CHAPTER 8

Home health care services

RECOMMENDATIONS

(For previous recommendations on improving the home health payment system, see text box on pp. 216–217.)

CHAPTER 8

Home health care services

Chapter summary

Home health agencies provide services to beneficiaries who are homebound and need skilled care (nursing or therapy). In 2011, about 3.4 million Medicare beneficiaries received home health services from almost 11,900 home health agencies. Preliminary data for 2010 indicate that Medicare spent about $19.4 billion on home health services.[1]

Assessment of payment adequacy

The indicators of payment adequacy for home health care are generally positive. Because these indicators are similar to those for last year, the Commission is repeating our recommendations from the March 2011 report for a rebasing of the episode rate commencing in 2013. This policy would lower payments beginning in 2013 and would result in no market basket increase for that year.

Beneficiaries' access to care—Access to home health care is generally adequate: 99 percent of beneficiaries live in a ZIP code where a Medicare home health agency operates, and 98 percent live in an area with two or more agencies.

- ***Capacity and supply of providers—***The number of agencies continues to increase, with more than 420 new agencies and almost 11,900 total agencies in 2011. Most new agencies are concentrated in a few states (Texas, California, Florida, Illinois). Most of the growth has been in for-profit agencies.

In this chapter

- ***Volume of services*—**The volume of services continues to rise. About 3.4 million beneficiaries used home health care in 2010, a 4 percent increase. The share of fee-for-service beneficiaries using home health care increased to 9.6 percent in 2010.

***Quality of care*—**Most patients who were not hospitalized at the conclusion of their home health care stay showed some improvement in function (walking, transferring, or bathing) in 2011. The risk-adjusted rate of hospitalization for patients from home health agencies declined slightly between 2006 and 2008.

***Providers' access to capital*—**According to capital market analysts, the major publicly traded for-profit home health companies have sufficient access to capital markets for their credit needs, although it is not as favorable as in prior years. For smaller agencies, the entry of over 400 new agencies in 2011 suggests that they have access to the capital necessary for start-up.

***Medicare payments and providers' costs*—**In prior years, payments consistently and substantially exceeded costs in the home health prospective payment system (PPS). For 2010, costs declined slightly while payments increased. Medicare margins for freestanding providers in 2010 were 19.4 percent, which is above the average of 17.5 percent in 2001–2009. Two factors have contributed to payments exceeding costs: Fewer services are delivered than is assumed in Medicare's rates, and cost growth has been lower than what is assumed in the market basket. The Medicare margin for home health agencies in 2012 is estimated to equal 13.7 percent.

Because these indicators of payment adequacy are similar to last year's indicators, the Commission is reiterating its recommendation from last year, which called for a rebasing of home health payments (with no update for payment rates) commencing in 2013.

Ensuring the efficient and effective use of the home health benefit

The home health benefit faces several challenges: incentives that may encourage patient selection, fraud and abuse, and incentives in the PPS that encourage volume. The Commission made several recommendations to address these concerns in our March 2011 report. The Commission recommended changes to the home health case-mix system that would base payments for therapy services on patient characteristics and would reduce incentives for selection among certain types of patients. To address the volume-rewarding aspects of the PPS, the Commission recommended that the Congress implement a copay for certain home health episodes. Finally, to address fraud and abuse, we recommended that the Secretary of Health and Human Services use her authority to investigate and stop fraud and abuse in areas with aberrant patterns of utilization. ■

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 hospital stay to qualify for home health care. The mix of episodes has gradually shifted to those not preceded by a hospitalization. The share of episodes not preceded by a hospitalization or other post-acute care facility increased from 52 percent in 2001 to 65 percent in 2009. Unlike most services, Medicare does not require copayments or a deductible for home health services.

Medicare pays for home health care in 60-day episodes. Payments for an episode are adjusted for patient severity by a case-mix index that is based on patients' clinical and functional characteristics and some of the services they use. If they need additional covered home health services at the end of the initial 60-day episode, another episode commences and Medicare pays for an additional episode. An overview of the home health prospective payment system is available at http://medpac.gov/documents/MedPAC_Payment_Basics_11_HHA.pdf. Additional episodes generally have the same requirements (e.g., beneficiary must be homebound, 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 prospective payment system (PPS) in 1983 led to increased use of home health services as hospital lengths of stay decreased. Medicare tightened coverage of some services, but the courts overturned these curbs in 1988. After this change, the number of agencies, users, and services expanded rapidly in the early 1990s. Between 1990 and 1995, the number of annual users increased by 75 percent and the number of visits more than tripled to about 250 million a year. Spending increased from $3.7 billion in 1990 to $15.4 billion in 1995. As the rates of use and lengths of stay increased, there was concern that the benefit was serving more as a long-term care benefit (Government Accountability Office 1996). Further, many of the services provided were believed to be inappropriate or improper. For example, in one analysis of 1995–1996 data the Office of Inspector General found that about 40 percent of the services in a sample of Medicare claims did not meet Medicare requirements for reimbursement, with most of these errors due to the services not meeting Medicare's standards for a reasonable and necessary service, the patient not meeting the homebound coverage requirement, or the medical record not documenting that a billed service was provided (Office of Inspector General 1997).

The trends of the early 1990s prompted increased program integrity actions, refinements to eligibility standards, temporary spending caps through an interim payment system (IPS) and replacement of the cost-based payment system with a PPS in 2000.[2] 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 8-1, p. 214). 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. Since implementation of the PPS, the number of home health episodes increased from 3.9 million in 2001 to 6.8 million in 2010. The number of agencies in 2011 is almost 11,900, about 1,000 more agencies than at the earlier peak of spending in 1997. 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. 2003, McCall et al. 2004). An analysis of all the changes in the Balanced Budget Act of 1997 (BBA) related to post-acute care, including the home health IPS and changes for other post-acute care sectors, concluded that the rate of adverse events generally improved or did not worsen when the IPS was in effect. A study by the Commission also concluded that the quality of care had not declined between the IPS and 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 BBA led agencies to reduce costs without compromising patient care.

