisitions.

For smaller or nonpublic entities, the entry of new providers indicates that access to capital for privately held agencies is adequate. In 2009, there was a net increase of 476 HHAs; virtually all of these agencies are for profit.

Medicare payments and providers' costs: Trends in services delivered have raised payments and providers' costs are higher in 2008

Change in the mix of services—from lower paid episode types to higher paid ones—has contributed to an increase in average payment per episode. The increase in the

volume of therapy episodes, discussed earlier, has increased payments. In addition, there has been a decline in lower paying low utilization payment adjustment episodes, which have fallen from about 15 percent in 2002 to 10 percent in 2008. Overall, average payment per episode has risen by about 3 percent annually from 2002 to 2007. In 2008, the average episode payment increased by 3 percent, rising to $2,786 per episode (factoring out claims in areas considered to be at high risk for program integrity concerns, growth in average payment was 2.4 percent in 2008).

An increase in reported case mix is a primary factor contributing to higher payments in 2008. The annual payment update to the base rate for 2008 was reduced from 2.9 percent to about 0.15 percent to account for past improvement in agencies' documentation and coding practice that increased case mix (and payments) without a corresponding increase in severity. However, the reported case mix under the revised system increased by 2.4 percent, greater than the annual average increase of 1 percent in prior years (excluding claims from areas affected by program integrity problems). The higher than usual increase in case mix helped to offset the –2.75 percent reduction CMS implemented.

Historically, HHA costs per episode have increased at a low rate, averaging 1.9 percent a year in 2001 through 2008. That rate is significantly lower than the rate of inflation indicated by the home health market basket, which has averaged 2.9 percent since the PPS was implemented. Costs in 2008 grew by 3.8 percent, higher than in previous years. It is not clear why costs increased so significantly in 2008, but there was a similar experience in 2005–2006 when cost inflation spiked in one year and was substantially lower the next.

Medicare margins continue to exceed costs in 2008

The 2008 HHA margins were 17.4 percent for freestanding agencies, up from the previous year (Table 3B-5). We focus on freestanding agencies because they are the majority of providers and because their costs do not reflect allocation of overhead costs from the hospital.

Since an individual HHA can serve a mix of urban and rural patients, we determine an agency's rural or urban designation based on where most of their episodes are located. Under this definition, in 2008, rural providers had slightly lower margins than urban providers, though both had margins greater than 15 percent. To gain a better understanding of providers that serve the least populated rural areas, we examined margins for agencies that were majority rural and for which more than 30 percent of episodes were in counties with urban populations of fewer than 2,500 people. For these agencies, margins were 15.2 percent, roughly the same as the margins of all agencies that were classified as serving mostly rural areas in 2008 (Table 3B-5).

Historically, Medicare margins have varied widely among HHAs. In 2008, the agencies in the bottom quintile of the Medicare margin distribution had an aggregate average margin of –12 percent, while the agencies in the top margin quintile had an aggregate average margin of 36 percent, consistent with the variation reported in prior years. The high margins suggest that some providers may be able to exploit the ambiguous nature of the benefit to deliver services that meet Medicare standards but are less costly than other providers. The high level of access, in addition to the rapid entry of new providers, also likely reflects the significant margins that are possible under Medicare payments.

The concern from the Commission's perspective is whether this variation reflects differences in provider efficiency or inaccuracies in Medicare payments. If high-profit agencies serve different patients or provide different services than low-margin agencies, these differences could indicate that payments do not accurately reflect costs in some instances. Our analysis of margins by provider, beneficiary, and episode characteristics suggests that providers can deliver quality care and earn significant profits under current payment levels and that providers with the lowest costs and the highest case mix have the best financial performance.

Agencies with high and low Medicare margins differed significantly in episode costs, but more analysis is needed to understand differences in case mix and payment

We assessed high- and low-margin agencies on a variety of metrics for freestanding agencies in 2007 (Table 3B-6, p. 210). The greatest difference between high- and low-margin agencies was in cost per episode. High-margin agencies had lower costs and higher episode volume. The cost per episode of high-margin agencies was about 40 percent lower than that for low-margin agencies, driven primarily by a lower cost per visit. The lower costs were likely related to the larger average size of high-margin agencies, as higher volume may permit them to achieve economies of scale that result in lower costs and better

