CHAPTER 9

Home health care services

RECOMMENDATION

9 The Congress should reduce Medicare payments to home health agencies by 5 percent in calendar year (CY) 2019 and implement a two-year rebasing of the payment system beginning in CY 2020. The Congress should direct the Secretary to revise the prospective payment system to eliminate the use of therapy visits as a factor in payment determinations, concurrent with rebasing.

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

CHAPTER 9

Home health care services

Chapter summary

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2016, about 3.4 million Medicare beneficiaries received care, and the program spent about $18.1 billion on home health care services. In that year, over 12,200 agencies participated in Medicare.

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 lived in a ZIP code where a Medicare home health agency operated in 2016, and 86 percent lived in a ZIP code with five or more agencies.

- ***Capacity and supply of providers*—**In 2016, the number of agencies fell slightly by 1.2 percent after a long period of growth. From 2004 to 2015, the number of agencies increased by over 60 percent. The decline in 2016 was concentrated in areas that experienced sharp increases in supply in prior years.
- ***Volume of services*—**In 2016, the volume of 60-day episodes decreased by 0.7 percent. The total number of users increased slightly, while the

In this chapter

- Are Medicare payments adequate in 2018?
- How should Medicare payments change in 2019?

average number of episodes per home health user declined by 0.9 percent. From 2002 to 2015, home health utilization increased substantially, with the number of episodes rising by over 60 percent and the episodes per home health user climbing from 1.6 to 1.9 episodes. Episodes not preceded by a hospitalization accounted for most of the growth in this period, and these episodes increased from about half to two-thirds of total episodes since 2001.

Quality of care—In 2016, performance improved on some quality measures. The share of beneficiaries reporting improvement in walking and transferring increased significantly, though this data may require closer scrutiny; the share of beneficiaries hospitalized or using emergency care during their home health stay was unchanged.

Providers' access to capital—Access to capital is a less important indicator of Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. The major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs. Several capacity acquisitions and expansion of capacity by publicly traded home health care firms indicate adequate access to capital.

Medicare payments and providers' costs—In 2016, Medicare spending for home health care was mostly unchanged, with an increase of about 0.1 percent. However, between 2002 and 2016, spending increased by over 80 percent. For more than a decade, payments under the home health prospective payment system (PPS) have consistently and substantially exceeded costs. In 2016, Medicare margins for freestanding agencies averaged 15.5 percent, largely consistent with the 16.4 percent average for these margins between 2001 and 2015. Also in 2016, freestanding HHAs' marginal profit—that is, the rate at which Medicare payments exceed providers' marginal cost—was 17.4 percent, suggesting a significant financial incentive for HHAs to increase their volume of Medicare patients. The projected margin for 2018 is 14.4 percent. Two factors have contributed to payments exceeding costs: Agencies have reduced episode costs by lowering the number of visits provided, and cost growth has been lower than the annual payment updates for home health care.

Freestanding HHAs' high margins have led the Commission to recommend a 5 percent reduction in the home health PPS base payment rate for 2019 and a two-year rebasing beginning in 2020. The historical overpayments Medicare has made need to be addressed. These two actions should help to better align payments with actual costs, ensuring better value for beneficiaries and the taxpayer without impeding access. The recommendation regarding the level of payments to HHAs is made in the context of the Commission's recommendation (discussed in the post-

acute care (PAC) chapter (Chapter 7)) to establish HHA payments using a blend of the unified PAC PPS and current HHA PPS relative weights beginning in calendar year 2019. A blend of the relative weights would redistribute payments within the HHA setting by increasing payments for medically complex patients and lowering payments for patients who receive rehabilitation therapy unrelated to their care needs. The recommendation would narrow the differences in financial performance across providers based on their mix of patients and would enable the Commission to recommend, and policymakers to implement, an aggregate level of payments that would better align payments with the cost of care.

We also recommend, as we have for the last six years, that Medicare eliminate the use of the number of therapy visits as a payment factor in the home health PPS concurrent with rebasing. A review of utilization trends and further research by the Commission and others suggest that this aspect of the PPS creates financial incentives that distract agencies from focusing on patient characteristics when setting plans of care. Eliminating the number of therapy visits as a payment factor would base home health payment solely on patient characteristics and result in a more patient-focused approach to payment. (Subsequent to the Commission's vote on this recommendation, the Bipartisan Budget Act of 2018 eliminated the number of therapy visits as a payment factor in the home health PPS, beginning in 2020.) ■

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. In contrast to coverage for skilled nursing facility services, Medicare does not require a preceding hospital stay to qualify for home health care. Also, unlike for most services, Medicare does not require copayments or a deductible for home health services. In 2016, about 3.4 million Medicare beneficiaries received home care, and the program spent $18.1 billion on home health services. Medicare spending for home health care more than doubled between 2001 and 2016, and this care currently accounts for about 4.6 percent of fee-for-service (FFS) spending.

Medicare requires that a physician certify a patient's eligibility for home health care and that a patient receiving services be under the care of a physician. In 2011, Medicare implemented a requirement that a beneficiary have a face-to-face encounter with the physician ordering home health care. The encounter must take place in the 90 days preceding or 30 days following the initiation of home health care. Contacts through nonphysician practitioners or authorized telehealth services may be used to satisfy the requirement.

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 the number of therapy visits provided. 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 received a 3 percent payment increase through 2017. (An overview of the home health prospective payment system (PPS) is available at http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_17_hha_final.pdf?sfvrsn=0.) Coverage for additional episodes generally has the same requirements as the initial episode (i.e., the beneficiary must be homebound and need skilled care). In 2016, Medicare proposed major changes to the case-mix system and unit of payment for the home health PPS (see text box on revisions to the home health PPS, p. 248).