TABLE 8–1 **Changes in supply and utilization of home health care, 1997–2010**

				Percent change	
	1997	2000*	2010	1997–2000	2000–2010
Agencies	10,917	7,528	11,815	–31%	57%
Total spending (in billions)	$17.7	$8.5	$19.4	–52	129
Users (in millions)	3.6	2.5	3.4	–31	37
Number of visits (in millions)	258.2	90.6	123.8	–65	37
Visit type (percent of total)					
Skilled nursing	41%	49%	52%	20	6
Home health aide	48	31	16	–37	–48
Therapy	10	19	33	101	72
Medical social services	1	1	1	1	–2
Number of visits per user	72.6	36.8	36.2	–49	–2
Percent of FFS beneficiaries who used home health services	10.5%	7.4%	9.6%	–30	30

Note: FFS (fee-for-service).
*Note: 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.

Home health margins since the PPS was implemented have been very high, as Medicare margins averaged 17.5 percent between 2001 and 2009. The high overpayments have led the Commission to recommend that home health rates be lowered to a level equal to costs (see text box, pp. 216–217).These high margins likely encouraged the entry of new home health agencies (HHAs), as the total number of agencies participating in Medicare has increased by about 575 agencies a year since 2002.

The Patient Protection and Affordable Care Act of 2010 (PPACA) includes several reductions intended to bring payments more in line with costs:

- 2011: The standard 60-day episode rate was reduced by 2.5 percent.
- 2012 and 2013: The market basket update was reduced by 1 percent.
- 2014–2016: A phased rebasing was implemented to lower payments to a level to reflect changes in average visits per episode and other factors that may have changed since the rate was originally set. The Secretary of Health and Human Services may lower payments by no more than 3.5 percent a year, for a cumulative reduction to payments of 14 percent by 2016. These reductions will be offset by the payment update for each year (adjusted by productivity as indicated below).
- 2015 and following years: The market basket was reduced by multifactor productivity for each year.

While these reductions will affect home health payments, experience suggests that many agencies will be able to adjust their operations to maintain positive financial performance. The experience of 2003, when Medicare implemented a 5 percent reduction to the home health base rate, is illustrative. The effect of this cut was offset by an increase in case-mix values and low annual cost growth of less than 1 percent. With these two factors to offset the reduction in the base rate, average Medicare margins fell by less than 3 percentage points to 15 percent. While the payment changes in PPACA are significant, experience with prior adjustments indicates that many agencies will likely be able to offset at least a portion of these reductions.

Ensuring the 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 too

narrow a policy could result in beneficiaries using other, more expensive services, while a policy that was too broad could lead to wasteful or ineffective use of home health care (Feder and Lambrew 1996). Medicare relies on the skilled care and homebound requirements as primary determinants of home health eligibility, but these requirements provide limited guidance.

As wide swings in past Medicare spending for home health illustrate, ensuring appropriate use of the benefit has been a challenge. The broad coverage criteria permit beneficiaries to receive services in the home even when a beneficiary is capable of leaving the home for medical care, which most beneficiaries do (Office of Inspector General 2001). Medicare does not provide any incentives for beneficiaries or providers to consider alternatives to home health care, and beneficiaries, once they qualify, 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 home health care. 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 standards do not require that skilled visits constitute the majority of the home health services a patient receives. For about 11 percent of episodes in 2008, most services provided are visits from unskilled home health aides. 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.

The variation in following program standards may be one factor driving the geographic variation in spending on home health care. For example, from 2006 through 2008, the core-based statistical area (CBSA) at the 25th percentile of the distribution of total price- and health status–adjusted Medicare spending had home health expenditures of $25 per beneficiary, while the CBSA at the 75th percentile equaled $49 per beneficiary. Though differences in practice patterns likely explain some of this regional variation in home health spending, the extent of the variation was so stark and so concentrated in certain CBSAs that it raised concerns about the integrity of home health services in these areas. The Commission made two recommendations to curb wasteful or fraudulent home health services (see text box, pp. 216–217).

In 2011, Medicare implemented two major changes to strengthen program integrity for Medicare home health services. In April 2011, CMS implemented a PPACA requirement for a face-to-face encounter with a physician or nurse practitioner when home health care is ordered. 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 ensure that physicians do not rely solely on information provided by HHAs when deciding about patient care. The lengthy period permitted for the encounter may make the requirement more flexible, but it does not ensure that beneficiaries receive an examination in a timely manner before home health care is delivered.

In 2011, CMS also implemented a new requirement for tighter supervision of therapy services provided under the home health benefit. Under the new requirement, patients need to be assessed by a qualified therapist at the 13th and 19th therapy visits. In these assessments, the therapist reviews the patient's progress and determines whether the patient will benefit from additional therapy visits. Medicare targeted these visit intervals because, under the current PPS, the payments increase substantially for episodes at the 14th and 20th therapy visits. The additional review is intended to serve as a safeguard against manipulation of therapy visits to garner increased payment.

Some progress has occurred in Medicare's efforts to reduce the vulnerability of home health outlier payments to fraud and abuse. In prior years, suspicious billing patterns suggested that some providers, particularly those in Florida's Miami–Dade county, were exploiting loopholes in the outlier payment policy. More than 56 percent of the county's claims in 2009 were outliers, much higher than the national average. In 2010, Medicare capped outlier payments to respond to concerns about abuse, limiting outlier payments to no more than 10 percent of an agency's Medicare revenue. Although issues with claims data prevent the Commission from fully analyzing the change in outliers in 2010, preliminary data suggest some progress. The number of outlier episodes in Miami–Dade has dropped by 50 percent. However, the aggregate number of episodes in the county does not appear to have dropped and may have increased. Even with the outlier cap in place, Miami–Dade remains one of the counties with the highest utilization of home health care in the nation.