TABLE 3B–6

Comparing the size and cost of high- and low-margin home health agencies, 2007

Characteristic	Low-margin agencies	High-margin agencies	All	Percent difference (high compared to low)
Medicare margin	–9%	37%	16.9%	N/A
Cost per episode (wage index and case-mix adjusted)	$2,256	$1,349	$1,736	–40.2%
Cost per visit (wage index adjusted)	$136	$89	$113	–34.3
Average total annual visits per provider	22,437	28,039	26,430	25
Average visits per episode (excludes low-use episodes)	21.7	19.4	20.3	–10.5
Share of episodes in:				
Urban counties	83%	85%	85%	N/A
Rural counties	17	15	15	N/A

Note: Values shown are medians for the quintile. High-margin quintile agencies were in the top 20 percent of the distribution of Medicare margins. Low-margin quintile agencies were in the bottom 20 percent of the distribution of Medicare margins. Excludes government agencies.

Source: 2007 cost reports, 20 percent sample of claims from home health datalink file, OASIS data.

financial performance. High-margin agencies also had lower costs because they provided about 11 percent fewer visits per full episode. Low- and high-margin agencies served about the same share of urban and rural patients. There was no significant difference in the quality composite scores of high- and low-margin agencies.

Our findings on patient severity were mixed but did not suggest that low-margin agencies serve more severe patients (Table 3B-7). High-margin agencies appeared to serve more severe patients based on the CMS–hierarchical condition category risk score, but there was no difference in the number of chronic conditions or functional impairments for the patients of high- and low-margin providers. We also compared the home health case mix for high- and low-margin agencies and found that high-margin agencies had higher case mix than low-margin agencies. Specifically, high-margin agencies provided more episodes that included 10 or more therapy visits and more episodes to patients in the two highest groups of clinical severity.

The analysis of the case mix of high- and low-margin agencies suggested that Medicare overpays for high case-mix episodes, as high-margin agencies had a case mix that was 7 percent higher. To explore this finding further, we compared agency case mix with changes in cost per episode, controlling for several factors. Our results indicated that for every 1 percentage point change in case mix relative to the mean, mean cost per episode changed more slowly (between 0.6 and 0.8 percentage point).[3] This result suggests that high-case-mix episodes appeared to be overpaid and low-case-mix episodes may have been underpaid. Since high-margin agencies have higher case mixes, the findings of this analysis indicate that these agencies tended to provide episodes for which payments are likely to exceed costs.

Our findings suggest that costs and visit volume are important factors in providers' financial performance. Results were mixed for patient severity and suggest that further analysis of the home health case-mix index is necessary. It appears that the home health case-mix adjuster may not accurately measure severity. The correlation between higher case mix and higher margins suggests that the system overpays for high-case-mix episodes.

Projecting margins for 2011

In modeling 2011 payments and costs, we incorporate policy changes that went into effect between the year of our most recent data, 2007, and the year of margin projection as well as those changes scheduled to be in effect in 2010. The major changes are:

- market basket updates in 2009 and 2010, offset by reductions for coding improvement that occurred in 2000 through 2005;
- a planned 2011 payment reduction of –2.71 to account for coding improvement in 2000 through 2005;

TABLE 3B–7

Comparison of patient severity for high- and low-margin agencies in 2007

Characteristic	Low-margin agencies	High-margin agencies	All	Percent difference (high compared to low)
CMS–HCC score	2.02	2.22	2.17	10%
Average number of activities of daily living with at least some reported difficulty	5.0	5.1	5.0	2
Mean number of chronic conditions per episode	7.0	7.0	7.0	0
Case mix	1.23	1.32	1.27	7
Therapy episodes as a share of total episodes	25%	30%	27%	20
Percent of episodes from high clinical severity case-mix groups	56%	66%	61%	18

Note: CMS–HCC (CMS–hierarchical condition category). Values shown are medians for the quintile. High-margin quintile agencies were in the top 20 percent of the distribution of Medicare margins. Low-margin quintile agencies were in the bottom 20 percent of the distribution of Medicare margins. CMS–HCC scores are for non-end-stage renal disease beneficiaries who qualified for full episode payment. Excludes government agencies.

Source: MedPAC analysis of 20 percent sample from home health datalink claims, Chronic Condition Warehouse, and CMS-HCC Model Output File.

- a case-mix increase of 2 percent a year (due to an increase in patient severity, coding improvement, and utilization changes); and
- an assumed average cost increase of 2.5 percent (high by historical standards).

On the basis of these factors, we project margins of 13.7 percent in 2011.

