CHAPTER 9

Home health care services

RECOMMENDATIONS

9 The Congress should direct the Secretary to reduce payments to home health agencies with relatively high risk-adjusted rates of hospital readmission.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

(Additionally, the Commission reiterates its previous recommendations on improving the home health payment system. See text box, pp. 234–236.)

CHAPTER 9

Home health care services

In this chapter

- Are Medicare payments adequate in 2014?
- How should Medicare payments change in 2015?
- Designing a home health care readmissions policy

Chapter summary

Home health agencies provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2012, about 3.4 million Medicare beneficiaries received home care, and the program spent about $18 billion on home health services. The number of agencies participating in Medicare reached 12,311 in 2012.

Assessment of payment adequacy

The indicators of payment adequacy for home health care are generally positive.

Beneficiaries' access to care**—**Access to home health care is generally adequate: Over 99 percent of beneficiaries live in a ZIP code where a Medicare home health agency operates, and 97 percent live in a ZIP code with two or more agencies.

- ***Capacity and supply of providers*****—**In 2012, the number of agencies continued to increase, with a net gain of 257 agencies. Most new agencies were concentrated in a few states, and for-profit agencies accounted for the majority of new providers.
- ***Volume of services*****—**In 2012, the volume of services declined slightly, and total payments declined by about 2 percent, or $400 million. Payments also declined due to a small reduction in the Medicare base rate,

though this decline was partially offset by an increase in the average case-mix index value. The lower spending comes after several years of increases; total spending between 2002 and 2012 increased by 89 percent. Between 2002 and 2012, the average number of 60-day episodes per home health user increased from 1.6 to 2.0, indicating that beneficiaries who used home health care stayed on service for longer periods of time.

***Quality of care*—**Quality was steady or showed a small improvement in measures of beneficiary function.

***Providers' access to capital*—**Access to capital is a less important indicator of Medicare payment adequacy for home health care because it is less capital intensive than most other health care sectors. According to capital market analysts, the major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs, although terms were not as favorable as in prior years. The significant number of new, smaller agencies in 2012 suggests that they had access to the capital necessary for start-up.

***Medicare payments and providers' costs*—**For more than a decade, payments have consistently and substantially exceeded costs in the home health prospective payment system. Medicare margins for freestanding agencies averaged 14.4 percent in 2012 and averaged 17.5 percent in 2001 through 2011. Two factors have contributed to payments exceeding costs: Fewer visits were delivered in an episode than is assumed in Medicare's rates, and cost growth has been lower than the annual payment updates for home health care. We project that average Medicare margins for home health agencies will be 12.6 percent in 2014.

The Commission reiterates payment recommendations from prior years

This report reiterates the 2011 recommendations the Commission made to rebase home health payments (Medicare Payment Advisory Commission 2011). The Patient Protection and Affordable Care Act of 2010 includes modest reductions in payment for home health care, but these policies will leave home health agencies with margins well above cost. Overpaying for home health services has negative financial consequences for the federal budget and raises the Medicare premiums that beneficiaries pay. Implementing the Commission's prior recommendation for rebasing would reduce payments more swiftly and better align Medicare's payments with the actual costs of providing home health services.

The Commission recommends the establishment of a financial incentive to reduce readmissions to home health care

The Commission recommends that Medicare establish a program to incentivize agencies to reduce avoidable hospital readmissions from home health care. This measure would apply to home health stays preceded by a hospitalization. About 29 percent of post-hospital home health stays result in readmission, and there is tremendous variation in performance among providers within and across geographic regions. The broad variation in performance suggests the potential for poorer performing agencies to lower their readmission rates. Implementing a readmission penalty for home health care could improve care for beneficiaries and lower Medicare spending. Such a policy would also align the incentives of home health agencies with those of hospitals under the Hospital Readmissions Reduction Program and would prepare these agencies for participating in coordinated-care models that seek to reduce avoidable readmissions, like those of accountable care organizations. ■

Background

Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, 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. In contrast to coverage for skilled nursing facility services, Medicare does not require a preceding hospital stay to qualify for home health care. Unlike for most services, Medicare does not require copayments or a deductible for home health services. In 2012, about 3.4 million Medicare beneficiaries received home care, and the program spent about $18 billion on home health services. Medicare spending for home health care has doubled since 2001 and currently accounts for about 4 percent of fee-for-service (FFS) spending. In 2012, the number of home health agencies (HHAs) participating in Medicare exceeded 12,300.

Medicare pays for home health care in 60-day episodes. Payments for an episode are adjusted for patient severity based on patients' clinical and functional characteristics and some of the services they use. If beneficiaries 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. Episodes delivered to beneficiaries in rural areas receive a 3 percent payment increase for 2010 through 2015. (An overview of the home health prospective payment system (PPS) is available at http://medpac.gov/documents/MedPAC_Payment_Basics_13_HHA.pdf.) Coverage for additional episodes generally has the same requirements (e.g., the beneficiary must be homebound and need skilled care) as the initial episode.

Use and growth of the home health benefit has varied substantially due to changes in coverage and payment policy

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. From 1990 to 1995, spending increased from $3.7 billion to $15.4 billion. 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 found that about 40 percent of the services in a sample of Medicare claims did not meet Medicare requirements for reimbursement, mostly because services did not meet Medicare's standards for a reasonable and necessary service, patients did not meet the homebound coverage requirement, or the medical record did not document that a billed service was provided (Office of Inspector General 1997).

The trends of the early 1990s prompted increased program integrity actions, refinements of coverage standards, temporary spending caps through an interim payment system (IPS), and replacement of the cost-based payment system with a PPS in 2000. 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 9-1, p. 218). The mix of services changed from predominantly aide services in 1997 to mostly nursing visits in 2000, and therapy visits increased between 1997 and 2012 from 10 percent of visits to 34 percent. Between 1997 and 2000, total spending for home health services declined by 52 percent. The reduction in payments had a swift effect on the supply of agencies, and by 2000, the number of agencies had fallen by 31 percent. However, after this period, the PPS was implemented, and service use and agency supply rebounded at a rapid pace. Between 2001 and 2012, the number of home health episodes rose from 3.9 million to 6.7 million. The number of agencies in 2012 was over 12,300, almost 1,400 more agencies than at the 1997 spending peak. Almost all the new agencies since implementation of the PPS have been for-profit providers.

The steep declines in services under the IPS do not appear to have adversely affected the quality of care beneficiaries received; one analysis found that patient satisfaction with home health services was mostly unchanged in this period (McCall et al. 2004, McCall et al. 2003). A study by the Commission also concluded that the quality of care had not declined between the IPS and the PPS (Medicare

TABLE 9–1

Changes in supply and utilization of home health care, 1997–2012

	1997	2000	2012	Percent change 1997–2000	Percent change 2000–2012
Agencies	10,917	7,528	12,311	–31%	64%
Total spending (in billions)	$17.7	$8.5	$18.0	–52	112
Users (in millions)	3.6	2.5	3.4	–31	38
Number of visits (in millions)	258.2	90.6	113.7	–65	25
Visit type (percent of total)					
Skilled nursing	41%	49%	52%	20	6
Home health aide	48	31	14	–37	–54
Therapy	10	19	34	101	77
Medical social services	1	1	1	1	–2
Number of visits per user	73	37	33	–49	–10
Percent of FFS beneficiaries who used home health services	10.5%	7.4%	9.4%	–30	28

Note: FFS (fee-for-service). Medicare did not pay on a per episode basis before October 2000.

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

Payment Advisory Commission 2004). The similarity in quality of care under the IPS and the PPS suggests that the payment reductions in the Balanced Budget Act of 1997 led agencies to reduce costs and utilization without a measurable difference in the quality of patient care.

A recent court case between the Department of Health and Human Services and the Center for Medicare Advocacy will require the program to clarify the language in its benefit manual regarding the coverage of services needed to maintain or prevent the deterioration of a patient's current condition. Coverage will hinge on existing requirements: that the beneficiary needs skilled care and meets the homebound requirement. In 2013, CMS released revised standards implementing the court settlement. It will be difficult to ascertain the impact of this change until experience is gained under the new standards. However, given the rapid growth the benefit has experienced in the past, it remains possible that utilization could increase.