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

The Commission's analysis has demonstrated several troubling patterns of utilization and agency profitability that suggest the need for significant change to Medicare's policies. The extraordinarily high utilization of home health care in certain counties suggests that fraud or abuse may be a significant factor driving spending in some areas. The high profitability of Medicare home health agencies, averaging more than 17 percent since 2001, indicates that Medicare overpays for home health services. The trends in therapy provision and agency profitability suggest that the financial incentives of the prospective payment system (PPS) may be influencing care. Finally, the lack of cost sharing may result in Medicare paying for home health services that are of limited or no value to the beneficiary or the program. The Commission made four recommendations to address these challenges in its March 2011 report.

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 last year the Commission recommended that the Secretary exercise this new authority to curb fraud in home health care. So far, it does not appear that the Secretary has used this authority in any broad capacity. Last year the Commission published a list of counties with extremely high utilization of home health care, and an updated list of these counties (see the table on p. 222) suggests that in 2010 many of the same areas still warrant further review. As the Commission recommended in its March 2011 report, these counties would be appropriate areas for the Secretary to exercise new PPACA authorities for investigating and interdicting home health fraud.

Implications 8-1

Spending

- The Congressional Budget Office has already scored savings from the PPACA provision, so its baseline already assumes savings for the new authorities. 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.

PPACA has legislated that a limited rebasing begin in 2014, but such a delay appears unnecessary given the current indicators for the home health sector. The Commission believes that rebasing should be implemented faster, as another year of high overpayments would represent another lost opportunity for reform. The rebasing should be phased in over a short period of time that allows for an appropriate transition to the lower level of payments (e.g., no more than three years). In addition, the Commission believes that our recommendation from last year, to eliminate the use of therapy thresholds in the PPS, should be implemented along with the rebasing. This change would ensure that under rebasing the distribution of payments among providers more accurately reflects patient severity.

Implications 8-2

Spending

- This recommendation would reduce Medicare spending $250 million to $750 million in 2013 and $5 billion to $10 billion over 5 years. The spending implication of this recommendation is based on Medicare spending projections that were made prior to a sequester, as the recommendation was developed and voted on before the sequester was triggered and became current law. If a Medicare sequester does occur, it will change the spending implication of the recommendation.

(continued next page)

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

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 to a beneficiary. Last year, the Commission recommended that Medicare eliminate the use of therapy visits provided as a payment factor in the PPS (Medicare Payment Advisory Commission 2011). We recommended that Medicare use patient characteristics to set payment for therapy, the same approach it uses for setting payment for all other services covered in the home health PPS.

Implications 8-3

Spending

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

Beneficiary and provider

- This recommendation would increase payments for hospital-based agencies, rural agencies, and small agencies. 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.

To encourage appropriate utilization, the Commission recommended that Medicare add an episode copayment for services not preceded by a hospitalization or other use of post-acute care.[3] The high rate of volume growth for these types of episodes, which have more than doubled since 2001, suggests there is significant potential overuse. The addition of a copayment would allow for 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 2013 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. ■

TABLE 8–2

Number of home health agencies continues to rise, 2002–2010

	2002	2004	2006	2008	2009	2010	Average annual percent change 2002–2010	Average annual percent change 2009–2010
Number of agencies	7,057	7,804	8,955	10,040	10,973	11,654	6.5%	9.3%
Agencies that opened	399	656	828	780	1,100	831	9.6	–24.5
Agencies that closed	277	183	176	167	150	181	–5.2	20.7
Number of agencies per 10,000 beneficiaries	2.0	2.1	2.5	2.8	3.1	3.3	6.2	6.4

Note: Agencies' census includes all agencies operating during a year, including agencies that closed or opened.

Source: CMS's Providing Data Quickly database and 2011 trustees' report.

Are Medicare payments adequate in 2012?

To address whether payments for 2012 are adequate to cover the costs efficient providers incur and how much providers' costs should change in the coming year (2013), we examine several indicators of payment adequacy. 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 2010, almost all beneficiaries (99 percent) live in a ZIP code served by at least one HHA, 98 percent live in a ZIP code served by two or more HHAs, and about 60 percent live in a ZIP code served by nine or more agencies.

Our measure of access is based on data collected and maintained as part of CMS's Home Health Compare database as of November 2011. 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 willing to serve a ZIP code did not receive a request in the previous 12 months. The analysis excludes beneficiaries with unknown or missing ZIP codes.

Capacity and supply of providers: Agency supply increases to record levels

In 2010, HHAs numbered 11,654, with a net increase of about 650 agencies. Most of the new agencies in 2010 were for-profit agencies. The number of agencies exceeded the previous record in the 1990s when supply exceeded 10,900 agencies. The high rate of growth is a particular concern because the new agencies appear to be concentrated in areas where fraud is a concern: California, Texas, and Florida. These states, like most, do not have state certificate-of-need laws for home health care, which can limit the entry of new providers.[4]

Since 2004, when 99 percent of beneficiaries lived in an area served by an HHA, the number of agencies per 10,000 fee-for-service (FFS) beneficiaries has risen 57 percent from 2.1 to 3.3 (Table 8-2). Some of this growth is due to a decrease in the number of FFS beneficiaries as more have enrolled in Medicare Advantage, but even when these beneficiaries are included, the number of agencies has increased by about 28 percent since 2004. Supply can vary significantly among states. In 2010, Texas averaged 9.6 agencies per 10,000 beneficiaries, whereas New Jersey averaged 0.4 agency per 10,000 beneficiaries. Some of this variation in supply is likely due to certificate-of-need laws, as New Jersey does have this requirement while Texas does not. The extreme variation demonstrates that the number of providers is a limited measure of capacity, as agencies can vary in size and capability. 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.