Medicare home health payments continue to be overly generous relative to HHAs' costs

The favorable financial performance in 2008 and projected performance for 2011 for Medicare home health are consistent with our findings from previous years. Since the advent of prospective payment, Medicare payments for home health services have consistently been more than adequate to cover costs, with an average margin of 17.4 percent from 2001 to 2008. Margins have remained high despite legislative changes to the market basket that reduced the annual increase in payment by an average of 1 percent from 2001 to 2005, a rate freeze in 2006, and administrative reductions for 2008 through 2011. These overpayments contribute to the insolvency of the Hospital Insurance Trust Fund and premium increases beneficiaries must pay for Medicare Part B, which finances a portion of home health care.

These overpayments may be attributable to the method followed to set home health payments initially. The BBA required that the PPS base rate for a home health episode be budget neutral so that aggregate spending would equal the spending that would have occurred if IPS had remained in effect. However, between 1998 and 2008, the average number of home health visits dropped from 31.6 to 21.6 visits (Table 3B-8).

Even though some reductions were made to the initial base rate, these adjustments did not anticipate the magnitude by

TABLE 3B–8

Beneficiaries receive fewer visits under PPS

	1998	2008	Percent change
Physical therapy	3.1	4.6	51%
Occupational therapy	0.5	0.9	74
Speech–language pathology	0.2	0.2	–14
Skilled nursing	14.1	11.8	–16
Medical social work	0.3	0.1	–57
Home health aide	13.4	4.0	–70
Total	31.6	21.6	–32

Note: Data presented have been rounded to the nearest tenth. Percent change calculated based on the nearest thousandth.

Source: CMS 2000; MedPAC analysis of home health standard analytical file, excluding low utilization payment adjustment episodes.

which HHA costs would fall. HHAs had profits of more than 23 percent in 2001, the first year the base rate was in effect (Figure 3B-1, p. 203). Because providers delivered fewer visits than assumed, the payments under PPS have been consistently greater than providers' costs.

The change in the number of visits and the mix of services did not reduce the quality of care provided. The Commission found that the quality provided under PPS was equal to the care provided during the IPS period (Medicare Payment Advisory Commission 2004). The fact that quality was maintained despite a 32 percent decline in visits per episode demonstrates the malleable nature of the benefit, as agencies managed to deliver the same quality with significantly fewer visits.

The changes after implementation of the PPS illustrate the influence of payment incentives on the services provided. Under cost-based reimbursement, providers delivered more visits because of the incentive to maximize volume. Under the PPS, they delivered fewer visits overall because payments are for a lump sum of visits rather than per visit. The exception has been payments for therapy, which rewarded providers for increased numbers of visits. The 2008 therapy payment changes and their effect on utilization illustrate how Medicare payments can influence the services provided (Figure 3B-2, p. 206).

Reductions to payment updates have not been effective in lowering home health margins

Adjustments based on the market basket may be inadequate to address high payments for home health care. Even in 2006, when the home health payment update was eliminated, agency margins remained high. The Deficit Reduction Act of 2005 eliminated the home health update for 2006, effectively freezing home health rates at the 2005 level. Despite this reduction, providers still had average margins of 15.9 percent. Agencies were able to offset the impact of the elimination of the payment update by reducing costs and shifting to a higher paying mix of services.

How should Medicare payments change in 2011?

Our review of home health indicates that access is more than adequate in most areas and that Medicare payments are well in excess of costs. On the basis of these findings, the Commission has concluded that home health payments need to be significantly reduced. In addition, efforts are needed to strengthen program integrity and quality measurement.

Update recommendation

RECOMMENDATION 3B-1

The Congress should eliminate the market basket update for 2011 and direct the Secretary to rebase rates for home health care services to reflect the average cost of providing care.

RATIONALE 3B-1

Most of our indicators suggest that home health payments are more than adequate. For 2011, the Commission is recommending that home health care rates be set to reflect the projected cost of the average home health episode. Under this recommendation, the Secretary would estimate the costs of care for 2011 by reviewing costs from a recent year. The costs would also be adjusted for any projected changes in service provision or costs between the year reviewed and 2011. Basing payments on providers' actual costs would effectively reset payment rates to lower levels.

IMPLICATIONS 3B-1

Spending

- Reduce Medicare spending by $750 million to $2 billion in 2011; more than $10 billion over five years.