Home health margins for freestanding HHAs have been very high since the PPS was implemented; Medicare margins averaged 17.5 percent between 2001 and 2011 (Figure 9-1). These high margins likely have encouraged the entry of new HHAs; the total number of agencies participating in Medicare has increased by an average of about 530 agencies a year since 2002. The high overpayments have led the Commission to recommend that home health rates be lowered to a level consistent with costs (Medicare Payment Advisory Commission 2011).

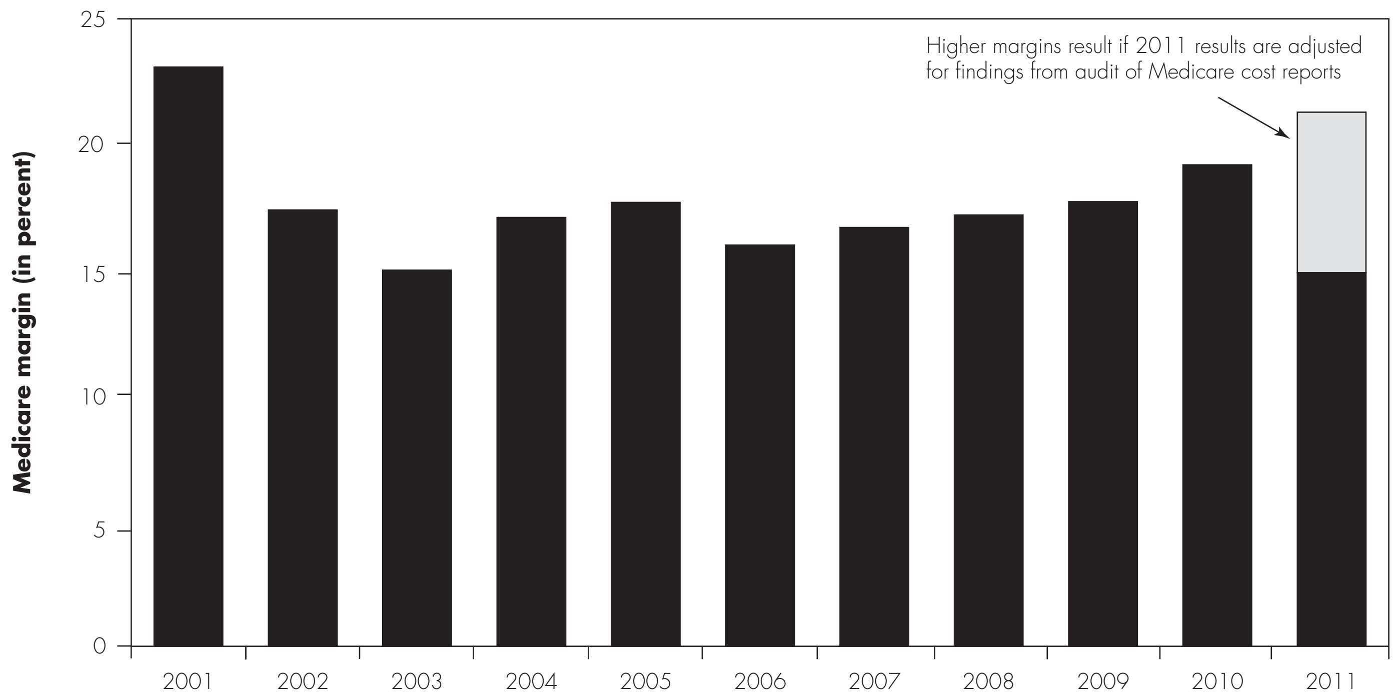
The average margin may be even higher than these amounts for many agencies. The margins the Commission reports rely on the cost and payment information reported by HHAs on Medicare cost reports. CMS stopped routinely auditing these cost reports when the PPS was implemented in 2001, but it recently conducted an audit of 100 HHA cost reports for 2011. The audit found that costs were overstated by an average of 8 percent in 2011. Because costs were overstated, the profit margin of 15 percent for 2011 was understated, and actual margins could have been significantly higher. If reported costs in earlier years were also overstated, then the margins for 2010 and earlier could also be significantly higher. However, audited cost reports are not available for this period, and it is difficult to determine how the degree of misstatement in costs and payments may have changed over this time.

Patient Protection and Affordable Care Act of 2010 changes to payment for home health services

In 2010, the Commission recommended that Medicare lower home health payments to make them more

FIGURE 9–1

Medicare margins of freestanding home health agencies since 2001



Note: An audit of 2011 cost reports indicated that home health agencies overstated their costs in this year by 8 percent. The figure shows the reported margin, without adjustment, in the solid line; the gray box indicates that margins would have exceeded 20 percent if the results were adjusted for the audit finding.

Source: Medicare cost reports.

consistent with costs, a policy referred to as payment rebasing. The Patient Protection and Affordable Care Act of 2010 (PPACA) includes several reductions intended to address home health care's high Medicare payments, but these policies may not achieve the Commission's goal of making payments more consistent with actual costs. The Commission has concerns that the rebasing called for in PPACA will ultimately be too modest and leave agencies with substantial profit opportunities while unduly burdening taxpayers and beneficiaries.

PPACA calls for the annual rebasing adjustment to be offset by the payment update for each year in 2014 through 2017. CMS set the rebasing reduction to the maximum amount permitted under the PPACA formula, which was equal to 3.5 percent of the 2010 base rate, or $81 per 60-day episode. However, the base rate has increased since 2010, so this reduction will be less than 3.5 percent and will equal 2.7 percent to 3 percent in 2014 through 2017. In addition, over this period, the payment update will raise payments, resulting in a cumulative net payment reduction of 1.6 percent (Table 9-2, p. 220). This modest reduction will likely leave substantial HHA margins, which have always exceeded 14 percent since the implementation of the PPS.

PPACA's approach to rebasing also affects low-utilization payment adjustment (LUPA) episodes, effectively preventing CMS from raising payments for these services to be equal to cost. The LUPA rate is applied in episodes with fewer than 5 visits and makes a per visit payment instead of the case-mix–adjusted 60-day episode payment. CMS's cost analysis found that the LUPA rates were too low by 20 percent to 33 percent. The statutory provisions in PPACA limit the degree to which CMS may change payments; as a consequence, the increase for rebasing covers only a portion of this shortfall. LUPAs are a small share of home health volume, about 9 percent of episodes and 1 percent of payments. However, they play an important role in the payment system because they guard against the incentive to provide more than four visits to receive a higher payment. The incentive to exceed the LUPA threshold is already substantial, with the average LUPA payment equaling $344, compared with $3,056 for

TABLE 9–2

Impact of PPACA rebasing on payments for 60-day episodes

	2014	2015	2016	2017	Cumulative change, 2014–2017
Rebasing adjustment	–2.7%	–2.8%	–2.9%	–3.0%	–10.9%
Legislated payment update	2.3	2.4	2.7	2.6	10.5
Net annual payment reduction	–0.5	–0.4	–0.2	–0.5	–1.6

Note: PPACA (Patient Protection and Affordable Care Act of 2010). Data are based on 2013 third-quarter forecast of home health market basket. Annual and cumulative impacts of payment changes are multiplicative. Data do not include impact of reduction in 2014 due to changes to the home health grouper.

Source: MedPAC analysis based on data from CMS.

the average full episode in 2010. If LUPA rates remain below cost, agencies have even more incentive to provide more than four visits in an episode to qualify for the full episode payment.

Ensuring appropriate use of home health care is challenging

Policymakers have long struggled to define the role of the home health benefit in Medicare (Benjamin 1993). From the outset, there was a concern that setting a narrow 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 broad coverage criteria permit beneficiaries to receive services in the home even though they are capable of leaving home for medical care, which most home health beneficiaries do (Wolff et al. 2008). Medicare does not provide any incentives for beneficiaries or providers to consider alternatives to home health care, and beneficiaries, once they meet program coverage requirements, can receive an unlimited number of home health episodes. In addition, the program relies on agencies and physicians to follow program requirements for determining beneficiary needs, but there is some evidence that they do not consistently follow Medicare's standards (Cheh et al. 2007, Office of Inspector General 2001).

Even when enforced, the standards permit a broad range of services. For example, the skilled care requirement mandates that a beneficiary need therapy or nursing care to be eligible for the home health benefit. The intent of the skilled services requirement is that the home health benefit serves a clear medical purpose and is not an unskilled personal care benefit. However, Medicare's coverage standards do not require that skilled visits be the majority of the home health services a patient receives. For about 9 percent of episodes in 2010, most services provided were visits from an unskilled home health aide. These episodes raise questions about whether Medicare's broad standards for coverage are adequate to ensure that skilled care remains the focus of the home health benefit. While Medicare typically covers unskilled care in the institutional post-acute care (PAC) settings, most home health episodes are not posthospital services. The aide service in home health is the only instance in which Medicare will cover these services for community-dwelling beneficiaries, and the eligibility for them does not require that a patient qualify for an acute level of care.