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

The home health benefit has changed substantially since the 1980s. Implementation of the inpatient hospital 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 home health agencies (HHAs), users, and services expanded rapidly in the early 1990s. Between 1990 and 1995, the number of annual users rose by 75 percent, and the number of visits more than tripled to about 250 million a year. Spending increased more than fourfold between 1990 and 1995, from $3.7 billion to $15.4 billion. As the rates of use and the duration of home health spells grew, 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 improper. For example, in one analysis of 1995 to 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.[1] Between 1997 and 2000, the number of beneficiaries using home health services fell by about 1 million, and the number of visits fell by 66 percent (Table 9-1, p. 246). The mix of services changed from predominantly aide services in 1997 to predominantly nursing visits in 2000, and therapy visits increased between 1997 and 2016 from 10 percent of visits to 39 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 2015, the number of home health

TABLE 9–1

Changes in supply and utilization of home health care, 1997–2016

					Percent change		
	1997	2000	2015	2016	1997–2000	2000–2015	2015–2016
Agencies	10,917	7,528	12,346	12,204	–31%	64%	–1%
Total spending (in billions)	$17.7	$8.5	$18.1	$18.1	–52	113	0.1
Users (in millions)	3.6	2.5	3.5	3.5	–31	38	0.1
Number of visits (in millions)	258.2	90.6	115.1	114.4	–66	27	–1
Visit type (percent of total)							
Skilled nursing	41%	49%	52%	51%	20	5	–2
Home health aide	48	31	10	10	–37	–66	–9
Therapy	10	19	37	39	101	94	5
Medical social services	1	1	1	1	1	–28	<–0.1
Number of visits per user	73	37	33	33	–49	–10	–1
Percent of FFS beneficiaries who used home health services	10.5%	7.4%	9.1%	9.0%	–30	24	–1

Note: FFS (fee-for-service). Medicare did not pay on a per episode basis before October 2000. Yearly figures presented in the table are rounded, but figures in the percent change columns were calculated using unrounded data.

Source: Home health standard analytical file 2016; *Health Care Financing Review*, Medicare and Medicaid Statistical Supplement 2002.

episodes rose from 3.9 million to 6.6 million (data not shown). The number of agencies in 2016 was 12,204, higher than the level of supply during the 1990s. Almost all the new agencies since implementation of the PPS have been for-profit providers (data not shown).

The steep declines in services under the IPS did not appear to adversely affect the quality of care that beneficiaries received; one analysis found that patient satisfaction with home health services was mostly unchanged in that period (McCall et al. 2004, McCall et al. 2003). In 2004, the

TABLE 9–2

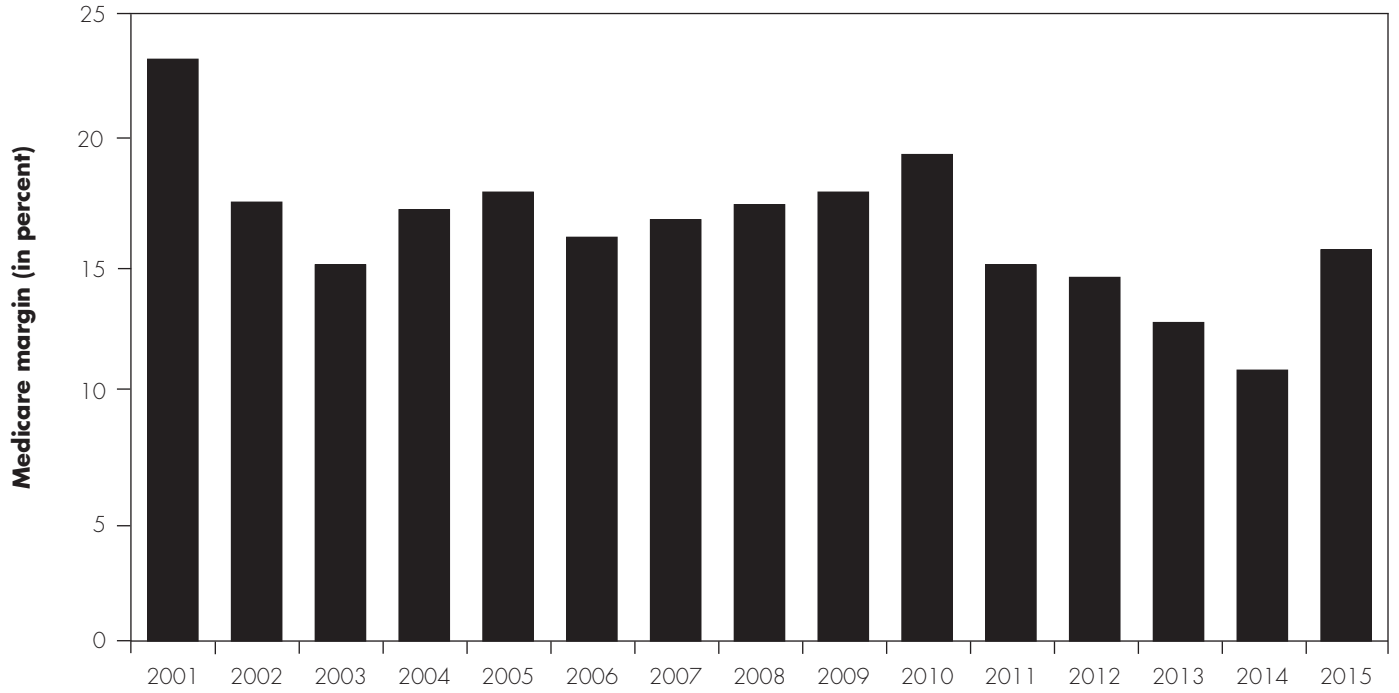
Medicare visits per episode before and after implementation of PPS

	Visits per episode				Percent change in:		
Type of visit	1998	2001	2015	2016	1998–2001	2001–2015	2015–2016
Skilled nursing	14.1	10.5	9.6	9.4	–25%	–9%	–2%
Therapy (physical, occupational, and speech–language pathology)	3.8	5.2	7.1	7.5	39	36	5
Home health aide	13.4	5.5	2.0	1.8	–59	–64	–9
Medical social services	0.3	0.2	0.1	0.1	–36	–52	<–0.1
Total	31.6	21.4	18.8	18.8	–32	–12	0.1

Note: PPS (prospective payment system). The PPS was implemented in October 2000. Data exclude low-utilization episodes. Yearly figures presented in the table are rounded, but figures in the percent change columns were calculated using unrounded data.

Source: Home health standard analytic file.

FIGURE 9–1 **Medicare margins of freestanding home health agencies have remained high since 2001**



Source: Medicare cost reports.

Commission also concluded that the quality of care did not decline between use of the IPS and the implementation of the PPS (Medicare 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.

Medicare has always overpaid for home health services under the PPS

Payments for home health care have substantially exceeded costs since Medicare established the PPS. In 2001, the first year of the PPS, average Medicare margins for freestanding HHAs equaled 23 percent (Figure 9-1). Freestanding providers accounted for about 90 percent of the episodes provided in 2016. 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 between 1998 and 2001would decline about 15 percent, while the actual decline was about 32 percent (Table 9-2). In addition, agencies have been able to hold the rate of episode cost growth below 1 percent in many years, lower than the rate of inflation assumed in the home health payment update. Consequently, HHAs were able to garner extremely high average payments relative to the cost of services provided. Since 2001, agencies have been able to reduce visits further, and between 2001 and 2015, freestanding HHA margins have averaged 16.4 percent (Figure 9-1). Furthermore, some evidence exists that these margins, based on unaudited cost reports, may be low. A CMS audit of 2011 cost reports found that a sample of 98 agencies overstated their costs by 8 percent; with this adjustment, margins for freestanding HHAs in 2011 would have been in excess of 20 percent.