TABLE 8–3 **Share of beneficiaries using home health services continues to rise, 2002–2010**

	2002	2003	2004	2005	2006	2007	2008	2009	2010	Average annual percent change 2002–2010	Average annual percent change 2009–2010
FFS beneficiaries (in millions)	35.0	35.9	36.5	36.8	36.2	35.6	35.4	35.4	35.7	0.3%	0.9%
Home health users (in millions)	2.5	2.7	2.8	3.0	3.0	3.1	3.2	3.3	3.4	3.9	4.1
Share of beneficiaries using home health care	7.2%	7.5%	7.8%	8.1%	8.4%	8.7%	8.9%	9.3%	9.6%	3.6	3.2
Episodes (in millions):	4.1	4.5	4.8	5.2	5.5	5.8	6.1	6.6	6.8	6.6	3.7
Per home health user	1.6	1.7	1.7	1.8	1.8	1.9	1.9	2.0	2.0	2.6	–0.4
Per FFS beneficiary	0.12	0.12	0.13	0.14	0.15	0.16	0.17	0.19	0.19	6.3	2.8
Payments (in millions)	$9.6	10.1	11.4	12.8	14.0	15.6	16.9	18.8	19.4	9.2	3.3
Per home health user	$3,803	$3,770	$4,039	$4,316	$4,606	$5,055	$5,359	$5,722	$5,679	5.1	–0.7
Per FFS beneficiary	$274	$281	$313	$348	$387	$439	$479	$530	$543	8.9	2.4

Note: FFS (fee-for-service).

Source: MedPAC analysis of home health standard analytical file 2010; expenditure data for 2010 are preliminary.

Episode volume continues to increase

The total volume of home health services, including the number of episodes and the share of beneficiaries using the services, increased in 2010, similar to the trend observed in prior years (Table 8-3). Episodes increased to 6.8 million in 2010, the share of beneficiaries using home health care increased to 9.6 percent, and the total number of users reached 3.4 million. The number of episodes per beneficiary increased slightly in 2010, indicating that volume continues to grow faster than the increase in FFS beneficiaries.

The number of episodes per user did not change significantly in 2010, but this metric is more than 20 percent higher than in 2002. Recent years—2002 to 2009—have seen a rapid increase in the number of episodes per user, from 1.6 episodes to 2.0. This rise in episodes per user suggests that, for some beneficiaries with high numbers of consecutive episodes, the benefit may be serving more as a long-term care benefit. This concern is similar to those in the mid-1990s that led to major program integrity activities and payment reductions. Notably, the rise in these episodes coincides with Medicare's PPS incentives encouraging additional volume: The per episode payment rewards additional episodes of service and increased payments for subsequent episodes in a consecutive spell of episodes.

The rise in episodes per user also coincides with a decrease in the share of episodes preceded by a hospitalization or stay in post-acute care (Table 8-4, p. 220). In 2001, about 47 percent of all episodes were preceded by a hospitalization or stay in post-acute care, but by 2009 the share had declined to 35 percent. A corresponding increase occurred between 2001 and 2009 in episodes not preceded by a hospitalization or stay in post-acute care, rising from 53 percent to 65 percent.

Changes in therapy volume consistent with prior years

CMS has periodically modified the therapy payment amounts in an attempt to reduce the incentives for manipulation. However, each modification has retained the number of visits as a payment factor, and changes in volume have generally followed the changes in payment.

For example, 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

TABLE 8–4 **Increase in home health episodes by timing and source of episode, 2001–2009**

	Number of episodes (in millions)		Percent change	Percent of episodes	
	2001	2009	2001–2009	2001	2009
Episodes preceded by a hospitalization or PAC stay:					
First	1.6	1.8	15%	40%	27%
Subsequent	0.3	0.5	57	8	7
Subtotal	1.9	2.3	21	47	35
Episodes not preceded by a hospitalization or PAC stay (community-admitted episodes):					
First	0.8	1.2	56	20	19
Subsequent	1.3	3.1	141	32	47
Subtotal	2.1	4.3	108	53	65
Total	3.9	6.6	67	100	100

Note: PAC (post-acute care). "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 hospitalization (including long-term care hospitals), 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 due to rounding.

Source: 2010 Datalink file.

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.

The results of the Commission's review of cost and utilization trends for therapy episodes illustrate how the visit thresholds have driven provider behavior. For example, the Commission found that agencies with higher Medicare profit margins in 2007 generally provided more episodes that qualified for extra therapy payments. The relationship between profit and amount of therapy provided suggests these services may be overvalued relative to nontherapy services.

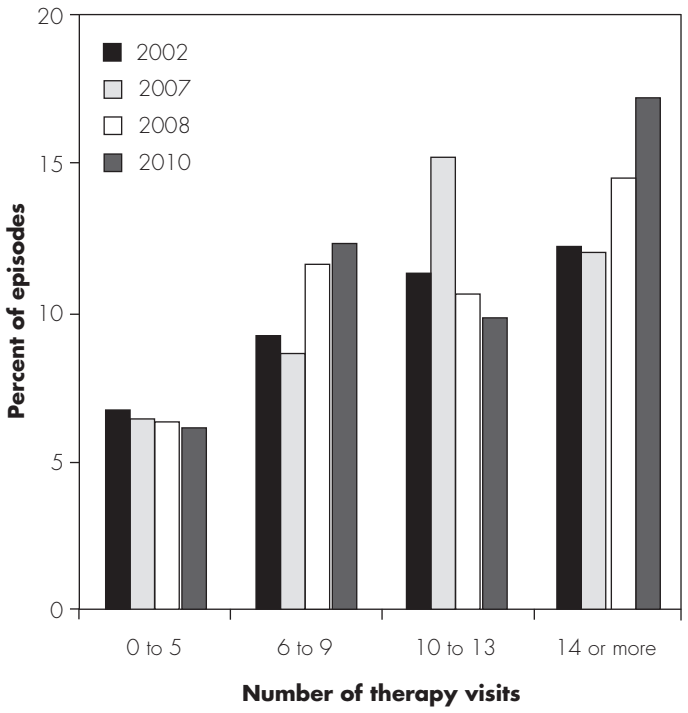
In response to the concern about the 10-visit threshold, CMS implemented changes in 2008 that lowered payments for episodes with 10 to 13 therapy visits and increased payment for episodes in the 6 to 9 and 14 or more therapy visit ranges. The changes in therapy utilization reflected the new incentives: Episodes with 10 to 13 therapy visits decreased 27 percent, while those with 6 to 9 therapy visits and 14 or more visits increased 43 percent and 27 percent, respectively (Figure 8-1). This change was the largest one-year shift in therapy volume since the PPS was implemented. Since 2008, the growth in episodes has followed this pattern, with episodes consisting of 14 or more visits growing significantly.