In 2010, the Commission made a recommendation to curb wasteful or fraudulent home health services (Medicare Payment Advisory Commission 2010). This recommendation calls on CMS to use its authorities under current law to examine providers with aberrant patterns of utilization for possible fraud and abuse. PPACA permits Medicare to implement temporary moratoriums on the enrollment of new agencies in areas believed to have a high incidence of fraud. Medicare implemented this moratorium authority for home health agencies in July 2013 in the Miami–Dade and Chicago metropolitan areas. Medicare also has the authority to require HHAs to hold surety bonds, but it has not exercised this authority.[1]

Are Medicare payments adequate in 2014?

The Commission reviews several indicators to determine the level at which payments will be adequate to cover the costs of an efficient provider in 2014. We assess

TABLE 9–3

Number of participating home health agencies continues to rise

	2003	2005	2007	2009	2010	2011	2012	Average annual percent change 2003–2011	Average annual percent change 2011–2012
Active agencies	7,235	8,353	9,291	10,568	11,453	12,054	12,311	6.6%	2.1%
Number of agencies per 10,000 beneficiaries	2.0	2.3	2.6	3.0	3.2	3.3	3.3	6.4	0.6

Note: "Active agencies" includes all agencies operating during a year, including agencies that closed or opened.

Source: CMS's Provider of Service file and 2013 annual report of the Boards of Trustees of the Medicare trust funds.

beneficiary access to care by examining the supply of home health providers and annual changes in the volume of services. The review also examines quality of care, access to capital, and the relationship between Medicare's payments and providers' costs. Overall, the Medicare payment adequacy indicators for HHAs are positive.

Beneficiaries' access to care: Almost all beneficiaries live in an area served by home health care

Supply and volume indicators show that almost all beneficiaries have access to home health services. In 2012, almost all beneficiaries (99.4 percent) lived in a ZIP code served by at least one HHA, 97 percent lived in a ZIP code served by two or more HHAs, and over 84 percent lived in a ZIP code served by five or more agencies.[2] These findings are consistent with our review of access from prior years.

Capacity and supply of providers: Agency supply surpasses previous peak

In 2012, 12,311 HHAs participated in Medicare, a net increase of 257 agencies from the previous year. Most new agencies in 2012 were for-profit agencies. The number of agencies exceeded the 1997 record when supply exceeded 10,900 agencies. The high rate of growth is a particular concern because the new agencies appear to be concentrated in states that have had a number of significant fraud reports, including California, Florida, and Texas. These states, like most, do not have state certificate-of-need laws for home health care, which can otherwise limit the entry of new providers.[3]

From 2003 to 2012, the number of agencies per 10,000 FFS beneficiaries rose 60 percent, from 2.0 to 3.3 (Table 9-3). Most of the new agencies were for profit. However, supply varies significantly among states. In 2012, Texas averaged 9.9 agencies per 10,000 beneficiaries, while New Jersey averaged less than 1 agency per 10,000 beneficiaries. Some of this variation was likely due to differences in agency size; for example, in New Jersey, the average agency provided 2,810 episodes compared with 391 episodes per agency in Texas. The extreme variation demonstrates that the number of providers is a limited measure of capacity because agencies can vary in size. Also, because home health care is not provided in a medical facility, agencies can adjust their service areas as local conditions change. Even the number of employees may not be an effective metric because agencies can use contract staff to meet their patients' needs.

Growth in episode volume slows after many years of rapid growth

In 2012, total spending for home health care dropped by about 2 percent (Table 9-4, p. 222), resulting from a slight decline in volume and a 1 percent decrease in average payment per episode. The per episode payment declined because of a reduction to the home health base rate, though this reduction was offset by an increase in the average case-mix value. The slight volume decline is in sharp contrast to utilization trends in prior years. From 2002 to 2011, the number of episodes increased by 64 percent, from 4.1 million to 6.8 million episodes. Between 2002 and 2012, the share of beneficiaries using home health care increased from 7.2 percent to 9.4 percent.

Home health care volume slowed in 2011 relative to prior years, which could be at least partially attributable to a new Medicare requirement: The physician certifying the need for home health care, or the physician's delegated nonphysician practitioner, must have had a face-to-

TABLE 9–4

Fee-for-service home health care services increased rapidly from 2002 to 2010

	2002	2006	2010	2011	2012	Average annual percent change 2002–2011	Average annual percent change 2011–2012	Cumulative change, 2002–2012
Medicare enrollees (in millions)	35.0	36.1	36.0	36.5	37.1	0.5%	1.6%	6%
Home health users (in millions)	2.5	3.0	3.4	3.4	3.4	3.5	–0.2	37
Share of beneficiaries using home health care	7.2%	8.4%	9.6%	9.6%	9.4%	3.2	–1.5	31
Episodes (in millions):	4.1	5.5	6.8	6.8	6.7	5.9	–1.5	64
Per home health user	1.6	1.8	2.0	2.0	2.0	2.2	–1.3	20
Per FFS beneficiary	0.12	0.15	0.19	0.19	0.18	5.5	–2.8	58
Payments (in billions)	$9.6	14.0	19.4	18.4	18.0	7.5	–2.0	89
Per home health user	$3,803	$4,606	$5,679	$5,347	$5,247	3.9	–1.9	38
Per FFS beneficiary	$274	$387	$539	$505	$487	7.0	–3.5	78

Note: FFS (fee-for-service). Percent change is calculated on numbers that have not been rounded.

Source: MedPAC analysis of 2013 home health standard analytical file.

face encounter with the patient when authorizing care. Office visits or telehealth encounters with a physician or nurse practitioner up to 90 days before or 30 days after the beginning of home health care qualify toward the requirement. The change was intended to ensure that beneficiaries receive a complete evaluation when home health care is ordered and that physicians do not rely solely on information provided by HHAs when making decisions about patient care. It is possible that the additional scrutiny required by this examination led to fewer referrals for home health care.

The decline in volume in 2012 relative to the prior year was concentrated in states with the highest utilization rates—Texas, Louisiana, Oklahoma, Mississippi, and Florida. Volume declined by 5 percent in Texas (more than 50,000 episodes) and by 8 percent in Louisiana. However, these areas experienced substantial growth in the previous 10 years. Even after these declines, these states had the highest utilization rates on a per beneficiary basis; as a group, the five states averaged 33 episodes per 100 beneficiaries, more than twice the average of all other states. In addition, growth continued in other areas, and 20 states had an increase in volume in 2012. California led this group with an increase of 25,000 episodes.

Since 2002, home health care stays have grown longer and less focused on post-acute care

Between 2002 and 2012, the average number of episodes per user increased by 20 percent. The increase indicates that beneficiaries are receiving home health care for longer periods of time and suggests that home health care serves more as a long-term care benefit for some beneficiaries. This concern is similar to those in the mid-1990s that led to major program integrity activities and payment reductions. The increase in episodes coincides with Medicare's PPS incentives that encourage additional volume: the unit of payment per episode encourages more service (more episodes per beneficiary), and the PPS makes higher payments for the third and later episodes in a consecutive spell of home health episodes.

The rise in the average number of episodes per beneficiary also coincides with a relative shift away from using home health care as a PAC service. Over the 2001–2011 period, the number of episodes not preceded by a hospitalization or PAC stay increased by 117 percent, compared with a 25 percent increase in episodes that were preceded by a hospitalization or PAC stay (Table 9-5). During that period, the share of all episodes not preceded by a

TABLE 9–5

Increase in home health episodes by timing and source of episode

	Number of episodes (in millions)		Cumulative growth	Percent of episodes	
	2001	**2011**		**2001**	**2011**
Episodes not preceded by a hospitalization or PAC stay:					
First	0.8	1.3	67%	20%	19%
Subsequent	1.3	3.2	148	32	46
Subtotal	2.1	4.5	117	53	66
Episodes preceded by a hospitalization or PAC stay:					
First	1.6	1.8	17%	40	27
Subsequent	0.3	0.5	66	8	7
Subtotal	1.9	2.3	25	47	34
Total	3.9	6.8	73	100	100

Note: PAC (post-acute care). "First" and "subsequent" refer to the timing of an episode relative to other home health episodes. "First" indicates no home health episode in the 60 days preceding the episode. "Subsequent" indicates the episode started within 60 days of the end of a preceding episode. "Episodes preceded by a hospitalization or PAC stay" indicates the episode occurred fewer than 15 days after a hospital (including long-term care hospital), skilled nursing facility, or inpatient rehabilitation facility stay. "Episodes not preceded by a hospitalization or PAC stay" (community-admitted episodes) indicates that there was no hospitalization or PAC stay in the 15 days before episode start. Numbers may not add to subtotals and totals due to rounding.