Beneficiary and provider

- Some reduction in provider supply is likely, particularly in areas that have experienced rapid growth in the number of providers. Access to care is likely to remain adequate, even if the supply of agencies declines.

RECOMMENDATION 3B-2A

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.

RATIONALE 3B-2A

This recommendation charges the Secretary with developing additional changes to home health payments to safeguard beneficiary care. Financial safeguards, such as profit and loss corridors or blended prospective and

cost-based payments, should be proposed as expeditiously as possible when the rebasing is implemented in 2011. These financial safeguards would help mitigate incentives to reduce services when payments drop because of the rebasing by redistributing payments from high-margin providers to low-margin agencies.

In both approaches the safeguards would be based on how providers changed the delivery of care after the rebasing, with the goal of redistributing payments to providers that maintained relatively higher levels of service. Agencies that held their visits per episode steady relative to a pre-rebasing benchmark would have relatively favorable treatment under the safeguards, and those that reduced their visits would receive more restrictive treatment. For example, under the profit and loss corridors, the adjustment for agencies that did not reduce their visits per episode could be more generous.

Approaches that mix PPS and corridors or cost-based payment involve trade-offs because, while softening the impact of rebasing, they could weaken incentives for provider efficiency. Unlike the current PPS, agencies that were able to lower their costs would see their payments fall, with efficiency gains resulting in lower provider revenue. However, the safeguards would not completely undermine the incentive for efficiency, as the risk corridors could be set narrowly enough so that they would recover or compensate for only a small fraction of excessive profits or extreme losses above the corridor thresholds. This result would maintain some of the rewards and penalties for efficiency. Avoiding a system that relies too heavily on cost to set payments would be prudent, as the cost-based system in effect in the early and mid-1990s proved vulnerable to abuse.

IMPLICATIONS 3B-2A

Spending

- Some administrative costs. The approaches could be implemented in a budget-neutral manner and should not have an overall impact on spending.

Beneficiary and provider

- This recommendation would provide incentives for agencies to preserve services during the rebasing. No impact on beneficiary access to care or providers' willingness to care for Medicare beneficiaries is expected.

RECOMMENDATION 3B-2B

The Secretary should identify categories of patients who are likely to receive the greatest clinical benefit from home health care and develop outcomes measures that evaluate the quality of care for each category of patient.

RATIONALE 3B-2B

The current home health quality measures focus mostly on improvements in activities of daily living or instrumental activities of daily living. The current measures reflect some important outcomes for home health care, but questions remain about the adequacy of the risk adjustment and the measures' direct relevance to the quality of skilled care provided in home health. The Commission believes more direct measures of the skilled care that is the primary purpose of the home health benefit would be appropriate. For these reasons, the Commission is recommending that the Secretary develop additional measures.

The additional measures should target the processes and outcomes related to specific diagnoses or conditions of patients likely to benefit the most from home health care. In developing these measures, the Secretary should review research and current data on home health outcomes, including the data from the Unified Post-Acute Care Instrument demonstration and other research into the efficacy of home health, to identify the patients who are appropriate for home health services. The categories of services and conditions examined should include rehabilitation, clinical indications for chronic conditions, and patients at high risk of hospitalization. For these subgroups of patients, the Secretary should develop measures that capture specific measures of performance, such as improvement in function related to primary rehabilitation diagnosis, changes in clinical indicators related to chronic conditions, and adverse outcomes such as hospitalizations or use of emergent care. By focusing on certain clinical factors related to the conditions associated with the need for home health care, the measures would provide more tangible measures of agency performance on homogeneous patient populations, facilitating more accurate comparison.

Further, identifying patients who are most appropriate for home health care could be a step toward better defining the benefit. Such information could be applied to a number of possible revisions to the home health benefit. Clinically appropriate measures with accurate risk adjustment are

critical to implementation of pay for performance. An understanding of the patients that benefit most from home health care could aid in development of revised "site-neutral" payment policies for post-acute care. In addition, the guidelines could inform efforts to develop bundled payment for acute and post-acute care. Finally, as mentioned earlier, Medicare could use this information to clarify guidance for providers.

IMPLICATIONS 3B-2B

Spending

- Savings of less than $50 million in the first year and less than $1 billion over 5 years. Some administrative costs.

Beneficiary and provider impacts

- No impact on beneficiary access to care or providers' willingness to care for Medicare beneficiaries is expected. Potential for improvement in beneficiary care.