In October 2011, the Senate Finance Committee completed an investigation into therapy practices of some of the largest home health care companies. The review concluded that the therapy practices found at some of these firms "at best represent abuses of the Medicare home health program. At worst, they may be examples of for-profit companies defrauding the Medicare home health program at the expense of taxpayers." (U.S. Senate 2011). The report concludes that Medicare needed to initiate changes that remove therapy as a PPS payment factor.

In 2011, CMS recognized that the refinements implemented in 2008 continued to include financial incentives to provide therapy and implemented several changes to reduce the potential for manipulation—namely, the requirement for agencies to review the need for additional therapy at certain points in an episode and changes to the case-mix index. CMS also raised the payment relative weights for nontherapy episodes and lowered them for therapy episodes, but the changes were smaller than would have occurred if Medicare had adopted the changes to therapy payments recommended by the

FIGURE 8–1

Growth in episodes by year and number of home health therapy visits, 2002–2010



Source: MedPAC analysis of home health standard analytical file.

Commission. For example, the Commission found that payments for nontherapy episodes would have increased by 29 percent under one approach to using patient characteristics, compared with the 7 percent payment increase under the CMS 2012 refinements. Moreover, basing payments solely on patient characteristics would have reduced payment for therapy episodes by 11 percent, compared with the 3 percent drop under CMS's 2012 revisions. However, because the CMS refinements left the therapy visit thresholds in place, it is likely that providers will continue to favor therapy patients over nontherapy patients and that financial incentives will continue to drive the amount of therapy a patient receives.

The need for the continual changes to the therapy thresholds demonstrates the distortions created by including therapy visits as a payment factor. The 2012 changes will reduce the incentive to provide more therapy, but agencies will still be able to gain higher payments by providing more services. For example, increasing from five to six therapy visits increases payment by $344 for certain episodes. For this reason, we maintain that Medicare should use patient characteristics for setting therapy payments to remove the financial incentives that remain in the program's home health payment policies (see text box, pp. 216–217).

Most urban and rural areas have comparable total utilization

Ensuring adequate access to care for all Medicare beneficiaries is a policy goal of the Commission and the Medicare program. In the past, some policymakers have been concerned about access in rural areas. Medicare currently pays a 3 percent add-on for episodes provided in rural areas, even though utilization does not differ significantly. Rural counties averaged 15 episodes per 100 beneficiaries in 2009, compared with 16 episodes per 100 beneficiaries for urban counties (Table 8-5).

Home health utilization tends to vary more among different regions of the nation than between urban and rural areas within regions or states. Regions or states with utilization that is high relative to the national average typically have above average utilization in both rural and urban counties, and states or regions with utilization below the national average generally have below average utilization in both urban and rural areas. For example, rural areas in Minnesota average 5 episodes per 100 beneficiaries, compared with 2 episodes per 100 beneficiaries in the urban area of LaCrosse, Wisconsin. Both LaCrosse and the rural areas of Minnesota are well below the national average. In contrast, the rural areas of Texas average 41 episodes per 100 beneficiaries, and the

TABLE 8–5 **Utilization by type of county, 2009**

Type of county	Number of home health episodes per 100 beneficiaries
Urban	15.8
Rural, by subcategory	
Micropolitan	14.4
Rural, adjacent to metropolitan	15.8
Rural, nonadjacent to metropolitan	14.8
All rural	14.8
National (all counties)	15.6

Note: An urban county includes a city that has a population of more than 50,000. A micropolitan county has a population of 10,000 to 50,000.

Source: MedPAC analysis of home health Datalink file and 2009 beneficiary annual summary file.

TABLE 8–6

Counties with high rates of home health care use

State	County	Share of FFS beneficiaries using home health	Episodes per user	Episodes per 100 FFS beneficiaries
TX	Brooks	37.5%	4.0	150.4
TX	Duval	36.4	4.3	155.4
TX	Starr	35.5	4.2	149.8
TX	Jim Hogg	35.3	4.0	140.6
TX	Jim Wells	30.9	4.0	123.0
TX	Willacy	30.8	3.8	116.3
TX	Hidalgo	30.1	3.9	116.9
MS	Claiborne	29.3	2.9	85.4
FL	Miami–Dade	28.5	2.6	75.3
TX	Zapata	27.5	4.3	118.4
LA	Madison	26.9	4.5	121.2
OK	Choctaw	26.2	4.2	109.5
TX	Cameron	25.7	3.5	88.7
TX	Webb	25.2	3.8	95.3
OK	McCurtain	24.9	4.4	109.6
MS	Sharkey	24.6	4.0	99.1
OK	Pushmataha	24.3	4.0	98.1
LA	Avoyelles	24.0	4.2	99.8
LA	East Carroll	23.6	4.4	104.8
TX	Red River	23.4	4.2	98.2
OK	Latimer	23.0	4.6	105.7
MS	Jefferson	22.6	3.7	84.2
TN	Hancock	22.5	3.6	80.5
LA	Washington	22.3	3.8	83.8
LA	St. Helena	22.3	3.8	84.4

Note: FFS (fee-for-service). Counties with fewer than 100 home health users have been excluded.

Source: MedPAC analysis of the 2010 home health standard analytical file; 2010 Medicare denominator file.

urban area of Dallas–Fort Worth averages 38 episodes per beneficiary. Texas is a state with above-average utilization in both urban and rural areas. The variation between these states is generally greater than the variation within them.

Table 8-6 reports the 25 counties with the highest utilization of home health care. Many of these counties are in states with high rates of Medicare utilization in general (Texas, Florida, and Louisiana), and many of these counties are rural, suggesting that Medicare's add-on payments based solely on rural designation are not as well targeted as they could be.

Access is not significantly different among subclasses of rural counties, and more populous rural areas do not always have higher utilization than less populous rural areas. Rural micropolitan counties (with a town of greater than 10,000) averaged 14.4 episodes per 100 beneficiaries in 2009, while remote rural areas (fewer than 10,000 residents and not adjacent to a metropolitan or micropolitan area) averaged about 14.8 episodes per 100 beneficiaries.