Patient Protection and Affordable Care Act of 2010 reductions have not significantly lowered payment for home health services

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

Revisions to the home health prospective payment system proposed by CMS

In the 2018 home health payment rule, CMS proposed implementing major revisions to the prospective payment system in 2019. Though CMS did not finalize these revisions, they are important because they would significantly restructure the payment system's incentives.

The new system, referred to as the home health groupings model (HHGM), would eliminate the use of the number of therapy visits as a payment factor in the system, consistent with the Commission's past recommendations. As noted by the Commission and others, the inclusion of the number of therapy visits provided can encourage additional utilization, and the therapy visit elimination would resolve this payment system vulnerability.

The HHGM would pay for services on the basis of diagnosis, functional status, and the incidence of prior home health or inpatient services. Episodes with prior home health services would be paid lower rates, reflecting the lower average service use of these visits. Conversely, episodes with a hospitalization in the prior 15 days would receive higher payments, reflecting that patients coming from an inpatient setting typically use more resources. Payments would also be increased for beneficiaries with selected comorbidities (such as heart disease, stroke, cancer, infectious diseases, and other commonly occurring comorbidities).

In 2017, CMS proposed to change the unit of payment for home health care from 60-day episodes to 30-day episodes. The shorter length was proposed because it better matches patterns of care and so would improve the accuracy of CMS's case-mix model. CMS found that for about 25 percent of current episodes, patients are discharged by the 30th day, so they do not have services in the 31st through 60th day of the current 60-day episode. CMS also found that visit frequency decreased with time, with a lower average number of visits in the second 30 days of an episode compared with the first 30 days. CMS concluded that using a 30-day episode, particularly one that factored in whether that episode immediately followed an initial 30-day period, helped to improve the accuracy of the case-mix model.

CMS currently makes a full 60-day payment for the 28 percent of episodes that are 30 days or shorter, so CMS's proposed rule included a budgetary adjustment that would remove the spending associated with the second 30-day period. CMS estimated that this adjustment, along with some behavioral changes by home health agencies (HHAs), would reduce spending by about 4.4 percent. In general, the proposal would shift funds from episodes with therapy visits to those with fewer or no therapy visits and from for-profit to nonprofit providers. In the November 2018 final rule, CMS withdrew the HHGM proposal, noting that it needed to review comments from the public.

In our September 2017 comment letter, the Commission supported several aspects of the proposed changes and called for caution on others. The elimination of the therapy thresholds would have been consistent with our long-standing recommendation. In addition, the 4.4 percent reduction would have helped to address the high payments Medicare makes for home health care, but we were concerned that a shorter unit of payment could lead HHAs to extend services beyond the 30-day episode to increase payment. We also commented that allowing higher payments for posthospital patients, though consistent with resource use patterns, could encourage HHAs to favor hospitalization during an episode of home health care. ■

consistent with costs, a process referred to as payment rebasing. The Patient Protection and Affordable Care Act of 2010 (PPACA) included several reductions intended to address home health care's high Medicare payments, including rebasing the payment system. However, these policies will not likely achieve the Commission's goal of making payments more consistent with actual costs.

PPACA offset the annual rebasing adjustment by the payment update for each year from 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 an annual reduction of $81 per 60-day episode. However, the size of the base rate has increased since 2010, so this reduction averaged

about 2.75 percent in each year from 2014 through 2017. In addition, over this period, the payment update has offset these reductions, resulting in a cumulative net payment reduction of 3 percent. This modest decrease is smaller than the payment reductions the industry has weathered in the past; since the implementation of the PPS in 2000, Medicare margins for freestanding HHAs have never been less than 10 percent.

PPACA required the Commission to assess the impact of these payment changes on quality of care and beneficiary access (Medicare Payment Advisory Commission 2014). To meet this mandate, the Commission examined the historical relationship between changes in payment and changes in quality and access for the 2001 through 2012 period. The volume of episodes grew substantially in this period, even in years that Medicare reduced home health payments. From 2001 through 2010, episode volume for urban, rural, for-profit, and nonprofit providers grew on a per beneficiary basis. These increases in utilization occurred in years in which the average episode payment decreased as well as in years in which the average episode payment increased, suggesting that PPACA's modest payment reduction has not had a negative effect on access. Utilization decreased slightly in 2011 and 2012, but these declines coincided with policy changes intended to address potential overuse, such as the face-to-face visit requirement and antifraud efforts in several high-use areas. The slowdown also coincided with an economy-wide slowdown in health spending and utilization.

The Commission examined three quality measures to assess the relationship between past payment reductions and quality, and the results suggest that payment changes during this period did not have a significant effect. During the 2001 to 2012 period, HHAs' overall rate of unexpected hospitalization during the home health episode—an indicator of poor quality—remained steady at about 28 percent, while average payment per episode increased in most years.[2] This finding suggests that hospitalization was not sensitive to changes in payments—that is, higher payments to HHAs did not lead to fewer hospitalizations, and conversely, lower payments did not lead to higher hospitalization rates. Performance on two functional measures of quality—the share of patients demonstrating improvement in walking and the share of patients demonstrating improvement in transferring—generally increased during this period. These improvements in quality occurred in years in which the average payment per episode fell as well as in years in which the average payment per episode increased, suggesting that changes in payment have little direct relationship to rates of functional improvement.

The Commission will continue to review access to care and quality as data for additional years become available. However, experience suggests that the small PPACA rebasing reductions will not change average episode payments significantly. Freestanding HHA margins are likely to remain high under the current rebasing policy, and quality of care and beneficiary access to care are unlikely to be negatively affected.

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 the home health benefit (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, such as outpatient services. Beneficiaries who meet program coverage requirements can receive an unlimited number of home health episodes and face no cost sharing. In addition, the program relies on agencies and physicians to follow program requirements for determining beneficiary needs, but evidence from prior years suggests that they do not consistently follow Medicare's standards (Cheh et al. 2007, Office of Inspector General 2001). Concerns about ensuring the appropriate use of home health episodes not preceded by a hospitalization, which have increased faster than those preceded by a hospitalization or post-acute care (PAC) stay, led the Commission to recommend a copayment for these episodes (Medicare Payment Advisory Commission 2011).

