Please refer to this errata sheet for a corrected version of Table 9-7.

TABLE 9–7 **Average home health agency performance on select quality measures**

	2013	2014	2015	2016
Share of beneficiaries that:				
Used emergency department care	11.7%	11.8%	12.2%	12.2%
Had to be admitted to the hospital	15.6	15.2	15.5	16.2
Share of an agency's beneficiaries with improvement in:				
Walking	58%	58%	63%	69%
Transferring	53	53	59	65

Note: All data are for fee-for-service beneficiaries only and are risk adjusted for differences in patient condition among home health patients.

Source: MedPAC analysis of data provided by the University of Colorado.

add-on, with most payments made in areas with higher than average utilization. For example, 79 percent of the episodes that received the add-on payments in 2016 were in rural counties with utilization higher than the median for all counties. Rural counties in the lowest fifth of utilization accounted for just 5 percent of the episodes that received the rural 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 these markets that appear to be more than adequately served by HHAs. Some of the counties with aberrant patterns of utilization suggestive of fraud and abuse are rural; for example, all but 4 of the 25 top-use counties in 2016 were 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 trend data (Table 9-7). In 2016, the share of patients who improved in walking and in transferring from the bed to a chair increased, while the share hospitalized increased slightly, and the share receiving emergency care did not change significantly.[6]

Like most categories of providers, the performance of HHAs varied significantly on their quality measures. For example, regarding the share of patients demonstrating improvement in walking in 2016, the values ranged from 54 percent for the agency at the 25th percentile of the distribution to 77 percent for the agency at the 75th percentile (data not shown). This broad variation indicates that opportunities exist for improving performance, particularly for low-performing agencies.

However, the annual data indicating improved quality should be viewed with caution:

- An HHA's functional data are driven by agency assessment practices, which could reflect the incentive to show improved agency performance to attract patient referrals or seek financial reward for better performance. HHAs self-report these data, and some measures are difficult to independently verify.
- Functional improvement data are collected only for beneficiaries who do not have their home health care stays terminated by a hospitalization, which means that beneficiaries included in the measure are probably healthier and more likely to have positive outcomes.
- The risk adjustment models for these measures rely on the relationship between patient characteristics and outcome measures for a base year of data, and apply this relationship to later years of data. Using a single model for later periods permits comparison across