Source: CMS Datalink file, 2012.

hospitalization or PAC stay rose from about 53 percent to 66 percent.

The Commission examined the characteristics of beneficiaries based on how they most frequently used home health care. Beneficiaries were classified into two categories based on their home health utilization: Beneficiaries for whom the majority of home health episodes in 2010 were preceded by a hospitalization or other post-acute stay were classified as PAC users of home health, while beneficiaries for whom the majority of episodes for 2010 were not preceded by a hospital or PAC stay were classified as community-admitted users.

The differences between the two populations suggest that Medicare is serving distinct populations within the home health benefit. In 2010, PAC users averaged 1.4 episodes, while community-admitted users averaged 2.6 episodes. About 42 percent of the episodes provided to community-admitted users were for dual-eligible Medicare and Medicaid beneficiaries; in contrast, the comparable share for PAC users was 24 percent. Community-admitted users also had a larger share of episodes with high numbers of visits from home health aides; for example, aide services were the majority of services provided in 11 percent of the episodes for community-admitted users compared with 4 percent for PAC users. Community-admitted users generally had fewer chronic conditions, tended to be older, and had a higher rate of dementia and Alzheimer's disease. The high share of community-admitted users who were also Medicaid eligible suggests that some of this utilization could have been due to state Medicaid programs inappropriately leveraging the Medicare home health benefit to provide long-term care. Under this practice, states shift the costs of at least some of their long-term care expenses to the Medicare program.

Volume of therapy services is influenced by incentives in Medicare's payment system

The number of therapy visits a beneficiary receives during a home health care episode is one of the factors that determine Medicare's payment for a home health episode. Generally, providing more therapy visits raises the episode payment. The Commission has long had a concern that allowing utilization to drive payment creates an incentive for agencies to provide more services regardless of clinical need; changes in episode volume generally reflect these incentives. In 2011, the Commission recommended that Medicare redesign the payment system to rely solely

TABLE 9–6

Most counties with the highest rates of beneficiaries using home health in 2012 are rural

State	County	Rural or urban	Share of FFS beneficiaries using home health services	Episodes per user	Episodes per 100 FFS beneficiaries
TX	Duval*	Rural	35.2%	4.4	154.5
TX	Brooks*	Rural	34.6	4.1	141.2
FL	Miami–Dade*	Urban	29.2	2.6	76.2
TX	Jim Hogg*	Rural	28.9	4.1	119.3
TX	Willacy*	Rural	28.5	3.5	100.9
MS	Claiborne*	Rural	27.7	3.0	84.2
TX	Jim Wells*	Rural	27.2	3.9	107.1
TX	Starr*	Rural	26.6	4.0	106.3
OK	Choctaw*	Rural	25.9	4.2	107.9
TX	Zapata*	Rural	25.1	4.3	108.6
LA	Madison*	Rural	23.8	4.4	104.1
LA	East Carroll*	Rural	23.4	4.4	103.0
TX	Webb*	Urban	23.3	4.0	92.3
TX	Collingsworth	Rural	23.3	4.3	99.8
TX	Hidalgo*	Urban	22.7	3.6	82.4
OK	McCurtain*	Rural	22.4	4.4	97.4
TN	Hancock*	Rural	22.4	3.2	70.8
MS	Holmes	Rural	21.9	3.3	72.2
TX	Red River*	Rural	21.6	4.0	85.7
OK	Latimer*	Rural	21.5	4.4	95.5
TX	Cameron*	Urban	21.5	3.2	69.0
TX	Throckmorton	Rural	21.3	4.1	87.7
LA	Avoyelles*	Rural	20.8	4.0	82.4
OK	Pushmataha*	Rural	20.7	4.0	82.6
LA	St. Helena	Urban	20.1	3.6	73.2
National average			9.4	2.0	18.0

Note: FFS (fee-for-service). Counties with fewer than 100 home health users have been excluded. The table includes the top 25 counties with the highest share of FFS beneficiaries using home health.
*County has been in the top 25 of counties ranked by utilization since 2011.

Source: MedPAC analysis of the 2012 home health standard analytical file and the 2012 Medicare denominator file.

on patient characteristics—not the number of services provided—for setting payment, but CMS has yet to implement this recommendation (Medicare Payment Advisory Commission 2011).

A review of historical trends in the volume of therapy services indicates that payment incentives generally influenced provider behavior. From 2001 to 2007, CMS had a single payment adjustment for therapy that increased payment for episodes with 10 or more therapy visits. In this period, the growth rate for episodes that just met the threshold was almost double the growth for all other home health episodes. This trend led to concerns that providers were deliberately targeting the 10-visit threshold.

Responding to these concerns, CMS implemented changes in 2008 that lowered payments for episodes with 10 to 13 therapy visits and increased payment for episodes in the 6 to 9 or 14 or more therapy visit ranges. The subsequent changes in therapy utilization reflected the new incentives: Episodes with 10 to 13 therapy visits decreased, while those with 6 to 9 therapy visits and 14 or more visits increased. This shift was the largest one-year shift in therapy volume since the PPS was implemented.

TABLE 9–7

Average agency performance on select quality measures

	2004	2008	2011	2012	2013
Share of an agency's beneficiaries with improvement in:					
Transferring	47%	51%	51%	52%	52%
Bathing	56	62	62	63	63
Walking			53	55	57
Medication management			43	45	46
Pain management			65	65	65
Unplanned urgent care use					11

Note: The measures for walking, medication management, and pain management changed in 2011 and are not comparable with data from prior years. Data are not available prior to 2013 for unplanned urgent care use. Data are risk adjusted for differences in patient condition among home health agencies.

Source: MedPAC analysis of CMS Home Health Compare data.

Since 2008, the growth in episodes has followed this pattern, with episodes involving 14 or more visits growing significantly.

In 2011, CMS tightened supervision requirements for episodes reaching the 14th and 20th therapy visit. Claims data for 2011 suggest that these requirements had some impact because the number of episodes with visits at and beyond these thresholds decreased relative to 2010. In 2012, CMS raised the relative weight payments for episodes with fewer than six therapy visits and lowered them for episodes with six or more therapy visits but retained the number of visits furnished as a payment factor. This adjustment at least partially addresses the Commission's past concerns that therapy services may be overvalued, but agencies can still garner higher payments by providing additional therapy visits. The distribution of episodes for 2012 in each of the therapy payment groups did not change significantly relative to the prior year, suggesting that the payment changes may not have been sufficient to significantly affect provider behavior.

Rural areas with high utilization benefit most from Medicare's rural add-on payment

In 2010, PPACA implemented an add-on payment of 3 percent for each home health care episode provided to beneficiaries in rural areas, presumably to bolster access to home health services. The high level of utilization in many rural areas results in Medicare's per episode add-on being poorly targeted, with many payments made to areas with above average utilization. The use of such a broadly targeted add-on, providing the same payment for all rural areas regardless of access, results in rural areas with the highest utilization drawing a disproportionate share of the add-on payments. For example, 71 percent of the episodes that received the add-on payments in 2012 were in rural counties with utilization above the national average (equal to or greater than the 60th percentile of episodes per FFS beneficiary among all counties). The rural counties in the bottom 40 percent of utilization, those below the national average, accounted for 11 percent of the episodes eligible for the add-on payment.

In its June 2012 report to the Congress, the Commission noted that Medicare should target rural payment adjustments to those areas that have access challenges (Medicare Payment Advisory Commission 2012). The large share of payments made to rural areas with above-average utilization does nothing to improve access to care in those areas and raises payments in markets that appear to be more than adequately served by HHAs. Some of the counties with aberrant patterns of utilization that suggest fraud and abuse are rural; for example, 20 of the 25 top spending counties in 2012 are rural areas (Table 9-6). Higher payments in areas without access problems can encourage the entry or expanded operations of agencies that seek to exploit Medicare's financial incentives. More targeted approaches that limit rural add-on payments to areas with access problems should be pursued.