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 serve a clear medical purpose and not be an unskilled, personal-care benefit. However, Medicare's coverage

TABLE 9–3

Number of participating home health agencies declined in 2016 but remained high relative to earlier years

						Percent change	
	2004	2008	2012	2015	2016	2004–2015	2015–2016
Active agencies	7,651	9,787	12,311	12,346	12,204	61%	–1.2%
Number of agencies per 10,000 FFS beneficiaries	2.1	2.8	3.3	3.3	3.2	55	–2.1

Note: FFS (fee-for-service). "Active agencies" includes all agencies operating during a year, including agencies that closed or opened at some point during the year.

Source: CMS's Provider of Service file and 2017 annual report of the Boards of Trustees of the Medicare trust funds.

standards do not require that skilled visits compose the majority of the home health services a patient receives. For example, in about 6 percent of episodes in 2014, 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.

Fraud and abuse are continuing challenges in home health care

In 2010, the Commission made a recommendation to curb wasteful and fraudulent home health services (Medicare Payment Advisory Commission 2010). This recommendation calls on the Health and Human Services Secretary to use the department's 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. In 2017, Medicare implemented statewide moratoriums for home health agencies in Florida, Illinois, Michigan, and Texas, expanding previously established local moratoriums in these states. There have also been numerous criminal prosecutions for home health fraud, most notably in Miami and Detroit. However, the Commission observes that many areas continue to have aberrant patterns of utilization. For example, even though Miami has been an area of concentrated effort by CMS and law enforcement agencies, this area still has a utilization rate well in excess of other parts of the country. The persistence of aberrant utilization patterns suggests that continued, or perhaps even expanded, efforts by all enforcement agencies are needed to address the scope of fraud in many areas. In addition, Medicare has other regulatory powers, such as requiring HHAs to hold surety bonds, but has not exercised this authority.[3]

Are Medicare payments adequate in 2018?

The Commission reviews several indicators to determine the level at which payments will be adequate to cover the costs of an efficient provider in 2018. We assess 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 2016, over 99 percent of beneficiaries lived in a ZIP code served by at least one HHA, 97.5 percent lived in a ZIP code served by two or more HHAs, and 86 percent lived in a ZIP code served by five or more agencies. These findings are consistent with our prior reviews of access.[4]

Though these indicators are positive, access to care is difficult to measure for home health care because the service has broadly defined standards. The capacity and capabilities of agencies vary, and agencies have discretion

TABLE 9–4 **Fee-for-service home health care services have increased significantly since 2002**

	2002	2011	2013	2014	2015	2016	Percent change 2002–2015	Percent change 2015–2016
Home health users (in millions)	2.5	3.4	3.4	3.4	3.5	3.4	37%	<0.1%
Share of beneficiaries using home health care	7.2%	9.4%	9.2%	9.0%	9.1%	9.0%	26	<–1
Episodes (in millions):	4.1	6.8	6.7	6.6	6.6	6.5	61	<–1
Per home health user	1.6	2.0	1.9	1.9	1.9	1.9	17	<–1
Per FFS beneficiary	0.12	0.19	0.18	0.17	0.17	0.17	48	–2
Payments (in billions)	$9.6	$18.4	$17.9	$17.7	$18.1	$18.1	87	<1
Per home health user	3,803	5,347	5,169	5,156	5,225	5,223	37	<–0.1
Per home health episode	2,645	2,916	2,899	2,908	2,965	2,988	12	<1

Note: FFS (fee-for-service). Percent change is calculated on numbers that have not been rounded; payment per episode excludes low-utilization payment adjustment cases.

Source: MedPAC analysis of home health standard analytical file.

in the patients they choose to serve. Also, because home health care services are not delivered in a facility, the number of agencies in a market is not a complete indicator of the availability of care. The size of agencies in an area is also important in determining market capacity. Agencies can also adjust their service areas and staffing as market conditions change. However, even with these caveats, the indicators for provider supply and the volume of services are generally positive.

Supply of providers: Agency supply surpasses previous peak

Since 2004, the number of HHAs in Medicare has increased by over 4,500 agencies, reaching 12,204 agencies in 2016 (Table 9-3). The number of agencies declined slightly in 2016 relative to the prior year, but even with this decline, the number of agencies nationwide is now higher than the previous peak in the 1990s when supply exceeded 10,900 agencies (data not shown).

The slight decline in 2016 was concentrated in Texas and Florida, states that experienced higher than average increases in supply in prior years. These states have been targeted by a myriad of antifraud measures, including criminal investigations and moratoriums on the entry of new agencies in the two states. The number of agencies exiting the program has increased in recent years in these states, and moratoriums have stopped the entry of new agencies. Even with declines in these states, however, their supply of agencies is more than three times the supply of agencies that were available there in 2001, with supply exceeding 3,600 agencies in 2016.

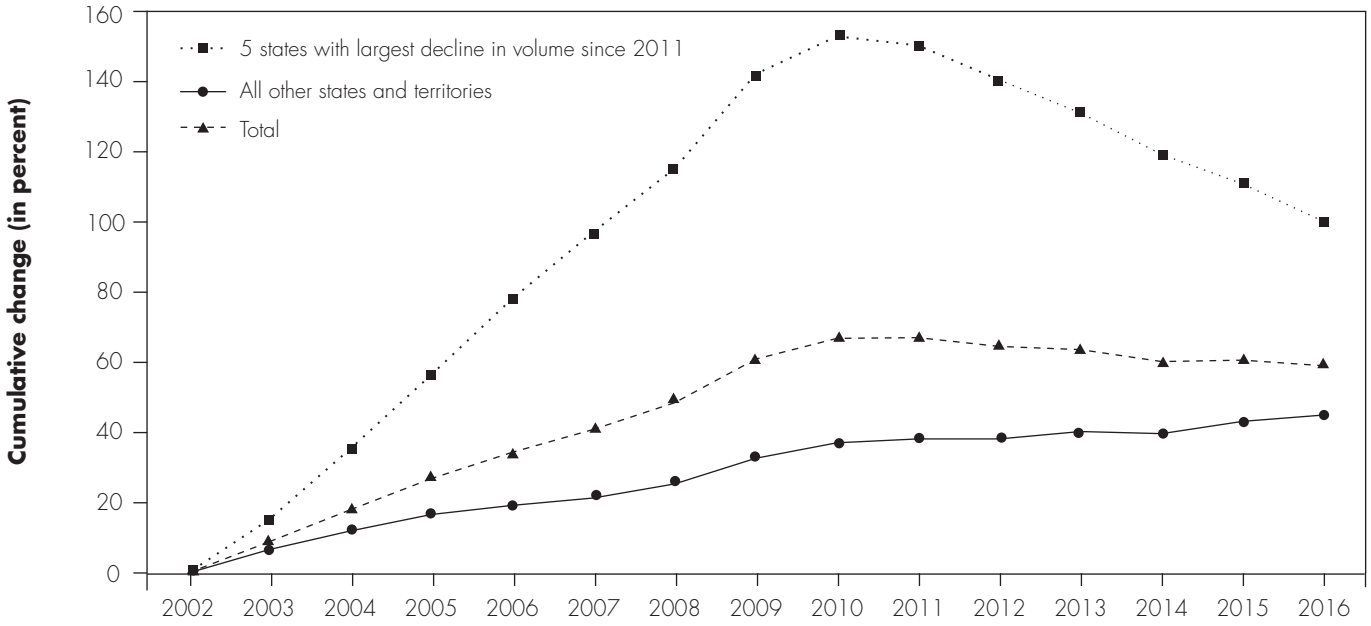
From 2004 to 2016, the number of agencies per 10,000 FFS beneficiaries rose 52 percent, from 2.1 to 3.2 (Table 9-3). Most of the new agencies were for profit. However, supply varies significantly among states. In 2016, Texas averaged 4.3 agencies per 10,000 beneficiaries, while New Jersey averaged less than 1 agency per 10,000 beneficiaries. 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.