Utilization in sparsely populated counties appears to be lower than in other rural areas, though there is significant variation within this category. Frontier counties—with six or fewer people per square mile—average about 9.4 episodes per 100 beneficiaries. While this number is lower than the average for other rural areas, it is not clear that it indicates an access issue. Many nonfrontier rural areas have utilization that reaches levels the Commission has suggested need to be investigated, so the average

TABLE 8–7 **Quality measures for 2011**

Functional measures	2004	2005	2006	2007	2008	2009	2010	2011
Improvements in:								
Transferring	50%	51%	52%	53%	53%	54%	54%	53%
Bathing	59	61	62	63	64	64	65	64
Walking								55
Medication management								46
Pain management								66

Note: The measures for walking, medication management, and pain management changed in 2011 and are not comparable to data from prior years.

Source: MedPAC analysis of CMS Home Health Compare data.

utilization for nonfrontier areas may be artificially high because of aberrant utilization patterns (see text box, pp. 216–217). In other words, the higher average utilization for nonfrontier counties may reflect inefficient use of the benefit, which would not be surprising given the payment system's high margins and volume-rewarding aspects. Also, patient preference and clinical needs may differ in frontier and nonfrontier counties. Because of these factors, the average utilization for nonfrontier counties may not represent an appropriate benchmark for assessing the lower utilization in frontier counties.

Mix of services varies for urban and rural beneficiaries

Though the overall number of episodes per beneficiary does not differ significantly in urban and rural areas, the mix of therapy and nontherapy episodes varies for urban and rural counties. About 37 percent of episodes in urban counties are therapy episodes, compared with about 30 percent of episodes in rural counties. For nontherapy episodes, the relationship is reversed: In rural counties, 70 percent of episodes are nontherapy, compared with about 63 percent of episodes in urban counties. The mix of services differs more between urban and rural areas than the level of utilization. Given the financial incentives to provide more therapy in the home health PPS, it is possible that some of the higher utilization in urban areas is a result of the design of the PPS. It is also possible that the different mix of services for rural areas reflects differences in patient acuity or preferences.

Payments in rural areas would increase if the Commission's recommendation to remove the therapy thresholds were introduced. Removing the therapy thresholds would increase payments for nontherapy episodes and decrease them for therapy episodes. As a result, rural areas, which have more nontherapy episodes, would see a significant boost in payment from the refinement. Areas with the lowest rates of therapy provision, such as frontier areas, would see higher payment increases than other areas. This increase, however, would be because of the greater frequency of nontherapy services in rural areas and not because the case-mix index deliberately targeted areas for higher payments on the basis of their rural character.

Quality of care: Quality measures generally held steady

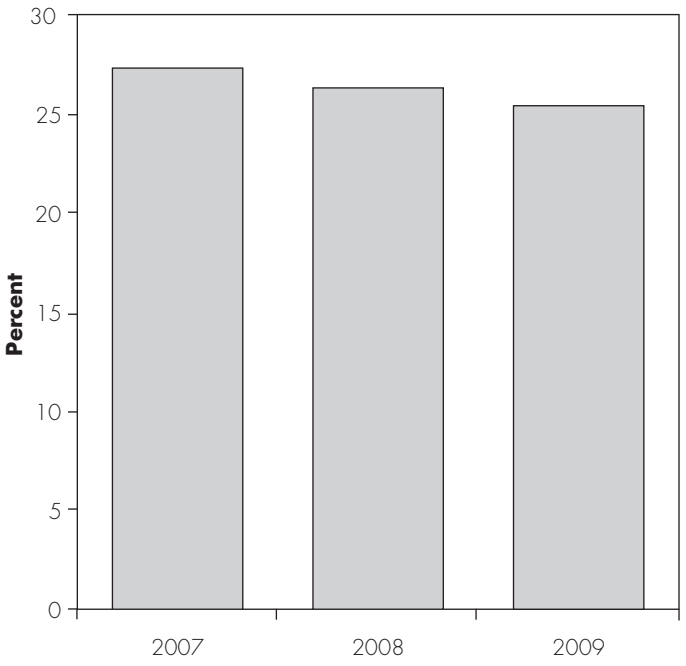
Quality measures appear to be steady for home health care on most measures. The Commission uses two sources of quality data for assessing home health care. Measures from Medicare's Outcome-Based Quality Monitoring (OBQM) data set provide measures of adverse event and functional improvement. The Commission has concerns that some aspects of the OBQM measures may be prone to manipulation, so we developed an alternative approach to measuring adverse events (hospitalizations).

OBQM measures with comparable data are steady for 2011

In 2011, CMS implemented changes for three of the five OBQM functional measures the Commission typically reports (walking, medication management, and pain management). The scale for these items was changed in 2011, so the measures of performance for these functions are not comparable to the data in prior years. For the two functional measures that were unchanged by CMS—transferring and bathing—the rates of patients reporting improvement were comparable for each year since 2007 (Table 8-7).

FIGURE 8–2

Thirty-day risk-adjusted hospitalization for home health patients declined, 2007–2009



Source: MedPAC analysis of University of Colorado data.

The measures indicating improvement in function may not reflect the experience of all patients because these data are collected only for patients who do not have their episode terminated by a hospitalization. This limitation is imposed for both policy and practical reasons. Hospitalizations are generally unplanned so there is no opportunity to assess patients' functionality before their episode ends. Also, Medicare's payment rules terminate a home health episode when a patient is hospitalized, so the patient is no longer in the care of the health agency. As a result, the functional measures report quality only for patients who were not hospitalized during their home health episode, and these patients are probably more healthy and more likely to have good outcomes.