RECOMMENDATION 3B-3

The Congress should direct the Secretary to review home health agencies that exhibit unusual patterns of claims for payment. The Congress should provide the authority to the Secretary to implement safeguards, such as a moratorium on new providers, prior authorization, or suspension of prompt payment requirements, in areas that appear to be high risk.

RATIONALE 3B-3

The Commission and others have observed aberrant patterns of behavior that suggest some agencies may be abusing the program. CMS, the Government Accountability Office, and OIG have examined outlier payments and found a pattern that indicates rampant fraud in South Florida. The home health industry has expressed concern about program integrity in home health and stated the need for expanded oversight (National Association for Home Care and Hospice 2009, Visiting Nurse Associations of America 2009). CMS and other enforcement agencies should continue to actively review HHA patterns of utilization and target agencies with patterns that are anomalous. These reviews should focus on the elements that appear to be most susceptible to manipulation by agencies. Possible areas of emphasis include:

- ***Therapy.*** As discussed earlier, the Commission concluded that therapy episodes appear to be overpaid relative to others and that the amount of therapy changed significantly in response to the 2008 revisions to the payment system. Payment review could be targeted at agencies that have unusually high rates of therapy episodes and agencies with the largest increase in the therapy episodes that are favored under the new system (those in the range of 6–9 and 14+ visits).

- ***Multiple episode spells of home health.*** Medicare permits beneficiaries to receive an unlimited number of home health episodes as long as a beneficiary meets the eligibility standards. This policy creates an area of potential abuse, as agencies can improve revenues by maximizing the number of episodes they provide. Fraudulent or abusive providers can pursue a number of approaches, such as stretching services over many episodes or continuing services for patients who are no longer eligible. Longer spells of home health care may be more frequent now because revisions implemented in 2008 increased payment for later episodes (third and subsequent episodes in a spell of home health). Similar to the examination of therapy payments, the Secretary and others should target agencies with high rates of later episodes and those that significantly increased the provision of these episodes after payments for later episodes increased.

- ***Agencies with significantly fewer average visits per episode.*** Under the PPS, agencies with fewer visits per episode will have lower costs and better financial performance. The Secretary could review the eligibility, care, coding, and financial results of agencies that provide significantly fewer visits per episode than average. The Secretary could examine medical records to ensure that patients are not being underserved or prematurely discharged. The Secretary could also review the survey history and rate of adverse events (such as hospitalizations or emergency room use) to gauge agency operations.

- ***Physician accountability.*** In cases of aberrant patterns of care, the Secretary could assess whether the efforts exercised by physicians in certifying care were adequate. The scope of review should scrutinize whether the physician made adequate efforts to certify that the patient was eligible for home health care and that the physician made adequate efforts to ensure that the services on the plan of care were necessary. One area to begin review includes physicians who certified services provided by the agencies involved in aberrant claims for outlier services in Miami–Dade County.

The Commission is also recommending that the Congress give the Secretary authority to respond swiftly when fraud is concentrated in certain regions. The Secretary should have the authority to temporarily suspend the enrollment of new home health providers in areas where the local trends suggest fraudulent or abusive patterns of care. Temporarily suspending enrollment in areas where providers are exploiting the program would help to keep questionable providers out of the program, reduce fraudulent payments, and decrease the investigative burden of high-fraud areas on the Secretary and other enforcement agencies.

IMPLICATIONS 3B-3

Spending

- Savings of less than $50 million in the first year and less than $1 billion over five years. Some administrative costs.

Beneficiary and provider impacts

- No impact on beneficiary access to care or providers' willingness to care for Medicare beneficiaries is expected.

Future refinements to the home health benefit

The Commission believes the home health payment system needs to be improved. There is significant variation in the services received by beneficiaries and costs of providers, and the current payment system appears vulnerable to abusive and fraudulent practices. Separate from the payment recommendations made in this chapter, additional changes that have the potential to improve the incentives of the current system should be examined. On the basis of our payment adequacy review, we plan to pursue several issues for further analysis:

- ***Understanding the factors driving growth in the length of home health spells.*** Proper oversight of multiepisode spells is important because Medicare pays for home health care on a per episode basis. The average number of episodes per beneficiary has risen 30 percent between 2002 and 2008. The Commission found that Medicare could strengthen oversight for patients with long hospice stays, and the Commission plans to explore the factors underlying growing home health lengths of spells to determine factors responsible and whether current program requirements need to be strengthened. This concern is particularly acute for post-2007 spells, because the 2008 refinements raise payments for the third or subsequent episodes in a home health spell.
- ***Changes in delivery of therapy.*** The new therapy thresholds in effect in 2008 changed the distribution of therapy services. Identifying the factors that determined whether a patient received more or fewer visits in 2008, and determining whether these changes had a significant impact on outcomes, is crucial to understanding the impact of the new thresholds. This analysis will allow us to assess whether the revised system provides better incentives for aligning therapy provision with patient needs.
- ***Refinements to the case-mix index.*** Our analysis of the 2007 case-mix index indicates that it favored higher case-mix episodes and undervalued lower case-mix episodes. Given the significant revisions to the case mix in 2008, we plan to revisit this analysis to determine whether this bias continues under the new system. We will examine whether there are patient characteristics or services that are misvalued under the new case-mix system.
- ***Review of quality measures.*** The Commission will assess the adequacy of the current OBQMs and the accuracy of the risk adjustment used in the measures. We will also examine additional measures that focus on specific categories of patients. The Commission is interested in identifying patients who the evidence suggests are appropriately served in home health based on their diagnoses or service needs and developing measures that more directly capture the quality of care provided.

However, while payment policy is crucial, addressing the current challenges for the benefit may involve changing other policies. For example, Medicare currently has no cost-sharing requirements for home health care. The current PPS could be modified to set a portion of the payment on a per visit basis and include a beneficiary copay. For providers, a per visit approach encourages them to tailor the number of visits provided to a beneficiary's specific needs. The per visit copay would require that beneficiaries weigh the value of an additional visit with the cost of the copay.

Strengthening physician accountability

The recent trends in fraud and abuse suggest a need to strengthen oversight of the home health benefit. The Medicare Act assigns responsibility for certifying patient eligibility for home health care to physicians, but recurrent fraud and abuse problems in the benefit raise questions about physician accountability. A 2001 study by OIG found a gap in physicians' comprehension of Medicare requirements (Office of Inspector General 2001). For example, about 38 percent of physicians reported that they were unclear about Medicare's homebound definition, and 50 percent reported that they did not understand the skilled need requirement for home care. In a recent rulemaking, CMS reviewed options for strengthening physician accountability but did not take any action (Centers for Medicare & Medicaid Services 2008). The Commission plans to assess several alternatives or modifications to current policy that would strengthen physician accountability and effectiveness in certifying for home health care:

- ***Requiring a face-to-face examination.*** Physicians may certify a patient for home health care without an examination. Considering the complexity of Medicare's requirements for home health eligibility, it seems likely that physicians may benefit from the information gained by an in-person examination. Establishing clear expectations for the purposes of these examinations would be critical to ensuring their effectiveness.
- ***Strengthening attestation procedures.*** CMS previously required that physicians complete a form, the CMS–485, to attest to a beneficiary's eligibility and need for home health care. The form stated key program requirements and notified physicians of the penalties for signing a false attestation. The form was retired in 2002, though the requirements for certification continued. While a number of guidelines remain that detail the documentation HHAs must collect from physicians, the use of a defined form ensured that the certification always followed a format that informed physicians of their responsibility. The lack of a specific format creates a vulnerability that unscrupulous providers may manipulate.
- ***Role of a patient's physician during a home health episode.*** Current law requires that a beneficiary be under the care of a physician while receiving home health care. This requirement plays several possible roles, such as ensuring oversight of home health services, encouraging beneficiary access to the usual source of care, and supporting continuity of care for the beneficiary after the episode is completed. However, Medicare has no specific expectations for the physician during the episode. Examining the role of outpatient care during an episode may provide insights for policy changes to strengthen the role of physicians for home health beneficiaries.

The above approaches seek to strengthen home health oversight through current program requirements for physician certification. However, the current magnitude of home health program integrity problems could suggest that measures beyond physician certification be considered. An alternative approach would be for Medicare to require a third party, such as a Medicare contractor or other entity, to evaluate a patient's need for home health care. The third-party entity would be responsible for assessing patient eligibility and need for home health care, facilitating greater consistency and stricter oversight in the application of Medicare requirements. ■

Endnotes

1 Excluding claims from areas with program integrity issues did not significantly change the episode and user growth rates.

2 Excluding claims from areas with program integrity issues did not significantly change the episode per beneficiary levels or growth.

3 The model estimated the change in cost per episode, controlling for agency case mix, wage index, and outlier episodes. The r-square for the model was 0.38.

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