Episode volume declined slightly in 2016

Episode volume in 2016 did not change significantly, with a small decrease of 0.7 percent in 2016, or about 50,000 episodes (Table 9-4). This decline is part of a trend that began in 2012, but this period of decline was preceded by a period of rapid growth (Figure 9-2, p. 252). Between 2002 and 2011, total episodes increased by 67 percent

FIGURE 9–2

Cumulative change in home health episode volume since 2002 for groups of states



Note: The five states with the largest decline in volume since 2011 include Florida, Illinois, Louisiana, Tennessee, and Texas.

Source: MedPAC analysis of home health standard analytic file from CMS.

from 4.1 million episodes to 6.8 million episodes. The decline since 2011 has been concentrated in a few states, with five states (Florida, Illinois, Louisiana, Tennessee, and Texas) accounting for most of the decline in episodes. However, utilization in these five states had more than doubled in the 2002 to 2011 period, higher than in most other areas (Figure 9-2).

Changes in average payment per full episode (defined as comprising more than four visits) underscore the limited impact of the PPACA rebasing policy that was implemented in 2014.[5] Average payment per episode increased in the first three years of rebasing (data for 2017 were not available at the time of publication), and the average payment per episode in 2016, the third year of rebasing, was 3.1 percent higher than the average payment per episode in 2013, before rebasing was implemented (Table 9-4, p. 251). The episode volume growth is even more remarkable since Medicare implemented additional payment reductions during this period, such as reductions for changes in coding practices. As the Commission has noted in the past, agencies have been successful in increasing payment through higher reported case-mix severity without incurring the higher costs that higher severity should incur.

The decline in home health utilization since 2011 reflects changes in both the demand for home health services and the supply of agencies. The number of hospital discharges, a common source of referrals, has declined since 2009, reducing some of the demand for post-acute care services. The period has also seen relatively low growth in economy-wide health care spending. In addition, several actions have been taken to curb fraud, waste, and abuse in Medicare home health care. CMS has implemented moratoriums on new agencies in several areas that have seen rapid growth in supply and utilization, including Illinois, Florida, and Texas.

The decline in episode volume since 2011 has not been uniform across the country. Since 2011, Florida, Illinois, Louisiana, Tennessee, and Texas (the five states with the fastest growing episode volume before 2011) have seen a decline of about 20 percent compared with an increase in

TABLE 9–5

Home health episodes not preceded by hospitalization or PAC stay increased at a higher rate than other episodes

	Episodes			Cumulative percent change	
	2001	2011	2016	2001–2011	2011–2016
Number of episodes preceded by a hospitalization or PAC stay (in millions)	1.9	2.2	2.2	14.8%	2.4%
Number of episodes not preceded by a hospitalization or PAC stay (in millions)	2.1	4.6	4.4	127.4	–7.7
Share of episodes not preceded by a hospitalization or PAC stay	53%	67%	66%	26	–3.3
Total (in millions)	3.9	6.8	6.6	74.0	–4.6

Note: PAC (post-acute care). "Episodes preceded by a hospitalization or PAC stay" indicates the episode occurred fewer than 15 days after a stay in a hospital (including in a long-term care hospital), skilled nursing facility, or inpatient rehabilitation facility. "Episodes not preceded by a hospitalization or PAC stay" indicates that there was no hospitalization or PAC stay in the 15 days before the episode began. Numbers may not sum to totals due to rounding.

Source: 2016 home health standard analytical file, Medicare Provider and Analysis Review file 2016, and 2016 skilled nursing facility standard analytical file.

volume of 30.1 percent in California. The remaining 44 states have seen 2.1 percent growth. This variation across states emphasizes that many areas continue to see growth despite the overall drop in episode volume since 2011. The volume decrease in areas that have been targeted by program integrity efforts suggests that these efforts can address excessive or unwarranted services, and the expansion of these efforts to other areas with excessive growth rates would be beneficial.

Home health care periods of service have increased in length and shifted in focus to episodes that are not preceded by a hospitalization

Between 2002 and 2016, the average number of episodes per user increased by 17 percent, rising from 1.6 to 1.9 episodes per user (Table 9-4, p. 251). The increase indicates that beneficiaries receive home health care for longer periods of time than previously and suggests that, for some beneficiaries, home health care serves more as a long-term care benefit. These concerns are 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 design 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 home health user coincides with a relative shift away from using home health care as a PAC service (Table 9-4 (p. 251) and Table 9-5). Between 2001 and 2011, episodes not preceded by a hospitalization or PAC stay increased by about 127 percent, while between 2011 to 2016, volume dropped by 7.7 percent. In contrast, from 2001 to 2011, episodes preceded by a prior PAC stay or hospitalization increased by almost 15 percent and have continued to increase slightly (2.4 percent from 2011 to 2016) in recent years. However, this increase has not significantly changed the share of episodes not preceded by inpatient or institutional PAC, and these episodes account for 66 percent of episodes in 2016—about the same level as 2011.