Alternative measure of hospitalization

Though the OBQM measures provide a useful snapshot of the quality of home health care, the Commission has been concerned that the measures offer an incomplete analysis of quality. The OBQM measures rely on self-reported data from the home health care Outcome and Assessment Information Set (OASIS), and it is difficult for Medicare to independently validate many of the outcomes collected. In addition, there has been concern that the OASIS measures may not be directly linked to the reason for referral to home health care. For example, Medicare collects information on the improvement in walking for all patients, not just those referred to home health care for a functional debility. To address these concerns, the Commission contracted with the University of Colorado to develop more clinically focused measures of the quality of home health care. Hospitalization was selected because this measure matters to both the program and the beneficiary, and data for the outcome could be validated through Medicare inpatient hospital claims data.

The Commission convened a technical panel to consider what conditions and period of time an alternative measure of hospitalizations should include.[5] The consensus of the panel was that hospitalization was a key outcome for most categories of patients and that focusing a measure on a few categories of patients could encourage patient selection. On the basis of this input, the Commission selected an all-cause hospitalization measure with a limited set of exclusions related to conditions in which hospitalization might be expected as a part of the normal course of treatment (e.g., cancer treatment and organ transplant complications). In addition, the measure included hospitalizations that occur up to 30 days after discharge from home health care.

Figure 8-2 depicts the risk-adjusted rate of hospitalization under the alternative measure. The trend shows that, after adjusting for changes in patient risk, the rate of hospitalization has been declining. Data underlying this calculation indicate that the improvement in hospitalization rates is attributable to a slight rise in the severity of the patient population, and across these years the actual rate of hospitalization has been steady at about 28 percent each year. Since the actual rate of hospitalization has been steady even as the risk of hospitalization has increased, the risk-adjusted rate of hospitalization shows improvement.

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

Few HHAs access capital through publicly traded shares or public debt, like issuing bonds. HHAs are not as capital intensive as other providers because they do not require extensive physical infrastructure, and most are too small to attract interest from capital markets. Information on publicly traded home health companies provides some

TABLE 8–8 **Medicare margins for freestanding home health agencies, 2009 and 2010**

	2009	2010	Percent of agencies, 2010	Percent of episodes, 2010
All	18.2%	19.4%	100%	100%
Geography				
Majority urban	18.5	19.4	86	91
Majority rural	17.0	19.7	14	9
Type of control				
For profit	19.8	20.7	87	79
Nonprofit	13.6	15.3	13	21
Government*	N/A	N/A	N/A	N/A
Volume quintile				
Lowest	8.9	9.9	20	3
Second	10.2	11.6	20	7
Third	14.9	13.9	20	11
Fourth	18.1	18.2	20	20
Highest	20.3	22.1	20	60

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

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

insight into their access to capital but has limitations. Publicly traded companies may have businesses 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.

Analysis of the for-profit companies indicates that they have adequate access to capital, though on terms less favorable than in previous years. The PPACA changes in home health policy in the 2011 and 2012 PPS regulations have trimmed revenues for the home health 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 on these firms and made lenders more cautious in the terms they offer home health firms seeking capital, but for-profit HHAs appear to still have access to capital for their operating needs.

For smaller or nonpublic entities, the entry of new providers indicates that access to capital for privately held agencies is adequate. In 2010, about 830 new HHAs entered Medicare; most of them are for-profit agencies.

Medicare payments and providers' costs: Payments increased by more than costs in 2010

In 2010, the average payment for a full home health episode of care increased by 4.5 percent. (This amount does not include payments for outlier episodes or episodes paid under the low utilization payment adjustment rates.) The rise in payments did not reflect a commensurate increase in costs. Costs per episode in 2010 declined by less than 1 percent compared with the prior year. This slight decline in costs contrasts sharply with the inflation indicated by the home health market basket, which increased by 1.7 percent in 2011. The annual trends for 2010, low or no growth for costs and relatively high growth for payments, are consistent with trends in the PPS since its inception in 2000. The ability of HHAs to consistently keep costs low while increasing revenue has contributed to the high margins HHAs have garnered under the PPS.

Medicare margins increased in 2010

In 2010, HHA margins in aggregate were 19.4 percent for freestanding agencies, up from the previous year (Table 8-8). Financial performance varied from 3 percent for the

TABLE 8–9 **Margins by volume and urban/rural classification, 2010**

Volume quintile	Majority urban	Majority rural
Lowest	10.5%	6.4%
Second	11.1	12.0
Third	14.2	12.5
Fourth	18.6	15.6
Highest	22.0	23.0

Source: MedPAC analysis of 2010 home health cost reports and standard analytic file.

agencies at the 25th percentile of the margin distribution to 27 percent for the agencies at the 75th percentile. We focus on freestanding agencies because they are 90 percent of providers and because their costs do not reflect an allocation of overhead costs, as with hospital-based agencies. Margins for hospital-based agencies in 2010 were –4.7 percent.

Since an individual HHA can serve a mix of urban and rural patients, we determine an agency's rural or urban designation according to where most of its episodes are provided. In 2010, rural providers had slightly higher margins than urban providers, but that is not surprising, as PPACA included a 3 percent add-on for episodes delivered in rural counties beginning in March 2010. In addition, the largest rural agencies, those in the top quintile, had significantly higher margins than other rural agencies.

Agency size is related to financial performance, with larger agencies having higher margins. Within each size quintile, urban agencies generally had higher margins than rural agencies (Table 8-9). However, this trend likely reflects the difference in the mix of services provided by HHAs and not necessarily a difference in cost among rural and urban areas. Rural agencies delivered more nontherapy episodes, which are not as profitable as therapy services. Conversely, urban providers delivered more therapy episodes. Implementing the revisions to the case-mix index that the Commission recommended would raise payments for rural agencies and lower them for urban providers.

Historically, Medicare margins have varied widely among HHAs. To better understand the factors driving this variation, the Commission examined in a prior analysis the characteristics of high-margin and low-margin agencies in 2007. Our analysis of margins by provider, beneficiary, and episode characteristics suggests that providers can deliver quality care and earn significant profits under current payment levels and that those with the lowest costs and the highest case mix have the best financial performance (Medicare Payment Advisory Commission 2010).