Quality of care: Quality measures generally held steady or improved

Medicare reports several quality measures on its Home Health Compare website, from which we obtained recent trends for measures associated with function and care management (Table 9-7). In general, the share of beneficiaries showing improvement in these measures has

TABLE 9–8

Medicare margins for freestanding home health agencies, 2011 and 2012

	2011	2012	Percent of agencies, 2012	Percent of episodes, 2012
All	15.0%	14.4%	100%	100%
Geography				
Majority urban	14.8	14.8	83	82
Majority rural	15.5	12.8	17	18
Type of ownership				
For profit	15.8	15.2	88	81
Nonprofit	12.0	12.0	12	19
Government*	N/A	N/A	N/A	N/A
Volume quintile				
First (smallest)	6.8	6.8	20	5
Second	8.3	8.0	20	7
Third	10.1	10.2	20	15
Fourth	13.5	13.2	20	26
Fifth (largest)	17.4	16.7	20	47

Note: N/A (not available). Agencies were classified as majority urban if they provided more than 50 percent of episodes to beneficiaries in urban counties and were classified as majority rural if they provided more than 50 percent of episodes to beneficiaries in rural counties.
*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.

increased since 2004, and measures either held steady or improved slightly in 2012 and 2013. However, these data are collected only for beneficiaries who do not have their home health care stays terminated by a hospitalization, which means that the beneficiaries included in the measure are probably healthier and more likely to have positive outcomes.

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

Few HHAs access capital through publicly traded shares or through public debt such as 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 care companies provides some insight into access to capital but has limitations. Publicly traded companies may have other lines of business in addition to Medicare home health care, such as hospice, Medicaid, and private-duty nursing. Also, publicly traded companies are a small portion of the total number of agencies in the industry. For these reasons, access to capital is a smaller consideration for home health than for other health care sectors receiving Medicare payment.

Analysis of for-profit companies indicates that they had adequate access to capital in 2012, though the recent declines in reimbursement for home health care have made capital more difficult to obtain. The PPACA changes in home health care policy implemented in the 2011 and 2012 PPS regulations have trimmed revenues for the home health care industry. In addition, several federal investigations have been launched into the therapy billing practices of some of the publicly held home health companies. These factors have weakened investor outlook for these firms and have made lenders more cautious in the terms they offer home health firms seeking capital, but for-profit HHAs still appear to have access to capital for their operating needs. Even with these concerns, some of the majorly traded home health firms completed substantial transactions that suggest they have adequate access to capital. Gentiva purchased Harden Healthcare for about $409 million, and Almost Family purchased two regional home health chains for approximately $110 million. For smaller or nonpublic entities, the entry of new providers indicates that access to capital for privately held agencies is adequate. In 2012, over 257 new HHAs entered Medicare; most of these agencies were for profit.

Medicare payments and providers' costs: Payments decreased in 2012 but costs decreased more

In 2012, average Medicare payments per episode declined by about 0.5 percent, a result of several policies intended to address changes in coding practices unrelated to patient severity and to reduce Medicare's historically high payments for this service. At the same time, however, the average cost per episode in 2012 declined by about 1.4 percent relative to the prior year. Low or no cost growth has been typical for home health care, and in some years we have observed a decline in cost per episode. The ability of HHAs to keep costs low has contributed to their high margins under the Medicare PPS.

Medicare margins remained high in 2012

In 2012, HHA margins in aggregate were 14.4 percent for freestanding agencies (Table 9-8). For-profit agencies had higher margins than nonprofit agencies, and urban agencies had slightly higher margins than rural agencies. Financial performance varied from –0.3 percent for the agency at the 25th percentile of the margin distribution to 23 percent for the agency at the 75th percentile (data not shown).

The Commission includes hospital-based HHAs in the analysis of inpatient hospital margins because these agencies operate in the financial context of hospital operations. Margins for hospital-based agencies in 2012 were –15 percent. The lower margins of hospital-based agencies are chiefly due to their higher costs, some of which may be due to overhead costs allocated to the HHA from its parent hospital. The lower inpatient costs due to shorter hospital stays may more than compensate for any losses from operating an HHA. Urban agencies had slightly higher rates than rural agencies, and larger agencies generally had higher margins than smaller agencies.

Relatively efficient HHAs serve patients similar to all other HHAs' patients

The Medicare Modernization Act of 2003 requires that the Commission consider the financial performance of an efficient provider in its review of payment adequacy. We examined the quality and cost efficiency of freestanding HHAs to identify a cohort that demonstrates better performance on these metrics relative to its peers (Table 9-9, p. 228). The measure of cost is risk-adjusted cost per episode, and the measure of quality is a risk-adjusted measure of hospitalization. (The hospitalization measure refers to a hospital stay that occurs during or after a home health episode of care.) Our approach categorizes an HHA as relatively efficient if the agency is in the lowest third on at least one measure (either low cost per episode or a low hospitalization rate) and is not in the highest third of the other measures for three consecutive years (2008 to 2010). About 15 percent of agencies met these criteria in this period.

Relatively efficient agencies had margins that were 6 percentage points higher with a hospitalization rate that was 23 percent lower compared with other HHAs, and the average cost per visit was 15 percent lower compared with other HHAs. Relatively efficient HHAs provided more episodes but about 1.8 fewer visits per episode. There was generally no significant difference between the patient attributes of relatively efficient providers and other agencies because they served similar shares of rural and dual-eligible beneficiaries. Compared with other regions, the Middle Atlantic, South Atlantic, and Mountain regions had greater shares of relatively efficient providers.

Projecting margins for 2014

In modeling 2014 payments and costs, we incorporate policy changes that will go into effect between the year of our most recent data, 2012, and the year for which we are making margin predictions, 2014. The major changes are:

- –0.1 percent payment change in 2013, the result of a positive payment update (1.3 percent) and a reduction for improvements in coding (–1.32 percent);
- –1.1 percent payment change in 2014, the result of a positive payment update (2.3 percent), a reduction due to changes to the grouper that lowered average payments (–0.6 percent) and the rebasing adjustment (–2.7 percent);
- 3 percent add-on in effect for episodes provided in rural areas in 2013 and 2014; and
- assumed episode cost growth of 0.5 percent a year for 2013 and 2014, a conservative assumption relative to the trend in recent years.

On the basis of these policies and assumptions, the Commission projects a margin of 12.6 percent in 2014. The margins for 2014 would be about 2 percent lower if the sequester required by the Budget Control Act of 2011 were included.

Medicare has always overpaid for home health services under PPS

Payments for home health care have substantially exceeded costs since Medicare established the PPS. In

TABLE 9–9

Performance of relatively efficient home health agencies

Provider characteristics	All	Relatively efficient provider	All other providers
Number of agencies	3,971	600	3,371
Share of for-profit agencies	82%	73%	83%
Medicare margin			
2010	19.1%	25.6%	19.1%
2009	18.6%	25.7%	18.6%
Quality			
Hospitalization rate (2010)	28%	23%	30%
Costs and payments			
Cost per visit, standardized for wages (2010)	$133	$116	$137
Average payment per episode (2010)	$2,884	$2,711	$2,916
Visits per episode			
Total visits per episode (2010)	17.6	16.2	18.0
Share of visits by type			
Skilled nursing visits	51%	52%	50%
Aide visits	16%	11%	17%
MSS visits	1%	1%	1%
Therapy visits	33%	35%	32%
Size, 2010 (number of 60-day payment episodes)			
Mean	991	1,092	973
Median	579	701	560
Share of episodes, 2010			
Low-use episode	8%	10%	9%
Outlier episode	2%	2%	2%
Community-admitted episodes	33%	41%	32%
Therapy episodes	36%	37%	35%
Share of agencies by region			
New England	4%	3%	4%
Middle Atlantic	6%	11%	5%
South Atlantic	15%	24%	14%
East North Central	19%	14%	19%
East South Central	5%	5%	5%
West North Central	6%	11%	5%
West South Central	30%	18%	32%
Mountain	6%	9%	5%
Pacific	10%	5%	11%
Beneficiary demographics, 2010			
Share of episodes provided to dual-eligible Medicare/Medicaid beneficiaries	35%	32%	36%
Average age	78	78	78
Share of episodes provided to rural beneficiaries	22%	22%	22%

Note: MSS (medical social services). Sample includes freestanding agencies with complete data for three consecutive years (2008–2010). A home health agency is classified as relatively efficient if it is in the lowest third in cost per episode or rehospitalization and is not in the highest third of either measure for three consecutive years. Quality is measured using a risk-adjusted measure of hospitalization, and cost is measured using risk-adjusted cost per episode. Sample includes freestanding agencies with complete data for three consecutive years. Agencies in high-utilization areas were excluded. Low-use episodes are those with four or fewer visits in a 60-day episode. Outlier episodes are those that received a very high number of visits and qualified for outlier payments. Community-admitted episodes are those episodes that were preceded by a hospitalization or post-acute care stay. Therapy episodes are those with six or more therapy visits.