Episodes that qualify for additional payment based on therapy services account for an increasing share of volume

Since the 2001 implementation of the home health PPS, Medicare has used the number of therapy visits as a factor in payment, and, not surprisingly, episodes that qualify for these payments have increased faster than those that do not. Under the current PPS, additional therapy visits

TABLE 9–6

Almost all of the top 25 counties with the highest rates of beneficiaries using home health in 2016 were rural

State	County	Share of FFS beneficiaries using home health services	Episodes per user	Episodes per 100 FFS beneficiaries
National average		9.0%	1.9	17
TX	Duval	36.3	4.6	167.2
TX	Brooks	31.5	3.7	117.2
TX	Jim Hogg	26.4	4.1	107.9
TX	Jim Wells	25.5	4.1	104.7
TX	Starr	23.2	3.9	89.5
LA	East Carroll	23.0	4.2	95.5
OK	Choctaw	22.9	4.1	94.7
TX	Zapata	22.6	4.1	93.1
TX	Willacy	22.2	3.4	76.4
TX	Foard	22.0	4.0	88.3
TX	Wilbarger	20.1	3.8	76.6
OK	Greer	20.1	3.7	73.7
TX	Webb*	19.9	3.9	76.8
TX	Baylor	19.7	3.3	65.5
KY	Cumberland	19.5	3.7	71.3
OK	Atoka	19.3	3.6	70.3
OK	Coal	19.3	2.9	56.1
TX	Culberson	19.0	3.1	58.3
MS	Holmes	18.8	3.0	56.8
TX	Falls*	18.8	3.2	60.0
MS	Sharkey	18.6	3.2	59.7
LA	Evangeline	18.4	3.3	60.3
OK	Haskell	18.3	4.0	72.3
LA	St. Helena*	18.0	3.7	66.8
MS	Yazoo*	18.0	2.8	51.0

Note: FFS (fee-for-service).
*Urban county; all others rural.

Source: MedPAC analysis of the 2016 home health standard analytical file and the 2015 Medicare denominator file.

increase payments once six or more visits are provided in an episode, and the share of these episodes increased between 2008 and 2016 from 37 percent to 48 percent. In past work, the Commission has found that agencies that provide more therapy episodes tend to be more profitable. The higher profitability and rapid growth in the number of these episodes suggest that financial incentives are causing agencies to favor therapy services when possible. In 2017, the Commission recommended that Medicare eliminate the use of the number of therapy visits provided in an episode as a payment factor (Medicare Payment Advisory Commission 2017).

Rural add-on payments disproportionately benefit areas that do not have low utilization

An add-on payment of 3 percent for each home health care episode provided to beneficiaries in rural areas expired in 2017. The intent of the add-on was presumably to bolster access, but the high level of utilization in many rural areas resulted in poor targeting of Medicare's per episode

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%	58%	69%
Transferring	53	53	53	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

Medicare initiated a value-based purchasing program for home health agencies in 2016

In 2016, Medicare initiated a value-based purchasing (VBP) program for home health care. The model will test whether home health agencies in nine states (Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington) improve or maintain high quality when they are subject to a VBP incentive. Under the demonstration, agencies with higher performance receive bonuses, while those with lower scores receive lower payments relative to current levels. Agency performance is evaluated against separate improvement and attainment scores, with payment tied to the higher of these two scores.

CMS will use 2015 as the baseline year for performance, with 2016 as the first year for performance measurement. The first payment adjustment began January 1, 2018, based on 2016 performance data. Between 2018 and 2021, the payment withhold increases from 3 percent to 8 percent.

CMS's home health VBP model adopts a scoring approach similar to that used in the hospital VBP program, including allocating points based on achievement or improvement and calculating those points based on industry benchmarks and thresholds. For each measure, agencies receive points along an achievement range, a scale between the achievement threshold and a benchmark.

The VBP program is an important step forward for moving Medicare away from volume-rewarding fee-for-service incentives, and the Commission has recommended an incentive to reduce rehospitalizations for home health agencies. Compared with its predecessor demonstration, the VBP design has been

(continued next page)

time, but it can also introduce distortions if the actual effect of the risk factors in later years differs from the relationship assumed in the base year for the model.

Several factors likely drive the trends observed, but methods of data collection may account for some of the differences. The functional quality measures (walking and transferring) show marked increases between 2015 and 2016, and are based on self-reported data from HHAs. These outcomes contrast with the mostly unchanged hospitalization measure, which is derived from Medicare claims for home health care and hospital services. The substantial increase in the functional measures for 2016 is particularly important because these data will be used in a nine-state pilot test of value-based purchasing (VBP). In 2018, agencies will receive penalties or bonuses depending on how they compare with other HHAs in their state (see text box on the VBP program for HHAs).

Most of the measures used in the VBP program to compute penalties and bonuses will be based on quality data reported by HHAs, including the walking and transferring measures discussed above. While 3 measures—discharge to community, rate of hospitalization, and emergency care use—will be claims based, the other 21 measures will rely on data reported by agencies. The divergent trends between claims-based measures of quality such as hospitalizations and the self-reported functional measures suggest that closer scrutiny of the functional measures is necessary.

Providers' access to capital: Access to capital for expansion is adequate

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-covered services, 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 most other health care sectors receiving Medicare payment.

Medicare initiated a value-based purchasing program for home health agencies in 2016 (cont.)

strengthened in that participation is compulsory for the agencies active in the nine states selected. The prior VBP demonstration was voluntary, and agencies with low quality could avoid penalties by not participating. In addition, by 2021, the demonstration places a significant portion of payments at risk (8 percent), which should ensure that even agencies with relatively high margins have an incentive to maintain or improve quality. Agencies that do not have the number of episodes (20) required to produce data for at least 5 measures will not be subject to the payment adjustment.

In our 2017 comment letter, the Commission noted several changes that could improve the VBP program. The program uses 20 measures, complicating the administration of the program and making it difficult for agencies to focus on quality improvement efforts. The Commission also recommended that the program focus on rewarding attainment (or the absolute level of performance) and not improvement. An agency's absolute level of performance matters most to a beneficiary and is best encouraged by rewarding attainment. In addition, rewarding improvement creates potential inequities in that agencies with equal or better achievement scores receive smaller incentive payments than agencies with lower attainment scores but higher improvement scores. The greatest rewards in a VBP program should flow to the agencies with the best quality, and attainment-based scoring better achieves this goal. ■

Analysis of for-profit companies indicates that these companies had adequate access to capital in 2016. Firms continued to expand home health capacity. For example, Almost Family Incorporated, LHC Group, and Encompass (formerly known as HealthSouth) acquired or opened new agencies. These capacity expansions by publicly traded companies suggest that access to capital remains adequate.

Medicare payments and providers' costs: Payments rose while cost per episode remained low in 2016

In 2016, average Medicare payments per episode increased by about 0.7 percent for freestanding agencies. Meanwhile, low or no cost growth has been typical for home health care, and in some years, cost per episode declined. The average cost per episode grew less than 1 percent in 2016, slightly greater than the annual decrease of about 0.6 percent for the last five years. The ability of HHAs to keep costs low in most years has contributed to their high margins under the Medicare PPS for freestanding HHAs.

