Impact of Home Health Payment Rebasing on Access, Quality, and Supply

Kristine A. Betz, M.A., NHA, Consultant

The April 3 and 4 Medicare Payment Advisory Commission (MedPAC) meeting reviewed the impact of past payment changes to home health care providers on access, quality, and supply to assess the impact of the Patient Protection and Affordable Care Act (PPACA) rebasing. The review considers the impact on for-profit, nonprofit, urban, and rural agencies.

Summary

The PPACA rebasing mandate phases in the reduction over four years, whereas MedPAC's policy recommended no more than two years. The PPACA set a limit on the reduction that allows it to equal no more than $81 per year, and CMS set it at this maximum amount. MedPAC's policy recommendation did not set a limit and would have permitted steeper reductions. The PPACA includes a payment update that averages about $70 per year, which offsets about 86 percent of the cut. The net effect is that the episode base rate in 2017, the last year of rebasing, will be 1.6 percent less than 2013. If the sequester were in effect, payments in 2017 would be 3.6 percent lower.

The PPACA mandate requires the Commission to consider the impact of the PPACA reductions on agency supply, access to care, and quality. The report is due January 2015, before data from the first year of rebasing is available. As a result, in the

PPACA-mandated January 2015 report, MedPAC will examine the impact of payment changes in 2001 through 2012. As part of MedPAC's analysis for the April meeting, historical trends were reviewed to assess the impact of rebasing on agency supply, utilization, and quality.

MedPAC's analysis indicates that average episode payment has increased in most years. The analysis also indicates that margins have remained high throughout this time period, regardless of how payment per episode has changed. Agency supply has changed within this time period. The years with a decline in average payment per episode are shaded. The overall supply of agencies doubled across this period, driven by a rapid increase in for-profit and urban agencies. For-profit and urban agencies increased each year, regardless of payment policy; non-profit and rural agencies experienced a decline in most years during this period. These trends suggest that changes in supply are not highly correlated with changes in the average episode payment.

MedPAC analyzed access, as measured through utilization, and how it has changed during this time period. Findings indicate aggregate utilization of FFS home health care has risen rapidly. The share of beneficiaries using home health has risen 50 percent, and the episodes per user have increased 30 percent. Utilization on a

per-beneficiary basis increased through 2010, but declined slightly in 2011 and 2012. The Commission attributes the decline to the following factors and thus unrelated to payment policy:

- Per-beneficiary utilization decline is less than 5 percent and is concentrated in five states that had abnormally high rates of utilization (Florida, Louisiana, Oklahoma, Mississippi, and Texas)
- Economy-wide, there has been a slowdown in the rate of growth of health care spending in recent years
- Medicare inpatient hospital discharges have declined since 2009
- In 201,1 Medicare established a requirement for a physician to conduct a face-to-face examination before ordering home health, and the DOJ and other government agencies expanded their efforts to combat fraud, waste, and abuse

MedPAC concludes rebasing to have a limited impact, if any, on access.

Lastly, MedPAC examined the impact of rebasing on quality using three measures: hospitalization during the home health stay, and two functional measures that examine improvement in walking and improvement in transferring at discharge. Hospitalization rates were mostly unchanged from 2003 to 2010. The steep increase in payment contrasts with the relatively flat rate of hospitalizations and suggest that there was not a relationship between payment and hospitalization during this time period.

Rates of improvement (transferring and walking) increased in most years throughout this period, regardless of the direction of payment policy, with the exception of transferring rate for 2009. In this year, the rate declined slightly while average payments per episode increased 3 percent. Overall, these trends suggest that changes in the functional rates of improvement were not highly correlated with changes in payment. The rates of improvement increased in 2011 and 2012 when payment fell, and the only year with a decrease, the rates for transferring in 2009, was a period that average episode payment increased. The results for both hospitalization and functional improvement suggest no tie to quality and, thus, MedPAC does not expect the reductions in payment as set forth by the PPACA to cause a decline.

4400 Baker Road, Suite 100 | Minneapolis, MN 55343 | 763.537.5700 | www.healthdimensionsgroup.com

Conclusion

Based on MedPAC's analysis thus far, the Commission expects rebasing to have a limited impact on the three areas requested to review. The supply of agencies has increased overall, regardless of the direction of payment policy. Utilization has increased in aggregate and on a per-beneficiary basis, and rates of improvement increased in most years. The rate of hospitalization was unchanged. MedPAC indicates that small changes in payment under PPACA rebasing are unlikely to significantly affect quality. The rebasing cut is small, only 1.6 percent over 4 years (3.6 percent with sequester). Past history suggests that some or all of payment cuts will be offset by growth in case-mix, so the payment reduction may be even smaller than expected. Higher case-mix has offset past attempts to lower the base rate, and margins have remained high despite past reductions to base payments.

MedPAC indicates that agencies have been able to sustain high margins in the face of past cuts by increasing case-mix. Agencies have also been effective at controlling costs. MedPAC concludes that past payment changes have not had a significant impact on access, supply, or quality.

4400 Baker Road, Suite 100 | Minneapolis, MN 55343 | 763.537.5700 | www.healthdimensionsgroup.com

About the Author

Kristine A. Betz, MA, CPG, NHA
Consultant, Continuum Strategies

Health Dimensions Group
4400 Baker Road, Suite 100
Minneapolis, MN 55343
P: 763.210.6722

E-mail: kristineb@hdgi1.com

Ms. Betz has a master's degree in gerontology and is a board-certified gerontologist and licensed nursing home administrator. As a consultant at Health Dimensions Group, Ms. Betz's areas of emphasis include market research and strategy development. She has considerable experience in population health across a variety of senior care environments and expertise in conducting market and regulatory research and data analysis across the entire senior care continuum. Previously, Ms. Betz was the director of home and community-based services for a multi-campus senior care organization in Minnesota and lead development and start-up efforts to open the organization's first palliative care residence.

About Health Dimensions Group

Health Dimensions Group is a fully integrated senior living health care management and consulting firm. For more than 20 years, we have partnered with hospitals, health systems, and long-term care and senior living providers to help them meet the ever-changing needs in their markets and plan for the future, while maintaining a healthy bottom line. For more information, visit www.healthdimensionsgroup.com or call 763.537.5700.