Source: Medicare cost reports and home health standard analytic file.

TABLE 9–10

Medicare visits per full episode before and after implementation of PPS

Type of visit	Visits per episode 1998	2001	2012	Change in visits per episode 1998–2001	2001–2012
Skilled nursing	14.1	10.5	9.3	–25%	–11%
Therapy (physical, occupational, and speech language)	3.8	5.2	6.2	39	18
Home health aide	13.4	5.5	2.6	–59	–52
Medical social services	0.3	0.2	0.1	–36	–32
Total	31.6	21.4	18.6	–32	–15

Note: PPS (prospective payment system). The PPS was implemented in October 2000.

Source: Home health standard analytic file.

2001, the first year of the PPS, average margins equaled 23 percent. The high margins in the first year suggest that the PPS established a base rate well in excess of costs. The base rate assumed that the average number of visits per episode would decline about 15 percent between 1998 and 2001, while the actual decline was about 32 percent (Table 9-10). By providing fewer visits than anticipated, HHAs were able to garner extremely high average payments relative to the services provided.

This structural mismatch between payment levels and cost growth led to the Commission recommending in March 2010 that Medicare rebase payments to be closer to costs (Medicare Payment Advisory Commission 2010). PPACA has some mandated reductions for home health care that begin to reduce payments, but these reductions would leave HHAs with margins well in excess of cost. Overpaying for home health care has negative financial consequences for the federal budget and the beneficiary; implementing the Commission's prior recommendation for rebasing would better align Medicare's payments with HHAs' actual costs.

How should Medicare payments change in 2015?

A review of the Commission's indicators suggests that access is more than adequate in most areas and that aggregate Medicare payments are well in excess of costs. Our recommendations from 2011 included multiyear payment changes intended to restructure the incentives of the home health benefit and address the high Medicare margins. These recommendations call for expanding efforts to fight fraud, improving beneficiary and provider incentives, and rebasing home health payments (see text box, pp. 234–236, for a summary of recommendations from 2011).

Designing a home health care readmissions policy

Home health care is commonly cited as a tool for avoiding hospital readmissions for patients receiving services after an acute hospital stay, and about 40 percent of home health stays are preceded by a hospital stay. However, it is not clear that this tool has been fully effective. On average, about 29 percent of posthospital spells of home health care result in readmission in 2010.[4] In addition, the rate of readmission varies drastically among regions and providers, suggesting that regions and providers with high rates have significant opportunity for improvement. For example, the agency at the 25th percentile of readmissions had a rate of 25 percent, compared with 39 percent for the agency at the 75th percentile.

There is also significant geographic variation among regions in the amount of Medicare spending for home health care, and this spending is highest in many of the states with the highest readmission rates. For example, agencies in four of the states with the highest utilization—Louisiana, Mississippi, Oklahoma, and Texas—averaged a readmissions rate of 38 percent. By contrast, agencies in the Pacific census region, which typically has lower rates of utilization, averaged a readmissions rate of 28 percent.[5]

TABLE 9–11

Comparison of agencies with the highest readmission rates (top quartile) with other agencies

	All other	Top quartile of readmission rates
Readmission rate	26%	58%
Average number of admissions	347	97
Agency length of stay	46.0	64.2
Share of agencies:		
In 4 states with highest rates of readmission (LA, MS, OK, TX)	19%	45%
For profit	69%	90%
Facility based	15%	4%
Rural	22%	16%

Source: MedPAC analysis of University of Colorado data on readmissions to hospitals from home health.

The agencies with the highest readmission rates averaged a rate of 58 percent, more than double the rate of all other agencies (Table 9-11). These measures suggest that significant improvements in readmission could occur if agencies with higher rates could achieve the performance of higher performing or even average performing agencies. Currently, Medicare does not tie HHA payments to readmissions or any other quality indicator.[6] Providing incentives for HHAs to reduce readmissions could improve care for beneficiaries, lower costs for Medicare, and move FFS reimbursement to an approach based on the value of care as opposed to one that rewards volume.

Home health care is the most frequently used setting of formal post-acute care among the four settings covered by Medicare; home health care is in a unique position to influence an episode of acute care as the provider that assists beneficiaries with the transition back to the home. Home health care can be a bridge between the higher level of care provided during institutional stays and the ambulatory care system that will be responsible for the beneficiary's care after discharge from inpatient facilities.

A readmission policy for home health agencies could help to align agency incentives with other providers that are seeking to reduce readmissions and encourage better care coordination. An incentive for HHAs would be consistent with the Hospital Readmissions Reduction Program (HRRP), which holds hospitals accountable for some readmissions. Data from the first year of the HRRP suggest that the incentive has led to lower readmission rates, and adding a similar incentive for HHAs would encourage them to work more closely with hospitals and accountable care organizations (ACOs). The Commission has also recommended a readmission incentive for skilled nursing facilities, which frequently discharge patients to home health care. Recommending a similar policy for HHAs would ensure consistent expectations for the two most common providers of PAC services covered by Medicare.

Focusing on readmissions in home health care would also be consistent with the concern that holding HHAs accountable for initial hospital admissions might be inappropriate because initial admissions could represent appropriate care for many conditions.

Defining the elements of a home health readmissions reduction program

The key elements of a home health readmissions program include a financial incentive strong enough to compel agencies to reduce unnecessary readmissions without penalizing agencies whose patients warrant hospital care and a quality assessment measure that accounts for the diversity of clinical conditions treated in home health care. The measure would apply to patients who are using home health as a PAC service, and not to those patients admitted to home health from the community with no prior hospitalization.

Financial structure of the policy

A readmission reduction policy would include a penalty for agencies with high rates of readmission. A target rate could be established based on the performance in an index year, for example the 40th percentile of the index year. Agency performance in future years would be compared with the target rate from the index year. Agencies with rates above the target would be subject to a reduction to their base rate, while agencies below it would not. Such an approach could encourage a significant number of agencies to improve. The Commission recently considered a similar approach when it reviewed the HRRP.

Only readmissions above the target rate would be included in this policy. The penalty amount could vary, depending on the magnitude of the incentive deemed necessary to motivate agencies to invest in the infrastructure necessary to reduce readmissions to an acute care hospital. One approach would be to set the penalty to the average Medicare payment for the home health care services

provided before the readmission. If a stronger incentive is necessary, the penalty could be set higher. Even a penalty twice the amount of home health services would be less than the cost to Medicare of the hospital readmission. To give agencies with high readmission rates the time and incentives to put the necessary readmissions mitigation process in place, Medicare should establish a stop-loss provision that limits the aggregate reduction in payments an agency can experience, but the reduction would increase over time. For example, the stop-loss provision could be set at a level comparable with that established for the HRRP: 1 percent of total Medicare payments to the agency in the first year, increasing to 3 percent of Medicare payments by the third year.

Setting a target readmission rate in advance would establish the rate agencies need to be below to avoid a payment reduction, and it would provide them with an opportunity to improve. Medicare savings would be achieved either through reduced hospital readmissions or through reductions to HHA payments. For example, if all providers lowered readmissions below the target, there would be no penalties. Instead, savings would be generated by reducing readmissions. In contrast, if readmissions did not improve, savings would come from holding back a portion of the Medicare payment to HHAs. Since agencies are compared with a fixed target, they would also have an incentive to collaborate and share lessons learned with one another. This model would be appropriate in fee-for-service Medicare, where we observe large disparities in performance between those agencies with the highest rates of readmissions and those in the rest of the industry. Adopting this model might encourage HHAs to participate in other new models of payment, such as the Medicare Shared Savings Program or the Pioneer ACO Initiative, that potentially include bonuses for better performance.