The most salient difference between high-margin and low-margin agencies was in cost per episode and agency size. High-margin agencies had lower costs and higher episode volume. The cost per episode of high-margin agencies was about 40 percent lower than that for low-margin agencies, driven primarily by a lower cost per visit. The lower costs were likely related to the larger average size of high-margin agencies, as higher volume permits them to achieve economies of scale that result in lower costs and better financial performance. The analysis of the case mix of high-margin and low-margin agencies suggested that Medicare overpays for episodes with high case-mix values, as high-margin agencies had case-mix values that were 7 percent higher than those for low-margin agencies. The higher case-mix values were attributable to high-margin agencies providing more therapy episodes (which have higher payment weights) and nontherapy episodes with high case-mix values.

Margins for subcategories of rural providers are high

The Commission separated rural providers into subcategories based on the urban influence codes to examine the possibility that the type of rural counties agencies served influenced financial performance. The analysis (Table 8-10), which classifies agencies based on the type of county where most episodes are provided, indicates that margins did not differ significantly on this basis.

Though there is a concern that agencies in more remote areas may have worse financial performance, these data indicate that margins increase as agencies move from serving more populated areas to less populated areas. Margins for agencies serving mostly micropolitan counties equaled 18.7 percent, while they were 20.9 percent for agencies predominantly serving the least populated rural counties. Agencies in more rural areas had better financial performance than other categories of rural counties.

Projecting margins for 2012

In modeling 2012 payments and costs, we incorporate policy changes that will go into effect between the year of

our most recent data, 2010, and the year for which we are making margin predictions. The major changes are:

- payment updates in 2011 and 2012, equal to market basket minus 1 percent (per PPACA) for each year;
- a reduction of 2.5 percent to the standard 60-day episode rate;
- a reduction of 3.79 percent to account for coding improvement in 2010 and 2011;
- a case-mix increase of 1 percent a year (due to an increase in patient severity, coding improvement, and utilization changes); and
- assumed episode growth of 0.5 percent a year for 2011 and 2012, higher than the trend for 2011.

On the basis of these factors, we project a margin of 13.7 percent in 2012.

Medicare continues to overpay for home health services

The high margins for home health care in 2011 reflect that payments substantially exceed costs and that the PPACA reductions and administrative adjustments by CMS have not significantly reduced payments. These findings are consistent with those of previous years; Medicare home health margins have averaged 17.5 percent since 2001. These high profits occur despite numerous legislative and administrative reductions. In every year but one, 2007, the payment update has been reduced through legislative changes, administrative action, or both. However, average payments have increased each year, in part because HHAs have increased the number of episodes that qualify for additional therapy payments. The combination of low cost increases and rising average payments has resulted in overpayments that are inconsistent with paying at a level to support the efficient provider and that contribute to Medicare's long-run sustainability challenges. Since home health care is financed through Part A and Part B, the higher payments contribute to the insolvency of the Hospital Insurance trust fund and to the cost of the Part B premium paid by beneficiaries. High payments may also encourage the entry of marginal or fraudulent providers who are disproportionately motivated by the financial returns offered by excessive payments.

These overpayments likely originated when Medicare established the initial PPS payment rates. The Balanced Budget Act required that the PPS base rate for a home health episode be budget neutral so that aggregate spending would equal the spending that would have occurred if IPS had remained in effect. However, between 1998 and 2001, the average number of home health visits per episode dropped from 31.6 to 21.4 and remained at about this level through 2009. Even though some reductions were made to the initial base rate, these adjustments did not anticipate the magnitude by which HHA costs would fall. HHAs had average Medicare profits of more than 23 percent in 2001, the first year the base rate was in effect. Because providers delivered fewer visits than was assumed, payments under PPS have been consistently greater than providers' costs. Medicare rates started out too high, and since then the cost increases have not kept pace with the annual payment update, permitting HHAs to maintain high margins.

TABLE 8–10 **Financial performance by type of agency, 2010**

Type of agency	Medicare margin	Cost per case	Payment per case
Urban	19.4%	$2,560	$3,179
All rural	19.7	2,097	2,615
Micropolitan	18.7	2,220	2,731
Rural, adjacent to urban	19.9	2,051	2,560
Rural, nonadjacent to urban	20.9	2,021	2,555

Note: Agencies are classified based on the county type where most of their episodes are provided.

Source: MedPAC analysis of 2010 home health cost report files and home health standard analytic file.

The need to reset the base rate in Medicare is particularly acute because the high margins exist across the range of agency types. Urban, rural, for-profit, and nonprofit agencies have margins in excess of 15 percent. While some agencies have margins significantly lower than average, the Commission's review found that these differences are primarily due to their higher costs. These higher costs do not appear to be related to patient severity as, for most measures, low-margin agencies did not serve more severe patients.

Low-margin agencies provided fewer episodes that qualified for additional therapy payments. Refining the case-mix adjuster, as discussed earlier, to eliminate the

therapy threshold would redistribute funds to lower margin agencies. It would still be necessary to lower the base rate to ensure that high margins do not continue, as changes in the case-mix adjusters affect only the distribution of payments among providers and not the total amount of spending.

How should Medicare payments change in 2013?

Our review of the Medicare home health benefit indicates that access is more than adequate in most areas and that aggregate Medicare payments are well in excess of costs. Because they are similar to last year's indicators, the Commission is standing by our recommendation from last year, which called for a rebasing of home health payments commencing in 2013. This policy would lower payments beginning in 2013 and would also result in no market basket increase for that year (see text box, pp. 216–217, for a summary of the recommendations from last year's report). ■

Endnotes

1 The spending totals for home health care in 2010 may change because of a payment error related to outlier episodes. The Commission will update its spending totals for 2010 when corrected data become available.

2 The IPS was created as a temporary measure to lower payments while a home health PPS was developed. From 1997 to 2000, the IPS implemented more stringent spending caps for the cost-based system that was in effect before PPS. In addition, the IPS included an agency level per beneficiary spending limit; this limit was calculated as a blend of an agency's per beneficiary utilization and the comparable regional average.

3 The recommendation applies only to full episodes, which include five or more visits.

4 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.

5 The panel included health service researchers, representatives from Medicare HHAs, and physicians with experience in home health care.

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