Medicare margins for freestanding HHAs remained high in 2016

In 2016, HHA Medicare margins in aggregate were 15.5 percent for freestanding agencies (Table 9-8, p. 258).[7] The aggregate Medicare margins varied from 0.6 percent for freestanding agencies at the 25th percentile of the margin distribution to 24.5 percent for freestanding agencies at the 75th percentile (not shown in table). For-profit agencies had higher margins than nonprofit agencies, and urban agencies had slightly higher margins than rural agencies. The profitability of freestanding agencies did not differ significantly for agencies with differing shares of Medicare revenues as a share of total payments. For example, agencies in the bottom quintile of Medicare payments as a share of total revenues had margins of 15.3 percent while agencies in the top quintile had margins of 14.4 percent.

The Commission includes hospital-based HHAs in its calculation of total Medicare margins for acute care hospital margins because these agencies operate in the financial context of hospital operations. Margins for hospital-based agencies in 2016 were –15.8 percent. The lower margins of hospital-based agencies are due chiefly to their higher costs, some of which are due to overhead costs allocated to the HHA from its parent hospital. Hospital-based HHAs help their parent institutions financially if they can shorten inpatient stays, lowering expenses in the most costly setting.

The financial performance in 2015 and 2016 permit an examination of the financial impact of the second

TABLE 9–8 **Medicare margins for freestanding home health agencies, 2015 and 2016**

	Medicare margin		Percent of agencies, 2016	Percent of episodes, 2016
	2015	2016		
All	15.6%	15.5%	100%	100%
Geography				
Majority urban	16.0	15.8	84	83
Majority rural	13.2	13.4	17	17
Type of ownership				
For profit	16.7	16.6	88	77
Nonprofit	12.1	12.0	12	23
Volume quintile				
First (smallest)	7.4	7.9	20	3
Second	9.6	10.1	20	6
Third	12.4	11.3	20	11
Fourth	13.8	14.1	20	19
Fifth (largest)	17.6	17.4	20	62

Note: 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. Components may not sum to totals due to rounding.

Source: MedPAC analysis of home health cost report files from CMS.

and third years of the rebasing required by PPACA. In both years, the margins for freestanding agencies have remained high, reflecting the Commission's concerns that the PPACA policy would not make sufficient reductions. The actual performance contrasts starkly with the home health industry's predictions. In 2013, the industry predicted that Medicare margins for freestanding agencies in 2014 would be 4.96 percent and 0.96 percent in 2015. These predictions were significantly lower than the actual performance of 10.8 percent and 15.6 percent, respectively.

Marginal profits

Another factor we consider when evaluating the adequacy of payments is whether providers have any financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for Medicare beneficiaries. If we approximate marginal cost as total Medicare cost minus fixed building and equipment cost, then marginal profit is:

Marginal profit = (payments for Medicare services – (total Medicare costs – fixed building and equipment costs)) / Medicare payments

On average, the marginal profit for freestanding HHAs was 17.4 percent in 2016. This substantial marginal profit indicates that these HHAs have an incentive to increase the volume of Medicare beneficiaries they serve.

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

Across all health care sectors, the Commission follows two principles when selecting a set of efficient providers. First, the providers must do relatively well across cost

TABLE 9–9 **Performance of relatively efficient home health agencies in 2015**

Provider characteristics	All	Relatively efficient providers	All other providers
Number of agencies	4,810	446	4,364
Share that are for-profit agencies	87%	82%	87%
Median:			
Medicare margin	14.0%	21.1%	13.2%
Hospitalization during stay and following 30 days (percent)	15.7%	14.3%	15.9%
Cost per full episode	$2,341	$2,236	$2,361
Patient severity case-mix index	0.99	1.04	0.99
Visits per episode			
Average visits per episode	17.6	16.8	17.9
Share of visits by type			
Skilled nursing visits	47%	47%	48%
Aide visits	9%	7%	9%
MSS visits	1%	1%	1%
Therapy visits	44%	45%	41%
Size (number of 60-day payment episodes)			
Median	495	776	474
Mean	897	1,401	846
Share of episodes			
Low-use episode	8%	10%	8%
Outlier episode	3%	3%	3%
Share of episodes provided to rural beneficiaries	21%	14%	21%

Note: MSS (medical social services). Sample includes freestanding agencies with complete data for three consecutive years (2013–2015). A home health agency is classified as relatively efficient if it is in the best third of performance for quality or cost and is not in the bottom third of either measure for three consecutive years. Low-use episodes are those with 4 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. Therapy episodes are those with six or more therapy visits. Components may not sum due to rounding.

Source: Medicare cost reports and standard analytic file.

and quality metrics. Second, the performance has to be consistent, meaning that the provider cannot have poor performance on any metric over a three-year period. The Commission's approach is to develop a set of criteria and then examine how many providers meet them. It does not establish a set share of providers to be considered efficient and then define criteria to meet that pool size.

We examined the quality and cost efficiency of freestanding HHAs to identify a cohort that demonstrated better performance on these metrics relative to its peers (Table 9-9). The cost measure was on a per episode basis, adjusted for risk (patient's health status) and local wages; the quality measures were risk-adjusted rates of hospitalizations and improvement in walking. Our approach categorized an HHA as relatively efficient if the agency was in the best performing third on at least one measure (either low cost per episode, a low hospitalization rate, or a high rate of beneficiaries showing improvement in walking) and was not in the worst performing third of any of these measures for three consecutive years (2013 to

2015). About 9 percent of freestanding agencies met these criteria in this period.

In 2016, relatively efficient agencies compared with other HHAs had median margins that were about 8 percentage points higher, a median hospitalization rate that was 1.6 percentage points lower, and a median cost per episode that was 5 percent lower. Relatively efficient HHAs provided more episodes but 1.1 fewer visits per episode. The mix of nursing, therapy, aide, and social services visits did not differ significantly between relatively efficient and other HHAs. Efficient providers tended to provide fewer episodes in rural areas.

Medicare margins for freestanding agencies are projected to remain high in 2018

In modeling 2018 payments and costs, we incorporate policy changes that went into effect between the year of our most recent data, 2016, and the year for which we are making the margin projection, 2018. The major changes are:

- payment rebasing change of –0.3 percent in 2017 (the net impact of the PPACA rebasing adjustments, partially offset by the payment updates for each year);
- 1 percent payment update for 2018;
- coding adjustments of –0.97 percent in 2017 and 2018, consistent with CMS's policy;
- sequester of 2 percent, which remains in effect for 2017 and 2018;
- assumed nominal case-mix growth of 0.5 percent in 2017 and 2018;
- expiration of the 3 percent add-on for episodes provided in rural areas in 2017; and
- assumed episode cost growth of 0.5 percent per year.