Several interventions are available to agencies that seek to lower their readmission rates, such as the use of protocols to improve communication between providers, providing patient coaches for beneficiaries to assist with transitions, and the use of advanced nurse practitioners who assist with improving the continuity of care (Boutwell and Hwu 2009, Coleman et al. 2006, Naylor et al. 2004). A recent systematic review of the literature on transitional care interventions identified several practices that demonstrated reduced rates of readmission, including improved processes for hospital discharges and care planning and better self-management support (Naylor et al. 2011).

Protecting access to care for dual-eligible Medicare and Medicaid beneficiaries

The risk-adjusted rates of readmission are higher for agencies that serve a higher than average share of beneficiaries who are dually eligible for Medicare and Medicaid. A home health care readmission policy should seek to establish incentives for all agencies to improve, without penalizing agencies that serve significant numbers of dual-eligible Medicare–Medicaid beneficiaries.

Adjusting for dual-eligible status in the risk-adjustment model would diminish any differences in outcomes experienced by this group, effectively masking their higher rates of readmissions. This approach could be viewed as tacitly accepting the higher rate for dual-eligible beneficiaries. The Commission supported an alternative approach for addressing this issue with respect to the HRRP. Providers would be compared with a peer group serving a similar share of dual-eligible patients. HHAs would continue to report their all-condition risk-adjusted readmission rate; it would not be adjusted for socioeconomic status and, thus, disparities would not be masked. Instead, each HHA's target readmission rate would be based on the performance of providers with a similar share of low-income patients.

Our review of the HRRP concluded that race did not have a consistent effect on outcomes. Other measures, such as education or race, are either not currently readily available or sometimes give inconsistent results across measures. For example, in an examination of acute care hospital measures, the effect for African American patients varied depending on the measure used. In a readmission measure, African American status indicated a higher rate of readmission, while such status was found to be tied to lower rates of mortality. Including race would tie Medicare payments to a patient's race, effectively creating financial incentives that may encourage patient selection based on this demographic.

The Commission's review of the HRRP found that a hospital's share of low-income patients was a stronger and more consistent predictor of readmissions than race or the disproportionate share hospital percentage (Medicare Payment Advisory Commission 2013). The University of Colorado, in a contract for the Commission, also examined the role of race and low-income status for readmissions in home health and found that Medicaid–Medicare dual-eligible status had a greater influence on readmissions risk than race (Nuccio et al. 2013). For home health care, we believe a similar approach that compares an HHA with

TABLE 9–12

Share of agencies with readmission rates greater than the 40th percentile of their peer group

	Percent
All agencies	60%
Freestanding	61
Facility based	46
For profit	65
Government	48
Nonprofit	44
Urban	60
Micropolitan	57
Rural, adjacent to urban	58
Rural, nonadjacent to urban	59
States with highest readmission rates	
Four highest states (LA, MS, OK, TX)	74
All other	55

Note: A micropolitan county has a population of 10,000 to 50,000.

Source: Based on MedPAC analysis of University of Colorado data.

a peer group that serves similar shares of low-income individuals will balance the need to protect access to care for these individuals by establishing a credible target for tying Medicare payment to readmissions. This approach would require that the performance target for an agency be established after the agencies have been separated into peer groups based on the share of their patients classified as low income (i.e., quartile, decile, etc.). An agency's target would be derived from a cohort of agencies with similar shares of low-income patients, not the overall national average.

In 2010, Medicare directed its quality improvement organizations (QIOs) to increase their assistance of low-performing providers. Agencies with high readmission rates could be appropriate candidates for these efforts. QIOs could engage with agencies to help them understand the cause of their high rates, develop potential interventions, and help monitor improvement efforts. These efforts could be targeted at agencies with higher readmission rates. However, it is not clear that QIO assistance would be necessary for many agencies to improve.

Defining the period of measurement

A readmissions measure should hold agencies accountable for the full period of care that they are serving a beneficiary. Similar to the HRRP measure of readmissions, the home health readmission measure could also include a 30-day period after the home health stay. Relatively few readmissions occur in the 30 days after the end of a home health stay, but the presence of a window would encourage agencies to prepare beneficiaries and their caregivers for remaining in the community without the assistance of home health. Some agencies would likely be concerned that including poststay readmissions would hold providers accountable for adverse events they cannot control. However, the home health benefit is intended to help beneficiaries develop efficacy in their own care, and the benefit covers many services such as beneficiary and caregiver education to facilitate this goal. At a technical panel convened by the Commission, a group of home health practitioners, health services research professionals, and physicians with home health care expertise supported a 30-day poststay window for measuring hospitalizations.

Types of readmission to include under a measure

Defining a readmission incentive also requires identifying the clinical scope of home health stays and the causes of readmissions to be included in a measure. The Commission's considerations regarding the HRRP readmissions measure may be instructive for home health care. One such consideration is for an "all-condition, potentially avoidable" measure. Under this approach, all discharges from a hospital to home health care are monitored, but only readmissions that are classified as potentially preventable are counted in the measure. An all-condition measure might be particularly important in home health care because many agencies are small and would not have a sufficient sample size for a statistically reliable measure under narrower parameters. In addition, avoiding a readmission is a key goal for most home health patients. Several methods have been developed for determining readmissions that would be clinically appropriate to attribute to providers. CMS's new measure of readmissions for home health agencies excludes readmissions defined as "planned admissions" under the Agency for Healthcare Research and Quality Conditions Category System, and this strategy could serve as an initial approach.

An illustrative example assessing the effects of a readmission penalty for home health agencies

The Commission modeled a readmissions policy consistent with the desired incentive and measurement elements

discussed above to assess its potential impact on home health agencies. This approach requires that agencies above a fixed target, such as the average readmission rate from a prior year, be subject to the policy's penalty. The policy excludes from its performance measurement readmissions that are planned or part of a course of treatment such as chemotherapy. This example also sorts agencies into peer groups based on the share of their beneficiaries that are dually eligible for both Medicare and Medicaid. Table 9-12 indicates the share of agencies in various categories that would be above the readmission target if it were set at the 40th percentile of readmission rates in 2010 of their dual-eligible peer group. These results do not assume any behavioral response by agencies to lower their readmission rates, thereby likely overstating the estimated share of agencies subject to a payment reduction. Consistent with the national trends in readmissions rates, for-profit agencies would be subject to the penalty at a higher rate than nonprofit agencies, and freestanding agencies would be subject to the penalty at a higher rate than provider-based agencies. Over 70 percent of agencies in the four states with the highest readmissions rates (Louisiana, Mississippi, Oklahoma, and Texas) would be subject to the payment reduction, and all four of these states have higher than average home health utilization. In our analysis, smaller agencies tended to represent a greater share of agencies subject to the penalty. On a national basis, agencies in rural areas generally were subject to the penalty at about the same rate as agencies in urban areas.

Recommendation

RECOMMENDATION 9

The Congress should direct the Secretary to reduce payments to home health agencies with relatively high risk-adjusted rates of hospital readmission.

RATIONALE 9

A hospital readmission policy for HHAs would create an incentive for agencies to improve the quality of care they provide and would lower Medicare spending. It would align HHA incentives with those of hospitals under the HRRP, and it would complement the incentives that skilled nursing facilities would have if Medicare were to implement the Commission's recommendation for a readmission policy for these facilities. Such a policy would also recognize home health care's unique role as a provider that facilitates the transition from inpatient settings to the community. Other providers may be unable to reduce avoidable readmissions without assistance from home health care, and HHAs would be better partners if they were subject to the same financial incentives.

The incentive could take several forms but should rely on a risk-adjusted measure of readmission. The clinical scope of the measure should include all posthospital home health stays but only measure readmissions that are due to causes considered potentially avoidable. The period covered by the measure should include the entire home health stay and 30 days after discharge. Including a follow-on period would recognize that the goal of home health care is to successfully transition a patient back to community-based care and would be conceptually similar to the 30-day postdischarge period included in the HRRP measure. The amount of the incentive should be large enough to motivate agencies to improve, particularly given the substantial costs of readmission to the beneficiary and the Medicare program.

CMS could use a modified version of the readmissions measure developed for hospitals to implement this recommendation. Its claims-based measure of readmission for hospitals focuses on the first 30 days of the stay, and it could use the same definition of potentially avoidable readmissions for the hospital-wide readmissions measure. The measure is risk-adjusted for clinical and functional severity. If the period were modified to include the entire home health stay with a 30-day home health window afterward, the measure would be consistent with the Commission's recommendation. CMS may also need to take measures to ensure that risk-adjustment information submitted by HHAs is accurate.