On the basis of these policies and assumptions, the Commission projects an aggregate margin of 14.4 percent in 2018 for freestanding agencies.

How should Medicare payments change in 2019?

Our review of the Medicare home health benefit indicates that access is more than adequate in most areas and that Medicare payments are substantially in excess of costs. On the basis of these findings, the Commission concludes that home health payments need to be significantly reduced. In addition to payment adequacy, the Commission is concerned that the current payment system provides a financial incentive for agencies to favor therapy services when delivering care. Though PPACA included a provision intended to lower payments, the reductions under this provision are modest, and substantial margins for many agencies are likely to remain, particularly for those that are efficient or focus on higher paying services.

RECOMMENDATION 9

The Congress should reduce Medicare payments to home health agencies by 5 percent in calendar year (CY) 2019 and implement a two-year rebasing of the payment system beginning in CY 2020. The Congress should direct the Secretary to revise the prospective payment system to eliminate the use of therapy visits as a factor in payment determinations, concurrent with rebasing.

RATIONALE 9

The data for 2016, the third year of rebasing under PPACA, indicate that Medicare continues to overpay for home health care and likely will continue to do so unless additional reductions are made. Under current policy, it appears likely that the average payment per episode in 2018 will be higher than the average payment in effect before rebasing. While the PPACA rebasing has restrained the increase in home health payments, the margins for 2016 and projected margin for 2018 indicate that payments will be substantially greater than costs unless significant additional reductions occur.

An immediate reduction of 5 percent in 2019 would represent a significant action to address the magnitude of the overpayments embedded in Medicare's rates. Subsequently, CMS should implement a revised rebasing beginning in 2020. Under the rebasing policy, CMS would assess the average margins of HHAs in the most recent year of data available (using audited cost reports to the extent feasible) and reduce payments in 2020 and 2021. The experience of the PPACA rebasing indicates that the continued updating of payments using the market basket update has undermined the goal of lowering payments, and a revised policy should not include these updates. In determining the amount by which to reduce payments, CMS could also use information on the costs of efficient providers, not just the average provider, since data suggest that efficient providers can deliver adequate service for

lower costs. With these adjustments, payments should be better aligned with costs compared with current policy.

The recommendation also calls for an end to the use of the number of therapy visits as a payment factor in the PPS when rebasing begins in 2020. The current system relies on a series of visit-number thresholds that increase payments beginning with 6 or more therapy visits and stopping at 20 visits per episode. Increasing the number of therapy visits increases payments significantly, sometimes by hundreds of dollars for a single additional visit. A Senate Finance Committee investigation of the therapy management practices of publicly traded home health companies concluded that CMS needs to eliminate the therapy thresholds in the home health PPS (Committee on Finance 2011). The continued use of these thresholds distorts the incentives of the payment system and distracts HHAs from focusing on patient needs and characteristics when delivering services. In 2017, CMS proposed the implementation of a new case-mix system that does not use therapy visits as a factor, but this proposal was withdrawn. The distributional effects of implementing a revised PPS would generally decrease payments for agencies that provide relatively more therapy episodes and raise payments for those that provide fewer of these services. (Subsequent to the Commission's vote on this recommendation, the Bipartisan Budget Act of 2018 eliminated the therapy thresholds beginning in 2020.)

Beyond the payment update recommendation, the Commission notes that the current home health rural add-on payment is poorly targeted. Because most of the funds are paid to rural areas with high rates of per capita home health utilization, we conclude that the add-on should not be extended. Overall margins for rural providers were 13.4 percent in 2016, indicating that, like urban providers, on average, these HHAs are paid well in excess of costs and generally do not need an additional subsidy. The untargeted higher payments in all rural areas do not create value for the beneficiary or the taxpayer. Future efforts to address the needs of rural areas should identify specific access problems and develop targeted policies that focus on the identified problems. The design of the current rural add-on payment does not fulfill this principle.

As discussed in the chapter on post-acute care (Chapter 7), before implementing a unified PAC PPS in 2021, the Commission recommends that the Congress direct the Secretary to establish home health payments using a blend of the unified PAC PPS and home health PPS relative weights. As noted in Chapter 7, the recommendation to blend relative weights does not affect the level of payments to a setting, but does affect the distribution of those payments across conditions. A blend of the relative weights would redistribute payments within the home health setting by increasing payments for medically complex patients and lowering payments to patients who receive rehabilitation therapy unrelated to their care needs. Based on HHAs' mix of patients and current therapy practices, the blend would have the effect of raising payments to nonprofit and hospital-based HHAs and lowering payments to for-profit and freestanding HHAs. The blended weights would narrow the relative profitability across types of stays, which would improve access for medically complex patients. Narrower differences in profitability would also mean there would be fewer financial incentives for providers to engage in patient selection. The redistribution across providers enables the Commission to recommend, and policymakers to implement, a level of payments that would better align payments with the cost of care.

IMPLICATIONS 9

Spending

- The payment reductions would lower payments relative to current law by $750 to $2 billion in 2019 and by $5 billion to $10 billion over five years. Our recommendation to eliminate the use of therapy visits as a factor in payment determinations would be budget neutral.

Beneficiary and provider

- Lowering payments should not affect providers' willingness to deliver appropriate home health care. Beneficiary access should not be adversely affected; indeed, it should be improved for patients requiring nontherapy care.
- The removal of therapy visits as a payment factor would be redistributive, after accounting for the effects of the recommendation mentioned above to reduce payments. In general, the change would lower payments for agencies with high numbers of therapy episodes and increase payments for agencies with relatively few therapy cases. ■

Endnotes

1 The Balanced Budget Act of 1997 ended coverage of home health care for the sole purpose of venipuncture services.

2 The rate is risk adjusted and excludes hospitalizations that were planned in advance or part of a normal course of treatment (for instance, organ transplant).

3 Surety bond firms review an HHA's organizational and financial integrity 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 covers 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) (Government Accountability Office 1999). Requiring a surety bond would prevent Medicare participation by agencies that a surety firm judges to be high risk.

4 As of November 2017, 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.

5 Medicare makes a case-mix-adjusted 60-day episode payment when more than 4 visits are provided. Episodes with four or fewer visits are paid on a per visit basis.

6 For bedfast patients, transferring includes the ability of the patient to sit upright or position themselves in bed.

7 The all-payer margins for freestanding agencies equaled 4.5 percent in 2016.

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