IMPLICATIONS 9

Spending

- This policy would lower Medicare spending by $50 million to $250 million in 2015 and yield less than $1 billion over five years.

Beneficiary and provider

- The quality of beneficiary care and the process of transitioning between providers could improve as better coordination between home health providers and hospitals occurs. The recommendation should not adversely affect beneficiary access or affect providers' willingness or ability to care for Medicare beneficiaries, particularly if implemented with safeguards to protect agencies that serve disproportionate shares of low-income beneficiaries. Payments would be lowered for providers with consistently high rates of readmissions. ■

Strengthening incentives for effective and efficient use of the home health benefit

In 2011, the Commission noted several problems with the home health care benefit and made several recommendations to reduce fraud, improve provider and beneficiary incentives, and eliminate the high overpayments under the home health care prospective payment system.

Recommendation 8-1, March 2011 report

The Secretary, with the Office of Inspector General, should conduct medical review activities in counties that have aberrant home health utilization. The Secretary should implement the new authorities to suspend payment and the enrollment of new providers if they indicate significant fraud.

The Patient Protection and Affordable Care Act of 2010 (PPACA) expanded Medicare's authority to stop payment for fraudulent or suspect services, and in 2011 the Commission recommended that the Secretary exercise this new authority to curb fraud in home health care. For many years, the Commission has published a list of counties with questionable utilization patterns (Table 9-6, p. 224). As the Commission recommended in the 2011 March report, these counties would be appropriate areas for the Secretary to exercise new PPACA authorities for investigating and interdicting home health fraud. The Department of Health and Human Services began exercising some of these authorities in 2013 when it announced a moratorium on the enrollment of new agencies in Miami–Dade County and Chicago. CMS expanded the moratoria to Fort Lauderdale, FL; Dallas, TX; Houston, TX; and Detroit, MI, in 2014. However, many other parts of the country with aberrant patterns of utilization also require further scrutiny. Medicare and the other enforcement entities should continue to review home health care spending and pursue providers that appear to engage in behavior that is potentially fraudulent or wasteful.

Implications 8-1

Spending

- The Congressional Budget Office has scored savings from the PPACA provision, so its baseline assumes savings based on the new authority. Implementing this authority would lower home health spending if fraud were discovered. CMS and the Office of Inspector General would incur some administrative expenses.

Beneficiary and provider

- Appropriately targeted reviews would not affect beneficiary access to care or provider willingness to serve beneficiaries.

Recommendation 8-2, March 2011 report

The Congress should direct the Secretary to begin a two-year rebasing of home health rates in 2013 and eliminate the market basket update for 2012.

Medicare has overpaid for home health since establishment of the prospective payment system (PPS) in 2000. The higher payments create financial incentives that can encourage providers to deliver services even when they are unnecessary or of low value. Payments should be rebased as soon practicable, with a short period of time that allows for an appropriate transition to the lower level of payments (e.g., no more than three years). Our recommendation would also eliminate the market basket update during rebasing. In addition, the Commission believes that its recommendation to eliminate the use of therapy thresholds in the PPS should be implemented along with rebasing. This change would ensure that providers do not attempt to offset rebasing with higher payments by increasing the number of therapy visits they provide.

The Commission expects that a rebasing may cause some agencies to leave the Medicare program, but this effect may be offset by the entry of new providers. The barriers to entry in home health care are lower than for other Medicare providers. It does not require extensive capital expenditures like facility-based providers, and many states do not require certificate-of-need analysis establish a new home health agency.

Implications 8-2

Spending

- This recommendation would reduce Medicare spending by $250 million to $750 million in 2015 and $5 billion to $10 billion over five years.

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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 appropriate care is likely to remain adequate, even if the supply of agencies declines.

RECOMMENDATION 8-3, March 2011 report

The Secretary should revise the home health case-mix system to rely on patient characteristics to set payment for therapy and nontherapy services and should no longer use the number of therapy visits as a payment factor.

The Commission is concerned that Medicare's home health PPS encourages providers to base therapy regimens on financial incentives and not patient characteristics. The PPS uses the number of therapy visits provided in an episode as a payment factor: the more visits a provider delivers, the higher the payment. The higher payments obtained by meeting the visit thresholds have led providers to favor patients who need therapy over patients who do not and have encouraged providers to deliver services that are of marginal value. The Commission's recommendation would use patient characteristics to set payment for therapy, the same approach Medicare currently uses for setting payment for all other services covered in the home health PPS.

Implications 8-3

Spending

- The payment policy changes are designed to be implemented in a budget-neutral manner and should not have an overall impact on spending.

Beneficiary and provider

- Patients who need therapy may see some decline in access, but these services would be available on an outpatient basis after the home health episode ended.

RECOMMENDATION 8-4, March 2011 report

The Congress should direct the Secretary to establish a per episode copay for home health episodes that are not preceded by hospitalization or post-acute care use.

The health services literature has generally found that beneficiaries consume more services when cost sharing is limited or nonexistent, and some evidence suggests that the additional services do not always contribute to better health. The lack of cost sharing is a particular concern for home health care, because the PPS pays for care on a per episode basis that rewards additional volume. The lack of a cost-sharing requirement stands in contrast to most other Medicare services, which generally require the beneficiary to bear some of the costs of Medicare services.

One concern with cost sharing is that it can lead beneficiaries to reduce their use of effective as well as ineffective care. Although some studies have found evidence of adverse effects of reduced care due to cost sharing (Chandra et al. 2010, Rice and Matsuoka 2004), the RAND health insurance experiment concluded that, on average, nonelderly patients who consumed less health care because of cost sharing suffered no net adverse effects (Newhouse 1993). The Commission's review of the impact of medigap insurance generally found that beneficiaries with this insurance had higher total Medicare spending (Medicare Payment Advisory Commission 2009). The results of the RAND health insurance experiment and the Commission's study suggest that a home health care copayment would decrease use of home health care and result in lower overall Medicare spending.

To encourage appropriate use, the Commission recommended that Medicare add an episode copayment for services not preceded by a hospitalization or other post-acute use.[7] The high rates of volume growth for these types of episodes, which have more than doubled since 2001, suggest there is significant potential for overuse. The addition of a copayment would allow

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Strengthening incentives for effective and efficient use of the home health benefit

beneficiary cost consciousness to counterbalance the permissiveness of the benefit's use criteria and the volume-rewarding aspects of Medicare's per episode payment policies.

Implications 8-4

Spending

- A copay of $150 per episode (excluding low-use and posthospital episodes) would reduce Medicare spending $250 million to $750 million in 2014 and $1 billion to $5 billion over five years. Expenditures for services would decrease because some beneficiaries who would otherwise use home health services might decline them. Since many of these services are funded by Part B, decreases in spending growth would reduce Part B premiums.

Beneficiary and provider

- Some beneficiaries might seek services through outpatient or ambulatory care, for which Medicare already has cost-sharing requirements. Some beneficiaries who need relatively few services would have lower cost sharing if they substituted ambulatory care for home health care. ■

Endnotes

1 Surety bond firms review the organizational and financial integrity of an HHA and agree to cover the Medicare obligations, up to a set amount, for those agencies that the surety bond firm believes are low risk. A surety bond would cover liabilities that occur when an agency does not repay funds it owes Medicare (for example, when an agency is found to have improperly billed for services).

2 As of November 2013, our measure of access is based on data collected and maintained as part of CMS's Home Health Compare database. The service areas listed are postal ZIP codes where an agency has provided services 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. At the same time, the definition may understate access if HHAs are willing to serve a ZIP code but did not receive a request in the previous 12 months. The analysis excludes beneficiaries with unknown ZIP codes.

3 Certificate-of-need laws vary from state to state, and not all states have them. In general, the laws require that an area have a demonstrated need for additional health care services before a new provider is permitted to enter the market.

4 This risk-adjusted measure of readmissions includes those that occur during a home health stay or within 30 days of the end of a stay.

5 The Pacific census region consists of California, Oregon, Washington, Hawaii, and Alaska.

6 Medicare has a pay-for-reporting program that requires agencies to submit quality data to receive a full market basket update.

7 The recommendation applied only to full episodes—those that included five or more visits.

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